



# Deaths in Mental Health Detention: An investigation framework fit for purpose?

## 2 Deaths in Mental Health Detention: An investigation framework fit for purpose?

For further information please contact: Deborah Coles, INQUEST  
Co-Director ([deborahcoles@inquest.org.uk](mailto:deborahcoles@inquest.org.uk))

With thanks to the Esmée Fairbairn Foundation and the Big Lottery Fund.

This report was written by Deborah Coles, Anna Edmundson and Ayesha Carmouche with the assistance of Helen Shaw and Tony Murphy, partner at Bhatt Murphy Solicitors. We also want to thank INQUEST caseworkers Anita Sharma, Selen Cavcav, Victoria McNally and Shona Crallan and the many families who shared their experiences with us.

# Contents

<b>Executive summary</b> .....	4
Terminology .....	4
Statistical background .....	5
The lack of independent investigation into deaths .....	5
Recommendations .....	6
<b>INQUEST’s expertise</b> .....	8
<b>Background – INQUEST’s work on deaths in mental health detention</b> .....	10
<b>The current investigation and inquest framework following deaths</b>	
<b>in mental health detention</b> .....	13
The impact of the right to life (Article 2, ECHR) .....	13
Investigations into the deaths of detained patients .....	15
Inquests into the deaths of detained patients .....	16
The Corporate Manslaughter and Corporate Homicide Act 2007 .....	17
Duty of Candour .....	17
<b>Statistics on deaths in mental health settings – INQUEST’s analysis</b> .....	19
Incomplete publicly-available statistics .....	19
Children in mental health settings .....	20
High numbers of deaths in mental health detention compared to	
those in police custody or prison .....	22
The numbers and circumstances of self-inflicted deaths .....	23
Higher number of self-inflicted deaths of women .....	24
Deaths following the use of restraint .....	25
Prevalence of “natural causes” deaths .....	25
<b>INQUEST’s work on deaths in mental health settings</b> .....	27
INQUEST’s and families’ experiences of investigations .....	29
Families’ experience of inquests .....	32
Funding family legal representation .....	36
<b>Other organisations’ views on the investigation of deaths in mental</b>	
<b>health detention</b> .....	39
<b>Conclusions and recommendations</b> .....	41
(1) Independent investigation of deaths .....	41
(2) Collation and publication of statistics .....	43
(3) Robust inquests and implementation of coroners’ recommendations .....	43
(4) Enabling family engagement .....	44
<b>Appendix 1 – Other models of investigation and family engagement</b> .....	44
The Prisons and Probation Ombudsman (PPO) .....	46
The Independent Police Complaints Commission (IPCC) .....	47
Family involvement in PPO and IPCC investigations .....	49

## Executive summary

INQUEST is the only charity working directly with the families of those who die in state detention and has a unique overview of the investigation and inquest process. For over 30 years INQUEST has drawn attention to the lack of public information about the number and circumstances of deaths in mental health settings and the closed nature of the investigation process. This is not a new problem but one largely hidden from public scrutiny, and the absence of transparency and accountability is a major cause for concern.

INQUEST provides advice and assistance to an increasing number of bereaved families whose relatives have died in mental health detention and who are concerned about the treatment and care of the deceased and the lack of rigour of subsequent investigations and inquests.

This report collates statistics, evidence and individual stories from INQUEST's monitoring, casework, research and policy work. It documents concerns about the lack of a properly-independent investigation system and the consistent failure by most NHSTrusts to ensure the involvement of families in investigations. Ultimately, it highlights the lack of effective public scrutiny of deaths in mental health detention that frustrate the ability of NHS organisations to learn and enact fundamental changes to policy and practice to protect mental health in-patients and prevent further fatalities.

The report identifies three key themes:

1. The number of deaths and issues relating to their reporting and monitoring.
2. The lack of an independent system of pre-inquest investigation as compared to other deaths in detention.
3. The lack of a robust mechanism for ensuring post-death accountability and learning.

### Terminology

The focus in this report is on deaths in mental health settings where the patient is either detained under the Mental Health Act 1983 (MHA) (under s.2, s.3 or pursuant to the provisions in Part III)<sup>1</sup> and those who are de facto detained whilst being treated "voluntarily" as informal patients. They are patients who are in hospital voluntarily but may be subject to provisions of the MHA should they try to leave. Both detained and informal patients are referred to as "in-patients" throughout this report.

1. Section 2 of the MHA contains a power to detain someone believed to be suffering mental disorder for assessment (and any necessary treatment). The order lasts for up to 28 days and cannot be extended or reviewed. Section 3 contains a power to detain someone for treatment of mental disorder. This order lasts for six months and can be renewed. Part III of the MHA contains sections relevant to decisions by criminal courts and prisons, including powers under ss.35 and 36 to remand an accused person to hospital for assessment/treatment; s.37 allows a crown court to impose a hospital order on a person convicted or found responsible for an offence; and s. 47 covers the "transfer direction", which authorises moving a convicted prisoner to hospital if they develop a need for mental health treatment whilst in custody.

## Statistical background

Our findings draw on statistical data from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), based at the University of Manchester, which publishes figures on both deaths of individuals detained under the MHA *and* those receiving in-patient treatment as informal patients. This is supported by information on detained patients' deaths from the Independent Advisory Panel on Deaths in Custody (IAP).

The number of deaths in mental health detention is high in comparison with other forms of custody. The most recent IAP figures show that out of 7,630 custody deaths recorded between 2000-2013, 4,573 deaths were of detained patients – making up 60% of the total numbers of all deaths in custody.<sup>2</sup> There were 282 deaths of detained patients in 2013, whereas the death toll for prisoners was 215, 15 for those in police custody or following police contact and 2 in immigration detention centres. Moreover, in 2012 the IAP reported a spike in detained patient deaths by 18% from the previous year. This increase in numbers was the highest since 2006.

The IAP has indicated a consistent trend in self-inflicted deaths of patients detained under the MHA, with an average of about 48 such deaths per year.<sup>3</sup> The figures for 2013 also show that over one-third (35%, n=42) of self-inflicted deaths in state custody were of patients detained under the MHA. Meanwhile, the July 2014 NCISH figures for in-patient deaths (individuals detained under the MHA and those receiving in-patient treatment as an informal patient) recorded that there was an average of 132 self-inflicted deaths per year between 2002 and 2012.<sup>4</sup>

Lastly, there has been a high rate of natural causes-related deaths between 2000 and 2013 amongst detained patients when compared to those in prison or police custody, with a rolling average of over 200 deaths every three years.<sup>5</sup>

## The lack of independent investigation into deaths

There is a glaring disparity between the manner in which deaths in mental health detention are investigated pre-inquest compared to those in other forms of state custody. Unlike deaths in police, prison or immigration detention or following contact with state agents – where the coroner's inquest is based on the independent investigation of the Independent Police Complaints Commission (IPCC) or the Prisons and Probation Ombudsman (PPO) – no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the inquest is reliant pre-inquest on the internal reviews and investigations conducted by the same trust responsible for the patient's care.

Since 2004 there have been significant improvements in the way that deaths in prison and police custody have been investigated, including more active participation of bereaved families in the investigation carried

2. Upcoming fourth statistical report by the Independent Advisory Panel (IAP) into deaths in custody between 2000 and 2013. The full report will be available here: [iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/statistics/](http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/statistics/)

3. Upcoming fourth statistical report by the IAP.

4. Combined figures for England and Wales from pp39 and 127 of *The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness (2014) Annual Report 2014: England, Northern Ireland, Scotland and Wales*, University of Manchester (2014). Available from [www.bbmh.manchester.ac.uk/cmhr/centrefor-suicideprevention/nci-reports/Annualreport2014.pdf](http://www.bbmh.manchester.ac.uk/cmhr/centrefor-suicideprevention/nci-reports/Annualreport2014.pdf).

5. Upcoming fourth statistical report by the IAP.

## 6 Deaths in Mental Health Detention: An investigation framework fit for purpose?

out by the PPO or IPCC. However, there have not been comparable developments in investigating deaths in mental health detention. Coroners themselves will attempt to investigate the circumstances of such deaths, but they have limited capacity and resources and without the pre-inquest support of an independent investigatory body may be unable to fully investigate systemic failings or to provide insight or guidance on the prevention of future deaths.

Bereaved families often struggle to be involved in internal investigations and face barriers to disclosure of basic information and relevant documents. It does not inspire family or public confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its own staff or systems. This lack of independence mirrors the discredited practices of the past following previous deaths in other forms of state detention.

In 2004, INQUEST welcomed the parliamentary Joint Committee on Human Rights' (JCHR) recommendation that there should be an independent body to investigate the deaths of people detained under the Mental Health Act pre-inquest. Since then, the courts have developed the law protecting the right to life of mental health patients; and in an effort to drive up standards, the government has published revisions to official guidance on the investigation of deaths in mental health detention. However, as demonstrated by the evidence in this report, this has not brought about the meaningful change that is necessary; and we conclude that the current investigation framework is not fit for purpose.

### Recommendations

We make a number of recommendations to address these shortcomings, including:



1. INQUEST recommends that a new, fully-independent system for investigating deaths in mental health settings be developed on a par with the way other deaths in state detention are investigated. In designing a new system, the models and experiences of independent investigation offered by the Independent Police Complaints Commission and the Prisons and Probation Ombudsman should be considered. A more open and learning culture could help to safeguard the safety of patients in the future.
2. Proper and meaningful involvement of families in the investigations into deaths in mental health settings. We recommend the development of a new approach to family involvement. This must be centred on transparency and communication, and policies and protocols should be developed to enshrine these commitments and practices. In addition, INQUEST re-iterates our recommendation that families should automatically be eligible for non-means-tested public funding for legal advice and representation following a death in a mental health

setting, to put them on an equal footing with the NHS Trusts and private providers that routinely instruct lawyers at these inquests.

3. Better collation and publication of statistics on deaths of mental health in-patients. INQUEST recommends the introduction of an agreed, coherent set of published statistics which includes all information necessary to provide an overview of the number and features of these deaths. This information would include characteristics such as age, gender, ethnicity and location of death; and type of death, e.g. self-inflicted, restraint-related or from “natural causes”.

4. The need for more robust inquests into these deaths and a better mechanism for ensuring implementation of coroner’s recommendations. INQUEST recommends that the Chief Coroner for England and Wales issues guidance to coroners setting out the requirements of Article 2 of the European Convention on Human Rights (ECHR)<sup>6</sup> in relation to deaths in mental health settings and clarifying what this means for the conduct of inquests. We also recommend that the Care Quality Commission and NHS England should work together to collate, analyse and publish an annual report drawing together all investigation, inquest jury and coroner conclusions and recommendations that have been made in respect to in-patient deaths in mental health settings of both detained and informal patients.

6. The right to life.

 It does not inspire family or public confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its own staff or systems. 

## INQUEST's expertise

1. INQUEST is the only charity in England and Wales that provides a free specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public.

2. Our specialist casework focuses on deaths in custody: in prison, in police custody and following police contact, in immigration and mental health detention – the latter is made possible with the support of Esmée Fairbairn Foundation and the Big Lottery Fund. Through our specialist casework service, INQUEST has worked with hundreds of family members who have been bereaved by a death in a mental health setting. Drawing on experience and evidence from casework, INQUEST has consistently raised concerns with government, parliamentarians and policy makers about the effectiveness of the state's investigative processes for identifying and rectifying dangerous practices and procedures to try and ensure that further deaths are prevented.

3. INQUEST is acknowledged as an expert in the field and is represented on the Ministerial Council on Deaths in Custody. The council was created in 2008 by the Ministry of Justice; it is part-funded by both the Department of Health and the Home Office. The first tier of this council consists of a Ministerial Board, of which INQUEST is a member. INQUEST's Co-Director Deborah Coles is also a founding member of the second tier, the IAP, whose independent experts are appointed by the Secretary of State for Justice and sponsored jointly by the Ministry of Justice, the Home Office and Department of Health.<sup>7</sup>

4. The combination of evidence-based casework, legal and policy work and INQUEST's multi-level campaigning was critical in persuading the government of the need for the independent investigation of police and prison deaths. It informed the creation of the Independent Police Complaints Commission and for the Prisons and Probation Ombudsman assuming responsibility for conducting investigations into fatal incidents in 2004. A similar independent investigative process is needed for deaths in mental health detention.



7. See <http://iapdeathsincustody.independent.gov.uk>



5. This report draws on INQUEST's casework and policy experience to collate statistics and information on deaths in mental health settings and their subsequent investigations and inquests.

6. This report touches on, but does not include a detailed discussion of, the deaths of mental health patients being treated in the community or the deaths of those who are (or should be) subject to the deprivation of liberty safeguards under the Mental Capacity Act 2005 and the Mental Health Act 2007. The treatment of those who have died and issues raised by the subsequent investigation process for both these groups gives rise to similar concerns, but deserves separate, dedicated reports.<sup>8</sup>

8. For more detailed analyses of the deaths of people with learning disabilities in hospital settings, see *Death by Indifference*, Mencap (2007) and the *Confidential Inquiry into premature deaths of people with learning disabilities*, Department of Health (March 2013) via [www.mencap.org.uk/campaigns/take-action/death-indifference](http://www.mencap.org.uk/campaigns/take-action/death-indifference). For details of the government's July 2013 response to the latter inquiry, please see [www.guardian.co.uk/society/2013/jul/12/no-review-board-deaths-learning-difficulties](http://www.guardian.co.uk/society/2013/jul/12/no-review-board-deaths-learning-difficulties)

 The combination of evidence-based casework, legal and policy work and INQUEST's multi-level campaigning was critical in persuading the government of the need for the independent investigation of police and prison deaths. 

## Background – INQUEST’s work on deaths in mental health detention

7. INQUEST has previously raised concerns about the deaths of detained patients, including the seminal cases of three black men in Broadmoor, Michael Martin (1984), Joseph Watts (1988) and Orville Blackwood (1991). These deaths followed the use of restraint and the forcible injection of tranquillising medication on patients detained under the MHA.

8. INQUEST also submitted evidence in March 1992 to the Ashworth Inquiry.<sup>9</sup> This government-led investigation into the multiple mismanagement and safeguarding failures at Ashworth high security hospital was an unprecedented insight into covert practices within mental health detention. In our submission to the Department of Health, we highlighted the secrecy surrounding a number of deaths which had taken place:

*Families’ experiences are characterised by lack of information, secrecy and often what they feel is indifference by the authorities and the institution in which the deceased has died. They have a desperate desire to know the circumstances of the death and to find out what has actually happened. What they feel is that they face a wall of silence. The system of finding out what happened is totally inaccessible.*

9. Following the death of David ‘Rocky’ Bennett in 1998, there was increased public and Department of Health focus on deaths in mental health settings. Mr Bennett was a 38-year-old black man who had been a detained patient in an NHS medium secure unit, the Norvic Clinic in Norwich, for three years. His death followed an incident involving the use of restraint. INQUEST worked closely with the family and their lawyers during the 2001 inquest where the jury unanimously decided that the cause of death was restraint asphyxia, returning a verdict of neglect. His death focused attention on widespread concerns about the treatment of people in detention and issues concerning racism in mental health settings, including an over-representation of people from BAME communities amongst those sectioned under the MHA and subject to coercive use of force, restraint and high levels of medication.

INQUEST worked with Mr Bennett’s family, lawyers and MP to persuade the Department of Health to hold an inquiry in public to examine the use of restraint across custodial settings and to look at what national

9. Committee of Inquiry into Complaints about Ashworth Hospital.

lessons should be learned. INQUEST's evidence to the Bennett Inquiry pointed out there is little, if any, opportunity for internal investigations to result in any kind of meaningful change unless the public has access to the (anonymous) results of those investigations. For this reason we urged the inquiry to comment on related investigation processes. INQUEST also drew attention to the lack of publication and dissemination of statistical information about deaths in mental health detention and the lack of information on deaths of people from BAME communities. The report of the Bennett Inquiry, published in December 2003, noted:

- There should be ministerial acknowledgment of the presence of institutional racism in the mental health services and a commitment to eliminate it.

10. The inquiry report also included two recommendations on transparency and investigations:

- Recommendation 11 stated that the Department of Health should collate and publish annually statistics on the deaths of all mental health in-patients, which should include ethnicity.
- Recommendation 22 stated that there was a need to review the procedures for internal inquiries by hospital trusts following the death of psychiatric patients, with emphasis on the need to provide appropriate care and support for the family of the deceased, as well as for staff members.<sup>10</sup>

11. In 2003, INQUEST submitted evidence to the parliamentary JCHR Inquiry into Deaths in Custody where we outlined the importance of independent investigations and noted:

*The deaths of detained patients remain shrouded in secrecy and are not in the public domain to the same extent as those that occur in police and prison custody. Of particular concern is the failure of government or any of its arms length bodies to even collate and publish annual statistical information about deaths of detained patients. The existing internal systems for examining and reporting these deaths are so poor that we believe some contentious deaths could escape any public scrutiny. And in relation to the inquest system there is no requirement for the coroner to sit with a jury – a matter that must be addressed in any forthcoming reform of the inquest system.*

12. In December 2004, the JCHR published their findings in their *Report on Deaths in Custody*<sup>11</sup> and recommended at para 340:

*In our view there is a case for a permanent investigatory body, with some level of overview of all cases, rather than ad hoc investigations in a few cases, in order to support Article 2 compliance. Since the case for such a body has been accepted in relation to police detention (with the establishment of the IPCC) and prison and immigration detention*

10. For example, see *Independent Inquiry into the Death of David Bennett*, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2004), available at [www.irr.org.uk/pdf/bennett\\_inquiry.pdf](http://www.irr.org.uk/pdf/bennett_inquiry.pdf)

11. *Deaths in Custody: Third Report of Session 2004-05 Vol I*, 2004

## 12 Deaths in Mental Health Detention: An investigation framework fit for purpose?

*(with powers of inquiry, albeit for the moment on a non-statutory basis, allocated to the Prisons Ombudsman) we can see no reason why deaths amongst this particularly vulnerable group of detained people should not be subject to a similar safeguard. [our emphasis]*

13. Following the JCHR recommendations, INQUEST continued to call for the independent investigation of deaths – particularly in the context of wider reform of the inquest system.<sup>12</sup> This led to the inclusion of clauses in the Coroners and Justice Act 2009 (CJA) which impose a duty on coroners to conduct a more thorough investigation into deaths in mental health detention<sup>13</sup> and stipulates that deaths in mental health detention which are “violent, unnatural or where the cause of death is unknown” should be scrutinised at inquests before a coroner sitting with a jury.<sup>14</sup> The provisions in the CJA on deaths in mental health detention came into force in July 2013.

12. INQUEST parliamentary briefing on the Coroners and Justice Bill, 2009.

13. s.1(2)(c).

14. s.7(2)(a).

“ Informal patients on mental health wards may be at just as much risk of suicide as detained patients and subject to equivalent levels of control. Yet NHS Trusts argued that these patients were not owed the same positive duty under the Human Rights Act...” ”

## The current investigation and inquest framework following deaths in mental health detention

14. The clarity provided by the Coroners and Justice Act 2009 that some deaths in mental health detention should be subject to more rigorous scrutiny as part of the inquest process is the latest in a series of developments which has strengthened the legal framework that protects the lives and safety of patients. However, this has done little to alter the independence of investigations pre-inquest. Hospitals still continue to investigate themselves for the months, sometimes years, before the inquest takes place and coroners continue to rely heavily on evidence gathered by the hospital.

### **The impact of the right to life (Article 2, ECHR)<sup>15</sup>**

15. Patients on mental health wards are at a particularly significant risk of suicide – for many it is the very reason for their admission – and are often extremely vulnerable because of their mental ill health. The public authority’s assumption of responsibility for vulnerable people is often total and includes the use of force and compulsory medical treatment. These factors have informed INQUEST’s work to ensure that deaths in mental health detention are subject to the same early scrutiny as deaths in other forms of state detention.

16. In 2008 INQUEST intervened (alongside Mind, JUSTICE and Liberty) in the landmark case of *Savage v South Essex NHS Trust*.<sup>16</sup> The House of Lords recognised that where mental health patients such as Carol Savage are detained under the MHA, the authorities have a positive duty under Article 2 of the ECHR to safeguard them from taking their own lives.

17. However, the law did not give the same protection to informal patients. For people who have experienced mental illness and self-harm, and for those who work closely with them, this seemed to be a glaring anomaly. Informal patients on mental health wards may be at just as much risk of suicide as detained patients and subject to equivalent levels of control. Yet NHS Trusts argued that these patients were not owed the same positive duty under the Human Rights Act because they were there by “choice”. INQUEST (with JUSTICE, Liberty and Mind) intervened in the test case challenging this position, which was brought by the parents of Melanie Rabone.<sup>17</sup> Ms Rabone had been admitted to hospital as an emergency patient following a suicide attempt and was undergoing

15. For more in-depth analysis, see Paul Bowen QC, “Article 2 and deaths in psychiatric settings following *Savage, Rabone and Reynolds*” in *Inquest Law*, Issue 24, July 2012.

16. *Savage v South Essex NHS Trust* [2008] UKHL 74.

17. *Rabone v Pennine NHS Trust* [2012] UKSC 2.

## 14 Deaths in Mental Health Detention: An investigation framework fit for purpose?

treatment for severe depression as an informal patient. There was a note on Melanie's file that if she tried to leave, she should be assessed under the MHA with a view to detaining her. Despite this, and against the wishes of her parents, she was granted leave from the ward. Shortly afterwards she took her own life. The internal investigation by the trust into Melanie Rabone's death took two years to complete, excluded her family (despite her father's attempts to secure involvement) and omitted key statements. The subsequent inquest lasted only half a day.

18. In February 2012, the legal position was clarified when the Supreme Court held that hospitals must ensure they take reasonable steps to safeguard the right to life of mental health patients in their care – regardless of whether they are detained or not – in circumstances where the authorities know or ought to know that there is a “real and immediate risk” to their life.<sup>18</sup> Relevant factors will include the vulnerability of the patient, the level of risk s/he posed and the degree of control exercised by the hospital over the patient

19. Following the deaths of in-patients where there has been or may possibly have been a breach of the duty to protect their lives, the state is under an obligation to conduct an investigation into the death. The Article 2 procedural obligations include:<sup>19</sup>

- ensuring that the full facts are brought to light;
- that culpable and discreditable conduct is exposed and brought to public notice, and those responsible are identified and brought to account;
- that suspicion of deliberate wrongdoing (if unjustified) is allayed;
- identifying and rectifying dangerous practices and procedures;
- ensuring that lessons are learned that may save the lives of others;<sup>20</sup>
- safeguarding the lives of the public, and reducing the risk of future breaches of Article 2.

20. The investigation into deaths that engage the right to life must meet minimum standards, including:<sup>21</sup>

- the investigation must be independent;
- the investigation must be effective;
- the next of kin must be involved to an appropriate extent;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the state must act of its own motion and cannot leave it to the next of kin to take conduct of any part of the investigation.

21. However, it is INQUEST's experience that inquests into deaths of in-patients are routinely not being conducted by coroners in a way that meets the core requirements of Article 2 (see paragraphs 65-67 of this report). The lack of an independent investigation pre-inquest hampers the ability to root out issues of system neglect or misconduct and also

18. The legal position was confirmed by the European Court of Human Rights in their ruling in *Reynolds v United Kingdom* (13 March 2012).

19. *R (on the application of Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653 at 31, 20(5), 41 and 62.

20. *R (JL) v Secretary of State* [2009] 1 AC 588, para 29.

21. *R (on the application of D) v. Secretary of State for the Home Department* [2006] All ER 946 at para 9 (iii).

jeopardises the welfare of future patients by failing to address such concerns.

### Investigations into the deaths of detained patients

22. There is no pre-inquest independent process in place for investigating deaths of those detained under the MHA.

23. The current system for NHS investigations of deaths of patients detained under the MHA is set out by various guidance documents. The National Patient Safety Agency (NPSA)<sup>22</sup> good practice guidance on the *Independent Investigation of Serious Patient Safety Incidents in Mental Health*<sup>23</sup> was published in 2008. This guidance augmented Health Service Guidance 94 (27),<sup>24</sup> issued in 2005. The process it creates for trusts includes:

- an initial internal management review within 72 hours;
- this is usually followed by an internal NHS mental health trust investigation which ordinarily takes the form of a Serious Untoward Incident (SUI) investigation (which is supposed to take place within 90 days);
- possible commissioning of independent investigations by Strategic Health Authorities (SHAs).<sup>25</sup>

24. Worryingly, existing guidance does not reflect the changes to the commissioning of health services that came into effect some time ago; so for example, current guidelines do not stipulate who is now responsible for conducting an investigation and how. There is an urgent need for updated guidance from the new statutory organisation, NHS England. In December 2013, the government tried to reassure parliamentarians that NHS England had been “working to make the investigation of deaths in hospital settings more independent. The work will conclude shortly, and guidance to NHS Commissioners will be published early in the New Year.”<sup>26</sup> Whilst this long-overdue work is welcome, it has yet to take place. Details of NHS England’s work are not in the public domain and have not included consultation with organisations such as INQUEST, members of the INQUEST Lawyers’ Group and, most importantly, the families we work with whose relatives have died in mental health detention. Without drawing on the knowledge of these groups with first-hand experience of the flaws in the current investigation process we are unconvinced any new guidance from NHS England will meaningfully address ongoing concerns.

25. The Department of Health does not publish the number of independent investigations that take place into deaths in mental health detention. INQUEST’s experience is that self-inflicted deaths are rarely if ever independently investigated pre-inquest. The only independent investigations into deaths in mental health detention in England, other than homicides, that we are aware of are those which took place into a

22. On 1 June 2012 the key functions relating to patient safety developed by the NPSA were transferred to the NHS Commissioning Board Special Health Authority and the NPSA was abolished. See [www.npsa.nhs.uk/corporate/news/transfer-of-patient-safety-function](http://www.npsa.nhs.uk/corporate/news/transfer-of-patient-safety-function)

23. [www.nrls.npsa.nhs.uk/resources/?EntryId45=59836](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836)

24. [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH\\_4104914m](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH_4104914m)

25. From 1 April 2013, NHS England took over from SHAs under new health commissioning arrangements.

26. See the response from the Minister for Policing, Criminal Justice and Victims, Damian Green MP, to questions raised in an adjournment debate led by Charles Walker MP in the House of Commons on 2 December 2013.

## 16 Deaths in Mental Health Detention: An investigation framework fit for purpose?

high-profile death caused by a detained patient being restrained by hospital staff<sup>27</sup> and into clusters of suicides by patients in one psychiatric unit.<sup>28</sup>

26. The Care Quality Commission (CQC) plays a limited role in monitoring deaths in mental health detention.<sup>29</sup> Providers are statutorily required (under the Health and Social Care Act 2008) to report all deaths of detained patients. No equivalent reporting requirement exists concerning the death of non-detained patients. The CQC receives between 300-500 notifications each year, and reviews 70-80 of these cases to identify any concerns that would require further regulatory action.<sup>30</sup> However, it does not assume an investigatory role following the deaths of detained patients.<sup>31</sup>

27. There is currently no specific NHS guidance on investigating the deaths of non-detained patients – some of whose deaths will engage Article 2 following the judgment in *Rabone*.<sup>32</sup>

### Inquests into the deaths of detained patients

28. An inquest is an inquisitorial fact-finding exercise, and is directed towards addressing four key questions: who the deceased was; and where, when and how they came by their death.

29. From 25 July 2013, the Coroners and Justice Act 2009 requires that deaths in mental health detention which are self-inflicted or involve the use of force are subject to a more thorough inquest and scrutiny by a coroner sitting with a jury. This development comes after judgments in the test cases of *Savage* and *Rabone* where it was held that self-inflicted deaths in mental health settings will engage the right to life protected by Article 2 (where detained or de facto detained). This means that in cases where Article 2 is engaged, investigations and inquests into these deaths are required to be thorough and far-reaching and the inquest must examine the broader question of “in what circumstances” the death occurred (so-called *Middleton*-type inquests).<sup>33</sup> Whether the Article 2 obligation to hold an enhanced inquest arises will depend on the individual facts and circumstances of each case. The new statutory requirement for enhanced inquests will not necessarily apply in all deaths of mental health in-patients – the provisions apply to deaths that are “violent, unnatural or where the cause of death is unknown”; so for example, it may not be applicable where an inpatient dies of “natural causes” unless there is evidence that, for instance, the treatment that they received did (or did not) contribute to their death.

30. Inquest juries now increasingly return narrative conclusions – particularly in complex death in detention settings. This is an inquest finding in which a jury can establish any disputed facts and give an explanation of what they think are the most important issues contributing to the death, including the identification of individual or systemic failings.

27. See the 2004 *Independent Inquiry into the Death of David Bennett*, p5.

28. See the 2012 review for Leicestershire Partnership NHS Trust by Professor Louis Appleby of eight suicides by in-patients between 2010-2012 in the Bradgate Unit, Glenfield Hospital. A redacted version of the report, provided following a Freedom of Information Act request, can be found at [www.leicspart.nhs.uk/\\_CommitmentstoCare-LouisApplebyreportandLPTresponse.aspx](http://www.leicspart.nhs.uk/_CommitmentstoCare-LouisApplebyreportandLPTresponse.aspx)

29. The CQC absorbed the former Mental Health Act Commission and, whilst the MHAC did not actively investigate all contentious deaths as they could have, they had automatic “properly interested person” status at inquests and were able to monitor inquests into deaths of detained patients.

30. Healthcare Inspectorate Wales is notified by all hospitals across Wales of the deaths of patients detained under the MHA and has also been reviewing its processes for the review of deaths. See: *Monitoring the Use of the Mental Health Act in 2009-2010*, Healthcare Inspectorate Wales, March 2011, paras 1.22-1.24.

31. The CQC confirmed this position at the February 2013 meeting of the Ministerial Board on Deaths in Custody: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/04/Bulletin-of-the-Twelfth-Ministerial-Board-12-February-2013.doc>

32. Decision in the case of *Rabone v Pennine Care Trust*, information available at IAP website: <http://iapdeathsincustody.independent.gov.uk/news/supreme-court-decision-in-the-case-of-rabone-v-pennine-care-nhs-trust/>



33. See the House of Lords judgments in *R (on the application of Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653 and *R (Middleton) v Secretary of State for the Home Department* [2004] 1 WLR 796.

34. Deborah Coles and Helen Shaw, *Learning from Death in Custody Inquests: A New Framework for Action and Accountability*, INQUEST (2012).

35. See Paragraph 7 of Schedule 5, Coroners and Justice Act 2009. Details of the procedures are set out in Regulations 28 and 19 of the Coroners (Investigations) Regulations 2013. All Reports to Prevent Future Deaths (formerly known as Rule 43 reports) and responses must be sent to the Chief Coroner. In most cases the Chief Coroner will publish the reports and responses on a dedicated website, [www.judiciary.gov.uk/about-the-judiciary/office-chief-Coroner/pfd-reports/index](http://www.judiciary.gov.uk/about-the-judiciary/office-chief-Coroner/pfd-reports/index). The Ministry of Justice publishes a *Summary of Reports and Responses under Rule 43 of the Coroners Rules* containing short summaries of Rule 43 reports. However, these are filtered, scant in detail and not a comprehensive overview of the reports.

36. Available from [www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/](http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/)

37. Section 2(1).

38. In July 2012, the Bradgate Unit at Glenfield Hospital in Leicester was investigated by police to determine whether a criminal offence under the CMHA had been committed in relation to a series of self-inflicted deaths and previous coroners' recommendations on staffing levels on the unit. No charges were brought.

Narrative conclusions can:

*...act as a valuable learning tool for state agencies responsible for implementing policy and practice and make a significant contribution to the prevention of similar future fatalities. Common subjects ... now include delays in discovering a self-suspension; identifying key systemic communication failures between different professionals and other system failures; lack of first aid training; delays in arranging transfer to hospital; and the non-availability of suitable emergency equipment.*<sup>34</sup>

31. Under the new legal framework in force from July 2013,<sup>35</sup> coroners now have a duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. These Reports to Prevent Future Deaths (PFDs) replaced Coroner's Rule 43 reports. Typically, they are used by coroners to address failures in the system brought to light by evidence during the inquest. A person or organisation who receives a report must now send the coroner a written reply within 56 days outlining what action has been taken in response to the report, or giving an explanation if no action has been taken. PFDs relating to mental health deaths can be found on the Office of the Chief Coroner's website.<sup>36</sup>

32. With the implementation of the CJA, the inquest system is undergoing a period of change. This, together with the developing case law on the application of the right to life, means that there are significant changes in the way that coroners and inquests scrutinise the deaths of mental health in-patients. In parallel with a new, more standardised and thorough approach to inquests into deaths in mental health detention, it is timely to consider how the pre-inquest investigation of deaths is conducted. This report is intended to contribute to that discussion.

### **The Corporate Manslaughter and Corporate Homicide Act 2007**

33. In future, repeated failures by hospitals and others to address known flaws in (for example) unit safety may well be open to more scrutiny in light of the Corporate Manslaughter and Homicide Act 2007 (CMHA).<sup>37</sup> The CMHA came into force in September 2011 and creates a new legal framework in which custodial agencies (including mental health hospitals and authorities) should receive and respond to the findings of investigations and inquests.<sup>38</sup> It is also to be welcomed that the health and safety issues presented by these deaths are increasingly being examined by external agencies, including the Health and Safety Executive (HSE).

### **Duty of Candour**

34. Our argument for more scrutiny of deaths in mental health settings supports other recent developments to improve openness in health care.

## 18 Deaths in Mental Health Detention: An investigation framework fit for purpose?

November 2014 saw the introduction of the statutory duty of candour – a legal duty to be open and honest with patients or their families when things go wrong that can cause harm. Unnatural and/or unexpected death would be understood by most people to be the ultimate harm. The creation of the duty of candour followed decades of campaigning by patient safety and justice campaign Action against Medical Accidents (AvMA) and a recommendation from Sir Robert Francis following the Mid Staffordshire public inquiry. The duty applies to all NHS Trusts and is regulated by the Care Quality Commission, which can sanction trusts who do not comply including, ultimately, criminal sanctions.

35. The duty of candour is one of a set of statutory fundamental standards contained in the CQC regulations under the Health and Social Care Act 2012. It applies to all NHS trusts in England from 27 November 2014 and will be extended in April 2015 to cover GPs and other primary care practitioners, private healthcare and social care providers registered with the CQC. This duty challenges a closed culture of complacency where it has been possible for the NHS to ignore coroner's reports<sup>39</sup> as we argue and to rely on internal investigations rather than ensuring there is a robust mechanism to support learning from serious untoward incidents to improve patient safety. Introducing independent investigations following deaths would complement this move towards greater transparency and be supportive of wider culture change that would not only support good practice but could also potentially save lives.

39. Tanya Claridge, Gary Cook and Richard Hale, "Organizational learning and patient safety in the NHS: An exploration of the organizational learning that occurs following a coroner's report under Rule 43", *Clinical Risk*, Vol 14, No 1, January 2008, pp8-13.

“ Unnatural and/or unexpected death would be understood by most people to be the ultimate harm. ”

## Statistics on deaths in mental health settings – INQUEST’s analysis

36. There is currently no single, complete and coherent set of data on the number of deaths in mental health settings in England and Wales, with differing sets of statistics focussing on different groups of patients. The most comprehensive data is gathered by:

- The IAP, in response to concerns about the high numbers of deaths in mental health detention, published their first comprehensive statistical bulletin in 2011 containing details of the deaths of detained patients,<sup>40</sup> which has since been updated on an annual basis. Their most recent statistics cover the period 2000 and 2013, and are based on data supplied by the Care Quality Commission. It must be stressed that these figures only relate to those detained under the MHA and *not* those individuals who are non-detained patients in a mental health setting.
- The NCISH annual report<sup>41</sup> analyses and publishes some figures on deaths, including both individuals detained under the MHA *and* those receiving in-patient treatment as an informal patient.

37. The monitoring and analysis of statistical data across different custody settings is an important part of INQUEST’s specialist work on the deaths of those detained by, or in the care of, the state. For the purposes of this report, we have attempted to analyse the available figures on the deaths of mental health in-patients (both detained and de facto detained) to understand what they reveal about trends and possible underlying issues.

Our analysis has produced the following observations:

### **(i) Incomplete publicly-available statistics**

38. The IAP figures reveal that there were 36 deaths of detained patients where the cause of death was “unknown” in 2010, 55 in 2011, 37 in 2012 and 42 in 2013.<sup>42</sup> This category includes those deaths categorised by the CQC as “Method unclear/other”, “Not known/unascertained” or “Awaiting information”. The figures in this category are subject to change as further information is received and deaths are re-classified following inquest hearings. However, it is of concern that there are a significant number of deaths in mental health detention where details of the cause of death are not forthcoming at an early stage, which could alert authorities to any trends emerging and enable preventative measures to be taken.

40. The IAP’s *Statistical Analysis* for 2011 and 2012 are available here: <http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/statistics/>

41. Available from [www.hqip.org.uk/assets/NCAPOP-Library/CORP-Library/NCISH-Annual-Report-pub-July-2012.PDF](http://www.hqip.org.uk/assets/NCAPOP-Library/CORP-Library/NCISH-Annual-Report-pub-July-2012.PDF)

42. See 2011 and 2012 IAP *Statistical Analysis*.

## 20 Deaths in Mental Health Detention: An investigation framework fit for purpose?

39. The statistics that are currently available in the public domain do not enable identification and analysis of *where* deaths in mental health settings take place, as statistics on death rates in individual units or by Clinical Commissioning Group area are not published. For example, between November 2010 and June 2012 there were 8 self-inflicted deaths of patients under the care of the Bradgate Unit in Glenfield Hospital, Leicester.<sup>43</sup> Professor Louis Appleby was commissioned by the Leicestershire Partnership Trust in 2012 to provide advice following the deaths, with the subsequent report providing important information about the demographics and statistics of the patients' deaths. The report was eventually published, albeit only after a Freedom of Information Act (FOI) request, and proved important in pinpointing institutional failures and ways to counteract problems for specific hospitals. It is clear from the Appleby Report that a large amount of useful data is collected by the NCISH, including age, legal status, leave arrangements, observation levels, place of death and method of suicide.<sup>44</sup>

40. Except by way of targeted FOI requests, there is currently no system for coroners or families to access information and statistics to check the number or nature of deaths that have occurred in specific settings (unlike other custodial deaths where this information is published). This means that patterns of deaths in individual hospitals or units which merit closer examination may escape public scrutiny.

41. The lack of publicly-available data is particularly concerning in relation to ethnicity where, as discussed earlier in this report (see paragraphs 7-9), there have been significant questions raised about an over-representation of black people in mental health settings and the coercive use of force that features in some of their deaths.

### (ii) Children in mental health settings

42. There has been concern about cuts to children's mental health services, both in terms of early prevention services and children and young people being placed on adult wards at long distances from home. It has also been impossible to identify the number of children who have died in a mental health setting from the current statistics. This denies an essential tool for oversight and monitoring of a highly-vulnerable group. The NCISH figures do not include details of the ages of those who die. The IAP figures, which relate to detained patients, currently only provide details on the 11-20 age group, with no breakdown for those under 18.<sup>45</sup> In effect, this lack of data undermines the specific rights of protection and care afforded to children outlined by the United Nations Convention on the Rights of the Child. INQUEST has raised this issue with the Children's Commissioner for England and recommended that the death of a child in a mental health setting should be reported directly to them in the same way that a similar death in a custodial setting would be.

43. Since the review was conducted there have been two further self-inflicted deaths of Bradgate Unit patients, in December 2012 and January 2013.

44. A redacted version of the November 2012 report by Professor Appleby for the Leicestershire Partnership Trust is available here: [www.leicspart.nhs.uk/Library/FOI\\_1213\\_443\\_RESPONSE\\_ReportbyTheNationalConfidentialEnquiryintosuicidesatLeicestershirePartnershipNHSTrust.pdf](http://www.leicspart.nhs.uk/Library/FOI_1213_443_RESPONSE_ReportbyTheNationalConfidentialEnquiryintosuicidesatLeicestershirePartnershipNHSTrust.pdf).

45. In correspondence with INQUEST, the IAP has confirmed that they are committed to stratifying the age group more informatively to show children and the 18-20 group.



The police conducted little or no investigation and concluded within 24 hours that no further action would be taken. ”

43. At the time of writing, INQUEST is working on four child deaths in mental health settings:

- Christopher Brennan, who died aged 15 at Bethlem Hospital, London on 31 August 2014. He was an in-patient in a locked ward, and died following an incident of self-harm. There has been no independent investigation into his death.
- 17-year-old Sara Green died at the Priory Hospital, Cheadle Royal in Cheshire. In this case there are numerous on-going investigations, including an HSE investigation and Serious Case Review. The family have had some involvement in the latter.
- Emma Carpenter died aged 17 in December 2006, weighing just over 25.5kg/4 stones. She was sectioned at Queens Medical Centre, Nottingham at the time of her death, supposedly receiving treatment for an eating disorder. The investigation carried out by the trust was not independent and an eating disorders expert suggested by the family was not allowed into the investigation as a panel member. Five years on from her death, the coroner finally agreed to hold an inquest, which is expected to be heard around March 2015.
- 14-year-old Amy El-Keria died on 13 November 2012, shortly after being admitted to the Priory Hospital Ticehurst in Sussex.

#### CASE STUDY

14-year-old Amy El-Keria had a history of complex mental and physical health issues including Tourette's, obsessive-compulsive, attention deficit and gender identity disorders and possibly Asperger's Syndrome. Her family had been fighting for years to get the help and support they needed to address her needs.

Amy was found on 21 August 2012 in her room at home with a ligature around her neck. Her family believed this was a call for help and agreed that Amy should be assessed in a psychiatric hospital to enable a better understanding of her difficulties and clarification of her pharmacological and therapeutic needs.

With the consent of her mother, Amy was admitted as a voluntary patient to a privately-run psychiatric unit, The Priory Ticehurst House near Hastings. This was her first admission to hospital. Apart from periods of home leave, Amy remained at this clinic until her death.

Amy was said by the hospital to be on 15-minute observations at the time of her death. According to hospital accounts, staff found Amy collapsed in her room at around 8.15pm on 12 November 2012 with a ligature around her neck. An ambulance was called and paramedics managed to resuscitate her. She was taken by ambulance to hospital. Clinical staff failed to travel with Amy or to notify her family of what had taken place; they were not told what had happened until 11pm. Amy was pronounced dead in the early hours of the following day.

Amy's case raises serious questions concerning her treatment and care by the clinic, including: their contact and communication with her family; her overall treatment; medication; therapeutic care; the use of restraint; the adequacy and quality of observations; the management of risk including

## 22 Deaths in Mental Health Detention: An investigation framework fit for purpose?

risk assessments; the management and safety of the environment; and search policies. Other questions also arise around staffing levels, the adequacy of consultant input, the supervision of nursing staff, compliance with key policies and record keeping.

INQUEST has been working closely with the family throughout the inquest process to ensure they are legally represented and supported during this extremely traumatic time.

The Priory refused to conduct an independent investigation. The Serious Incident Investigation that followed Amy's death was conducted by another part of The Priory Group. The final report has been highly criticised by the family for failing to address many of the gaps and failures in the care that Amy received, and also for the conflicts in evidence and failures and/or irregularities in record keeping and compliance with policies. The police conducted little or no investigation and concluded within 24 hours that no further action would be taken.

Amy's inquest will be the family's only opportunity for an independent and detailed examination of the circumstances surrounding her death. It will be the first and only time that staff involved in Amy's care are required to give an independent account of their actions.

The coroner has overseen shocking delays in the inquest into Amy's death, which has caused inevitable distress to the family, and was very slow to rule on the issues of Article 2 and whether or not to have a jury or to order disclosure. The coroner has recently ruled that Article 2 applies, but that the inquest will be held without a jury. More than two years since Amy died, there is still no date for the inquest hearing.

44. Finally, the published statistics do not identify whether the death has occurred in a public or privately-run institution, which is highly relevant to monitoring the performance and conduct of private companies. This is concerning both as private providers may not be subject to the provisions of the Freedom of Information Act (so it is difficult to find alternative ways to source this data) and because of the growing numbers of mental health patients being placed in privately-run services. Recently-obtained data from 23 of the 58 mental health trusts in England revealed that the number of patients funded for out-of-area care by private services rose by a third between 2011-12 and 2012-13.<sup>46</sup> It is particularly relevant in the context of child deaths, given the large number of private companies providing in-patient mental health services for children and adolescents.

### **(ii) High numbers of deaths in mental health detention compared to those in police custody or prison**

45. The IAP figures record that in the 14-year period from 2000 to 2013 there were a total of 4,573 deaths, giving an average of 327 deaths in mental health detention each year.<sup>47</sup> This is significantly more than the average of 178 deaths in prison and 24 deaths in police custody each year during the same period.

46. In 2012 there was a considerable increase in detained patient deaths of 18% from the previous year, where 341 individuals died compared

46. See "Concern as number of mental health patients placed in private hospitals rises by a third", Andy McNicoll, *Community Care*, 23 April 2013.

47. Upcoming fourth statistical report by the IAP.

48. Upcoming fourth statistical report by the IAP.

49. Upcoming fourth statistical report by the IAP.

50. NCISH annual report (2014).

51. NCISH annual report (2014), combined figures for England and Wales from pp39 and 127.

52. NCISH annual report (2014), combined figures for England and Wales from pp40 and 127.

53. See Table 3, *Report by the National Confidential Inquiry into suicides at Leicestershire Partnership NHS Trust*, pp8-9: [www.leicspart.nhs.uk/Library/FOI\\_1213\\_443\\_RESPONSE\\_ReportbyTheNationalConfidentialEnquiryintosuicidesatLeicestershirePartnershipNHSTrust.pdf](http://www.leicspart.nhs.uk/Library/FOI_1213_443_RESPONSE_ReportbyTheNationalConfidentialEnquiryintosuicidesatLeicestershirePartnershipNHSTrust.pdf)

54. *Report by the National Confidential Inquiry into suicides at Leicestershire Partnership NHS Trust*, p37.

55. NCISH annual report (2014), combined figures for England and Wales from pp39 and 127.

56. *Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2012*, IAP (2014), p22. Available from <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/IAP-Statistical-analysis-of-recorded-deaths-2000-to-2012-Publication.pdf>

57. These figures should be viewed with some caution. In 2009, there were 23 deaths where the cause of death was unknown, 36 in 2010 and 55 in 2011. It is likely that the figures for self-inflicted deaths of detained patients may increase once reclassified.

with 289 the year prior. Over the 14-year period between 2000-2013, there has been a downward trend in deaths, but still the number of deaths in mental health settings account for 60% of all deaths in state custody.<sup>48</sup>

### (iii) The numbers and circumstances of self-inflicted deaths

47. IAP figures record that, of the 119 self-inflicted deaths in state custody in 2013, over one-third (35%, n=42) were patients detained under the MHA.<sup>49</sup> Longitudinal data from 1 January 2000 to 31 December 2013 shows that the average number of self-inflicted deaths of patients detained under the MHA has remained relatively stable over the period at about 48 such deaths a year.

48. July 2014 NCISH figures for in-patient (individuals detained under the MHA and those receiving in-patient treatment as an informal patient) deaths recorded that between 2002 and 2012 there were 1,445 in-patient deaths by suicide in England and Wales,<sup>50</sup> representing an average of 132 deaths per year.<sup>51</sup> During the same period, the number of self-inflicted detained patient deaths in England and Wales was 373 – an average of 34 per year.<sup>52</sup>

49. Figures gathered as part of the NCISH survey record that informal patients accounted for 75% (n=1,108) of the 1,493 suicides of in-patients in England between 2000-2009.<sup>53</sup> This gives an average of 111 deaths of informal patients per year.

50. The same figures<sup>54</sup> record that:

- 65% of inpatients were on low observation levels at the time of their death (compared to only 3% who died whilst on high observation);
- 29% of deaths occurred on the ward and 68% of the deaths took place off hospital grounds;
- yet only 52% of inpatients who died had leave that had been agreed at the time of their death and more than a third (36%) were absent without leave.

51. The most recent publicly-available NCISH figures also document that between 2002 and 2012, 315 in-patients in England and Wales died by hanging or strangulation on the ward (accounting for 22% of in-patient suicides).<sup>55</sup>

### (iv) Higher number of self-inflicted deaths of women

52. According to the IAP's figures for 2012, women accounted for 43% of the self-inflicted deaths in mental health detention that year (whereas 98% and 100% of self-inflicted deaths were carried out by men in prison and police custody respectively).<sup>56</sup> Over a four-year period there was a steep rise in the numbers of self-inflicted deaths of women, with 7 deaths in 2009, 17 in 2010, 15 in 2011 and 22 in 2012.<sup>57</sup>

#### CASE STUDY

Rebecca Overy was just 18 when she was found collapsed with a ligature around her neck on 23 June 2013 in Annesley House, a privately-run adult secure hospital in Nottingham.

Rebecca had a history of mental health problems and self-harm, and was initially detained under the Children's Act at the age of 13. After she turned 14, she was re-diagnosed with a condition that met the criteria to hold her under the Mental Health Act. As she approached her 18th birthday, she was finally making progress at a private hospital in Woking where she was being treated, and plans were being made for her eventual release. She had secured a college place to study animal welfare and her mother had found her voluntary work at an animal charity. Whilst she was in this hospital, she was allowed on frequent outings with her mother where they would go shopping together. Her room in the unit looked like a typical teenager's room. She had posters on her wall and would listen to music. It was her music which got her through the day.

The decision to transfer her to an adult unit a day after she turned 18 came as a shock to her family and also to Rebecca. Sadly, funding was withdrawn for her to continue to stay in her existing unit a bit longer until transitional arrangements were made. When Rebecca arrived at Annesley House, her CD player was taken away and she was placed in a unit where she was surrounded by older women. Her family described the environment where she found herself more like a prison than a caring environment. Over the following weeks, the family watched in desperation as her spark disappeared.

Following her death, it became apparent that from her admission onwards she had 42 incidents of self-harm and had to be restrained on a substantial number of occasions. During this time she was repeatedly tying ligatures, swallowing batteries and choking on objects. At the time of her death, the Care Quality Commission was also investigating allegations of bullying and abuse by both patients and staff at Annesley House.

An internal investigation was carried out by Partnerships in Care, the private company running the clinic, but the family had no opportunity to get involved with this investigation.

The inquest into Rebecca's death revealed multiple failures: a long history of suicide and self-harm which escalated after her speedy transition to adult mental health care, coupled with the cancellation of visits and tight restrictions. Another conclusion reported that reduced observations, from constant to every five minutes, gave her the window of opportunity to prepare a ligature.

Rebecca's mother and step-father stated at the conclusion of the inquest:

*Following the inquest into Rebecca's death the healthcare professionals have all moved on with their lives, but we will not ... Unfortunately, for us they obviously had lessons to learn so they took away our beautiful daughter, our future family, our future grandchildren and our world will always be a darker place because of what they did NOT do for our precious Rebecca.*



**(v) Deaths following the use of restraint**

53. Despite the recommendations following the death of David ‘Rocky’ Bennett, it is disturbing that patients continue to die in psychiatric units as a result of being subject to physical restraint. A recent report by Mind also points to a “staggering” variation in the use of restraint in mental health trusts, inconsistent reporting and a lack of progress in the regulation and minimisation of its use.<sup>58</sup> According to the 2013 IAP bulletin, the majority of restraint-related deaths are of patients detained under the MHA, making up 78% (48) of all such deaths between 2000 and 2013.<sup>59</sup> IAP figures should be viewed with caution; they do not include informal patients and are based on CQC statistics that in turn rely on information received from the trusts. What we also cannot know from the statistics as currently collected is the number of deaths which are directly linked to the use of restraint. This is particularly problematic as the CQC statistics register restraint that occurred any time in the seven days before a death, making it difficult to identify if the restraint contributed to the death. Meanwhile, the NCISH has indicated that between 2002 and 2012 they were notified of 24 deaths within 24 hours of restraint in England and Wales; 6 of which occurred within 1 hour of restraint.<sup>60</sup> This array of confusing statistics only serves to obscure the true picture of restraint-related deaths in mental health settings.

54. INQUEST has highlighted how a disproportionate number of people from BAME communities and/or those with mental health problems have died following the use of force, raising questions about discriminatory treatment and the attitudes and assumptions by some practitioners about the propensity of violence of particular groups of people.

**(vi) Prevalence of “natural causes” deaths**

55. The majority of detained patients’ deaths are ascribed to “natural causes”: 57% of total deaths from natural causes (190 out of 331) in 2013 were of patients detained under the MHA.<sup>61</sup> Earlier figures also record that from 2000 to 2012, 3,270 detained patients died from natural causes (compared with 1,212 such deaths in prison and 133 in police custody).<sup>62</sup>

56. This classification covers a broad range of circumstances and includes those where death was inevitable, where there were poor levels of physical health care and those deaths that could be viewed as preventable or avoidable. Many deaths in prison in this category currently result in critical comment or recommendations from investigative bodies and inquests about the treatment received by the person who died and the potential preventability of their death. Deaths of mental health in-patients from natural causes may raise complex causative issues, given the side-effects of high-dose, multiple medication on individuals’ physical health.

58. See *Mental Health Crisis Care: physical restraint in crisis*, Mind (2013). Available from [www.mind.org.uk/assets/0002/5642/Physical\\_restraint\\_FINAL\\_web\\_version.pdf](http://www.mind.org.uk/assets/0002/5642/Physical_restraint_FINAL_web_version.pdf)

59. Upcoming fourth statistical report by the IAP.

60. NCISH annual report (2014), p17.

61. Upcoming fourth statistical report by the IAP.

62. IAP, *Statistical Analysis* (2014), “Table 7: Number of natural cause deaths, broken down by gender across custodial sectors: 2000-2012”, p27.

## 26 Deaths in Mental Health Detention: An investigation framework fit for purpose?

57. The treatment of the physical health needs of mental health patients has been raised as a matter of concern for some years. Analysis of recent trends within the IAP statistics show a downward trend, whereby the number of deaths from natural causes had decreased from 268 in 2009 to 212 in 2013.<sup>63</sup> Yet, while this is welcome progress, context must be given, and it remains crucial to focus on the huge disproportionality of these deaths in mental health settings. INQUEST hopes that both the government and public service providers will place greater emphasis on better screening and the treatment of physical health problems of detained mental health patients.<sup>64</sup> For example, an inquest into the death in 2011 of a patient at the Grafton Unit of St Andrews Hospital in Northamptonshire found that it was the result of natural causes. However, serious questions about the monitoring and treatment of the patient's physical health were raised when it emerged recently that this was one of four deaths of patients over a seven-month period where the use of anti-psychotic drugs were possible contributory factors.<sup>65</sup>

63. The IAP has warned that this reduction should be viewed with some caution, given the numbers of deaths where the cause is currently "unknown". It is likely that figures for natural causes deaths of detained patients may increase once re-classified.

64. For example, the mandate to the NHS Commissioning Board contains a specific focus on improving the physical health of mental health patients: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://mandate.dh.gov.uk/2012/11/13/nhs-mandate-published/>. There is also increased activity by the relevant professional bodies to raise the profile of this issue, supported by the Mental Health Implementation Framework which sets out what organisations can do to implement the six high-level objectives of the mental health strategy, *No Health without Mental Health* ([www.gov.uk/government/publications/national-framework-to-improve-mental-health-and-wellbeing](http://www.gov.uk/government/publications/national-framework-to-improve-mental-health-and-wellbeing)). Work by the CQC to re-analyse natural causes deaths of detained patients and access to a richer source of data on natural causes deaths through the new Mental Health Minimum Data Set should help identify and prevent more unnecessary deaths from "natural causes" in the future.

65. For more details, see [www.guardian.co.uk/society/2013/jul/07/call-inquiry-deaths-psychiatric-hospital](http://www.guardian.co.uk/society/2013/jul/07/call-inquiry-deaths-psychiatric-hospital)

## INQUEST's work on deaths in mental health settings

66. As well as INQUEST's case files and work with bereaved families and their legal representatives, the sources used to draw up these individual stories include any SUI or other investigation reports, witness statements and legal notes from the inquest hearings, narrative verdicts and coroners' Rule 43 reports.

58. These general statistics form a helpful backdrop to understand the themes emerging from INQUEST's specialist casework and this section of the report includes four individual stories of men and women who have died in mental health detention since 2008.<sup>66</sup>

59. Analysis of INQUEST's recent casework queries reveals that:

- Between 2009 and 2014, INQUEST's caseworkers worked on 144 cases involving mental health in-patient deaths.
- 40% of this caseload concerned the deaths of women.
- There has been a sharp increase in the number of families contacting us for advice after deaths in mental health detention with the specialist casework service delivered to families on 16 new cases in 2011; 32 in 2012; 35 in 2013 and 49 in 2014.
- INQUEST's caseworkers also gave advice on a large number of queries about mental health-related deaths in the community – particularly those involving potential failures by crisis mental health teams or the absence of available support services. From January 2011 to December 2014 alone, INQUEST handled 185 requests for advice in relation to these deaths.

60. Common features in many of those individual deaths and, more broadly across our specialist casework, include:

- No independent pre-inquest investigation to allow for a thorough inquiry into a contentious death.
- Lack of support and information to bereaved people following a death.
- Lack of understanding by some coroners about their responsibilities to hold Article 2 inquests.
- Poor systems of information sharing and communication.
- Failures of understanding and compliance with basic policies and procedures, including around risk assessment and observations.
- Poor record keeping.
- Inadequate staffing levels and inappropriate skill mixes needed to ensure the safe care of patients (including the use of agency staff unfamiliar with patients and procedures).
- Inadequate levels of clinical oversight.
- Inadequate treatment and response to dual diagnosis needs.



The hospital conducted a Serious Untoward Incident investigation, but the family were not included or informed of the investigation when it took place, and have been refused disclosure of the investigation report.”

## 28 Deaths in Mental Health Detention: An investigation framework fit for purpose?

- Poor understanding around the processes and duties applying to non-detained patients.
- Poor treatment of physical health.
- High levels of absconson and poor implementation of missing person policies.
- Poor application of search policies.
- Poor input and communication with families, particularly around care and risk factors.
- Unsafe environments (including access to ligature points on wards and units).
- Inadequate emergency medical responses and both a lack and poor use of emergency lifesaving equipment (for example, limited access to ligature cutters or working defibriliators).
- Failures around training and learning.

### CASE STUDY

Natasha Raghoo was 34 when she died on 5 May 2012. Natasha had a history of bipolar disorder and received care from the South London and Maudsley NHS Trust (SLAM). On 25 April 2012, recognising the signs of a relapse, Natasha contacted SLAM who were to provide medical care in the family environment. Instead, the police were called and she was detained under s136 of the MHA at her home. Despite her family being present, who were familiar with her condition, the police acted aggressively in taking her into custody, to such an extent that Natasha was on the floor backing away from the police in fear.

Without consulting Natasha's family, the police transferred her to the Queen Elizabeth Hospital in Woolwich. The hospital was some distance from her home as no other place of safety suite was available nearby. She was then transferred to The Dene secure unit in West Sussex as a voluntary in-patient, and it was there that she showed increasing signs of agitation and distress.

During her time in hospital, Natasha's physical health deteriorated rapidly; she became dizzy, incoherent and her tongue was swollen. On the morning of 5 May 2012, she was found in her room foaming at the mouth. Paramedics were called but they were unable to resuscitate her.

The initial police conclusion was that Natasha had died of an allergic reaction as a result of a nut allergy. However, her family believes she died from a reaction to the medication which the medical staff had prescribed her. The official cause of death was anaphylactic shock from an unknown allergy.

The family raised concerns about the lack of continuity of care provided to Natasha, and the fact that her own concerns were ignored by staff at The Dene. Very distressingly for the family, the hospital did not notify them when Natasha died. The hospital conducted a Serious Untoward Incident investigation, but the family were not included or informed of the investigation when it took place, and have been refused disclosure of the investigation report.

The inquest was held on 13 February 2014, following which the coroner produced a critical report of Natasha's care preceding her death, highlighting in particular the lack of sharing of patient information amongst staff, inadequate staff training, insufficient observations of Natasha and poor communication with the family.

### INQUEST's and families' experiences of investigations

61. Recent inquests, including those into the deaths outlined in the individual stories in this report, have exposed the serious anomaly that exists when someone dies in mental health detention.

“ It cannot inspire family or public confidence to have a hospital investigate itself over a death that may have been caused or contributed to by failures of its own staff or systems. This mirrors the discredited practices of the past with police investigating police and internal prison service investigations prior to the establishment of the IPCC and PPO ... [it is] iniquitous that institutions responsible for the treatment and care of mentally ill people should not be subject to similar scrutiny. ”

62. INQUEST's experience is that the practice of NHS Trusts in investigating these deaths, and the issues raised by them, is consistently falling short of the existing guidance, quite apart from the requirements of Article 2 and practice in other custodial settings. This was well illustrated during our discussions with a mental health trust that is held out as an example of good practice within the NHS. At that trust, the unit co-ordinating investigations into deaths of detained patients and liaising with families operates as a separate business unit from the service unit under investigation, although within the same trust. “Independent” investigation panels appointed following deaths consist of members from outside the service units under investigation but from within the

same trust. Consideration of involving someone from outside the trust would only be given in the most serious of cases, for example, homicides or a cluster of suicides. The trust could only recall one recent case in which outside one panel member had been brought in. In all other cases, the investigation panels consisted of trust employees.

63. As INQUEST's Co-Director Deborah Coles has noted:

*It cannot inspire family or public confidence to have a hospital investigate itself over a death that may have been caused or contributed to by failures of its own staff or systems. This mirrors the discredited practices of the past with police investigating police and internal prison service investigations prior to the establishment of the IPCC and PPO ... [it is] iniquitous that institutions responsible for the treatment and care of mentally ill people should not be subject to similar scrutiny.*<sup>67</sup>

64. Casework continues to demonstrate that the lack of a pre-inquest independent investigation impacts on all aspects of the response to deaths in this setting. Compared to other custody settings, action following a death is marked by the lack of systems, framework, established culture, policies and practices for the proper investigation of the deaths and the involvement of families. The complexity of the NHS structure and the fact that every trust operates differently in relation to psychiatric care and treatment adds a further level of complexity and difficulty in navigating the issues in these cases.

67. See Deborah Coles, “Deaths in mental health detention: INQUEST's policy and parliamentary work”, *Inquest Law*, Issue 24, July 2012.

### 30 Deaths in Mental Health Detention: An investigation framework fit for purpose?

65. The result is that families face an uphill battle for even basic involvement and information, and are having to address demanding and complex issues at every stage of the process, from the most basic needs of disclosure of evidence through to arguments around the application of Article 2.

Experiences reported to INQUEST's caseworkers over the last five years include:

- Not a single independent investigation at the evidence-gathering stage following a self-inflicted death.
- Lack of family liaison with trusts following the death.
- Not being provided with any information about the investigation process, a family's right to have involvement in that process or where to access independent advice and support.
- Little if any opportunity to raise concerns or questions.
- Not being provided with the terms of reference for the investigation.
- Not being given basic documentation, for example medical records.
- Refusal to consult on the draft report.
- Lengthy delays.
- Refusal to provide the family with a copy of the final report on the grounds that it is an "internal investigation".
- Failure to pass on a copy of the internal report to the coroner.
- Arguments by private mental health providers concerning the application of Article 2 and the refusal of FOI requests on the grounds of not being public bodies.

#### CASE STUDY

Jane ('Janey') Antoniou was 53 years old when she died at Northwick Park Hospital in Harrow on 23 October 2010. She was described in her obituary in *The Independent* newspaper as "one of the country's most respected campaigners for the support of those with mental illness". In 2001 she received a Superintendent's Commendation from the Metropolitan Police for training thousands of police officers on schizophrenia.

Janey had lived with schizophrenia for 25 years, had a history of self-harming and had been admitted to hospital on many occasions for in-patient treatment. In late September 2010 she required a crisis admission to Northwick Park. Initially admitted on an informal basis, she was later sectioned under s3 of the MHA. In the three and a half weeks between her admission and death, Janey absconded and attempted to self-harm, including with ligatures, a number of times.

On the day before her death, despite knowledge that Janey had received highly distressing news, close observations had been stopped and no additional care arrangements were put in place. When ward staff entered her room at 6.40am the following morning, they found the room in disarray and Janey collapsed on the floor with a dressing gown cord around her neck. The ward staff called a resuscitation team but failed to start CPR. Janey could not be revived.

By the time Janey's husband Michael contacted INQUEST four months after her death, no family liaison support had been provided to him by the



I could never have done this on my own without the support of INQUEST. The trust was more concerned about deflecting criticism than establishing the truth. My experience since Janey's death has made it crystal clear that there is an absolute need to have independent investigations. ”

hospital, he had no knowledge of the circumstances surrounding her death and no understanding of the investigation and inquest processes that were to follow. An inquest hearing had already been listed for just one day. INQUEST arranged urgent referral of the case to an experienced inquest lawyer and the hearing was adjourned to allow more time for preparation.

Even with the assistance of an expert legal team and the help of INQUEST, Michael Antoniou faced difficulty and obstruction throughout the investigation process. For example:

- The trust refused to carry out an independent investigation and, instead, an “Internal Panel of Inquiry” took place. This included interviewing of staff and evidence-gathering by the same hospital where Janey had died.
- He was told that he would not receive the investigation report and would only be informed of its findings.
- The trust initially refused, and later delayed, giving him access to key information and documents relevant to the investigation on the grounds that it was an internal exercise.
- Michael Antoniou’s input into the investigation was not sought and the trust failed to keep him informed and updated on its findings and progress. Despite being a key witness to wider events, he was never interviewed.
- There were extensive delays in publishing the investigation report and a failure to either notify him or offer any explanation for those delays.

The inquest process eventually spanned eight pre-inquest reviews from April 2011 on. The hearings were marked by a closed approach by the trust’s legal representative. A final two-week inquest hearing took place at the end of April 2012, which was challenging and legally complex. Arguments for the disclosure of key evidence continued throughout and previously undisclosed witness evidence came to light late on. Issues exposed during the hearing included the failure by NHS staff to follow approved risk and care procedures.

The jury concluded that Janey Antoniou had died following self-harm by use of a ligature and their narrative verdict included criticisms of the failure by key clinical staff to pass on relevant information concerning her suicide risk. The coroner issued a far-reaching Rule 43 report recommending ligature cutters be available on all mental health units; development of an overview risk and care management form similar to that used in the prison setting; and the development of national guidance concerning the use of higher-level observations.

Following the inquest, Michael Antoniou still has questions and concerns that remain unanswered. A further witness statement (not disclosed by the trust until after the hearing) also came to light. He brought a judicial review of the trust’s approach to the investigation of her death and the Secretary of State for Health’s failure to provide a system of independent investigation of deaths in mental health detention prior to the inquest. Although acknowledging the public policy argument supporting the need for an independent system of investigation, the Administrative Court failed to uphold that Article 2 alone gives rise to this requirement. An appeal of that decision remains underway. However, in November 2014 Dr Antoniou was refused a Protective Costs Order and consequently cannot afford to continue with his appeal. INQUEST has written to the Court of Appeal to express its concerns and a final decision is awaited.

## 32 Deaths in Mental Health Detention: An investigation framework fit for purpose?

66. Michael Antoniou is an academic and university lecturer. Despite being a highly articulate and capable person, he found the investigation and inquest process complex and harrowing. He describes the process being “a battle every step of the way”, with a deep suspicion generated by the trust’s unwillingness to engage or share information. The fact that, until he contacted INQUEST, he did not think he had any right of involvement and was only entitled to sit and listen at the one day inquest hearing is an indicator of a lack of proper systems and practices around family involvement. Unlike most families, he was already linked into the mental health charity Rethink Mental Illness as a result of Janey’s work. Their swift contact with INQUEST and our subsequent involvement meant that the initial inquest hearing was adjourned so he could access expert legal advice:

*I could never have done this on my own without the support of INQUEST. The trust was more concerned about deflecting criticism than establishing the truth. My experience since Janey's death has made it crystal clear that there is an absolute need to have independent investigations.*

67. Michael Antoniou’s experiences are consistent with feedback the IAP received from the bereaved families of detained patients who took part in a Listening Day meeting in September 2011. The report<sup>68</sup> documents families’ comments, including:

- Their sense of shock and trauma on being told the news, and the absence of any further information or immediate emotional support: *“They told me that she died. I was in shock. I told them not to leave me like this”* and *“the Coroner gave us a card about counselling services but we did not want to contact NHS for any help. The same NHS who caused our son to die?”*
- Families’ common perception that trusts are simply going through the motions in an effort to hide or manipulate the truth with discussions feeling like a *“fishing exercise to find out what we knew already”* and *“they couldn’t answer our questions without legal representatives”*.
- The lack of basic information and disclosure of documents provided on a drip-feed basis, with families describing an atmosphere of *“them against us”*, *“they didn’t disclose anything, it was a battle to the end”* and *“the shutters came down as soon as I started to ask questions”*.

### Families’ experience of inquests

68. Coroners’ approaches to these inquests vary substantially around the country. Some always sit with a jury, hold an enhanced *Middleton*-type inquest and ensure as far-reaching scrutiny as possible, and others do not.

68. The event was organised on behalf of the IAP by INQUEST following an independent tendering exercise. The full report by the consultants Baker Brown is available here: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/02/IAP-Listening-Day-Report.pdf>



*They didn’t disclose anything, it was a battle to the end ... the shutters came down as soon as I started to ask questions.*



69. Coroners generally rely on other agencies to gather relevant evidence before the inquest hearing and have limited resources and powers to direct any initial investigations. The rigour and thoroughness of inquests into deaths in mental health detention are ultimately dependent on the internal hospital investigation. The shortcomings in the current process mean that potentially relevant evidence is often not identified, gathered and preserved, or is affected by the other objectives of those who have both control of the material and an interest in the outcome. This incomplete or tainted evidence then flows through the inquest system and is effectively “fruit of the poisonous tree”.

70. INQUEST is concerned that the superficial nature of the investigations and speed with which some cases can move to the inquest hearing leaves many families without any meaningful chance of establishing the circumstances of their relative’s death and – crucially – whether it was preventable. The fact that juries may not be mandatory in some inquests into in-patient deaths means that they are often accorded cursory treatment and listed for final hearings of just a few hours. With inadequate scrutiny, there is a danger that many of the underlying issues can be glossed over and the opportunity for critical learning is lost. The picture is particularly stark for families unable to secure legal representation.

71. At the other end of the spectrum, some inquest hearings take place at least one and often many years after a death in mental health detention. This not only means that some families face a lengthy wait for answers, but also – in the absence of independent investigation – that there can be significant delays in public scrutiny of the death. This in turn leads to delays in urgent learning and change in order to prevent further fatalities.

#### CASE STUDY

ZR died in early 2011 and was an informal patient in a psychiatric unit in south-east England at the time of her death.

Six weeks earlier she suffered a mental health crisis and entered her local psychiatric unit. ZR had been diagnosed with borderline personality disorder and alcohol dependence. On several occasions during her admission she returned onto the ward intoxicated. On the evening of her death, despite being aware of particularly distressing personal circumstances occurring that day and despite ZR returning to the ward heavily intoxicated, staff allowed her to leave the ward at night-time unescorted and still intoxicated. ZR was killed when she was struck by a car on the nearby motorway. The hospital did not instigate their missing persons procedure until contacted by the police to say there had been a fatality.

Within days of ZR’s death, the hospital had concluded a Serious Untoward Incident investigation. ZR’s family was given no opportunity to have any input or involvement in that process. The investigation was

### 34 Deaths in Mental Health Detention: An investigation framework fit for purpose?

conducted by the ward manager; the subsequent report was a few pages long and contained little evidence or scrutiny of ZR's care and treatment. Her family concluded that the hospital was wholly conflicted in its approach and found the investigation's conclusion that no root cause analysis was necessary insulting.

The family decided to instruct specialist lawyers (at their own expense), deciding that this would be the only way of establishing the truth surrounding ZR's death. The family waited for nearly two years before the inquest was held for five days in late 2012. Through detailed questioning of the medical staff by the families' lawyer, evidence was brought to light exposing serious failures around the systems and care in operation on the ward.

This included: widespread failures in staff knowledge and implementation of key policies; lack of care planning and risk assessment; confusion and misunderstanding around staff roles in terms of care and decision making; serious failures in communication; and poor record keeping. There was little evidence of proper care or treatment being provided to ZR, with the only consultant psychiatric input coming from half-day weekly ward rounds. The family's impression was of a shambolic unit "little more than a holding centre", with patients allowed to come and go with few restrictions.

In contrast to the shortcomings of the SUI investigation, the coroner returned a highly critical verdict concluding that failures in almost all aspects of ZR's care had caused or contributed to her death, including in the treatment of her alcohol consumption, risk assessment, psychiatric care, medical records, missing persons policy and management by the ward manager. The coroner issued a far-reaching Rule 43 report recommending that reform of all of these areas was urgently required in order to prevent another death in similar circumstances.

At great emotional and financial cost, ZR's family had been able to ensure the truth concerning their relative's death was brought to light and wide-scale failures were exposed and addressed. They were left devastated by the findings and level of failure.

Compounding this was the knowledge that, in the months following ZR's death, two further deaths of patients from the same unit had occurred – including one involving similar circumstances to ZR. Her death initiated a police investigation, which included concerns about the number and frequency of patients going missing from the unit. What cannot be known is whether the deaths of two other patients could have been prevented had the initial SUI investigation been conducted as it should have been and failures identified earlier.

NB ZR's case study has been anonymised at her family's request. Dates and details regarding the unit in which she was treated have been removed for this reason.

72. Although there are more deaths in a mental health context than in any other custody setting, far fewer families appear to seek formal advice. Although the reasons for this have not been explored in detail, a number of factors seem to contribute to this situation, including: the lack of information given to families about where to go for specialist advice and

support; the subsequent lack of awareness on their part that they have any rights in the process that follows a death; the speed with which the investigation and inquest process takes place in many of these cases, leaving insufficient time for families to focus on issues which go beyond their immediate shock and grief; and possible stigma relating to suicide and mental health.

#### CASE STUDY

Michael Carroll was 28 years old when he died in January 2010 whilst being treated as a detained patient at St James' Hospital in Portsmouth.

His family describe a happy child who, as a teenager, began to experiment with drugs which they believe impacted on his mental health. Michael was eventually given a dual diagnosis of schizophrenia and poly-substance abuse. His mother was closely involved with his treatment and care throughout his life.

Michael's last hospital admission started in November 2009 when he was detained under section 2 of the MHA and admitted to the Maples Unit at St James' Hospital. In early December his detention was made subject to section 3. His mother continued to visit and see Michael regularly, including during escorted leave from the hospital. However, unknown to her, the hospital made a decision granting Michael unescorted leave. This was temporarily suspended when Michael was suspected of using drugs, but was reinstated. Around 7pm on the evening of 21 January 2010, Michael was allowed to leave the hospital ward alone. He was reported missing when he later failed to return. At around 8am the following day, Michael was found dead by a woman walking her dog in the grounds of the hospital. His death was caused by a heroin overdose.

Michael's mother was contacted that morning by the hospital and told bluntly about her son's death. She was not given information about the investigation process. She first learnt about this nearly a week later, on 28 January, when she read a news article about Michael's death in the local press which included a quote from an associate director of the Mental Health Business Unit at the trust saying that an investigation would be conducted.

In the months that followed, there was a continuing lack of communication from the trust. To the extent that any contact was made, this was instigated by Michael's mother. She wrote to the trust on 1 January 2011 stating that she felt unsettled by the inquiry being carried out and felt totally shut out. On 11 January, nearly a year after his death, the trust finally wrote to Michael's mother providing a copy of the report and, for the first time, offering a meeting to discuss the investigation. She felt that the report was inadequate and failed to address key facts and evidence concerning Michael's care. The trust did not provide any of the evidence gathered in the course of the investigation.

Michael Carroll's family continued to experience distressing delay and had to wait for nearly two and a half years before an inquest finally took place in June 2012 – for just one day. The coroner's court failed to send the family either the witness list or any case papers relevant to the inquest hearing until specifically requested by the family. These were not made available to the family until the day before the hearing. Medical records,



The process was rushed from start to finish and the family were silenced whenever they attempted to ask questions or explore the issues that concerned them...”

essential to understanding the care and treatment provided to Michael, were not placed before the court and were not received by the family until after the inquest.

The trust was represented by a barrister at the inquest hearing, but Michael's family had not been able to afford their own lawyer, so were unrepresented. With just three witnesses called to give evidence, the family felt that key witnesses were absent. The process was rushed from start to finish and the family were silenced whenever they attempted to ask questions or explore the issues that concerned them about Michael's treatment and the circumstances of his death. During legal discussions between the trust's lawyer and the coroner, no attempt was made to either involve the family or explain what was going on. One of the few things to emerge in evidence during the inquest was that Michael had refused to take medication shortly before he was allowed to leave the ward and had to be given alternative medication to calm him down as he was becoming very anxious. None of this had appeared in the trust's investigation report.

Michael's sister was so distressed by the poor conduct of the hearing that she had to leave the court. The jury were sent out at 5pm. They were directed by the coroner to return a short verdict and were not asked to address questions concerning Michael's care or the circumstances of his death. Forty minutes later, the jury returned a verdict of accidental death. The coroner did not make any Rule 43 recommendations.

The family left the court "utterly exhausted and shell-shocked". After waiting more than 2½ years for answers, they felt totally let down by a system which they describe as "inhumane and ineffective".



Many families remain unrepresented during the investigation and inquest in these cases, leaving them ill-equipped to respond to often complex and demanding arguments. ”

### Funding family legal representation

73. The unnatural or unexpected death of a loved one in the care of the state is a deeply traumatic event. There is no automatic right to funding for families' legal representation and applying for exceptional funding is complicated, intrusive, unfair and rarely granted. The government perpetuates the myth that inquests into deaths in state care are informal hearings where grieving families can be expected to represent themselves. This ignores the reality of their experiences. Many families remain unrepresented during the investigation and inquest in these cases, leaving them ill-equipped to respond to often complex and demanding arguments around disclosure, scope, technical evidence, witnesses, expert medical evidence, the application of Article 2 and inquest law.

74. Families who are not granted legal aid may make the difficult decision to be unrepresented or pay privately for legal representation. This is in stark contrast to the position of NHS Trusts, whose legal representation at inquests will be paid for by the taxpayer, and the representation of medical staff which is paid for through their trade union or professional association membership. Their role at the inquest is increasingly to defend their policies and practice and to limit the scope of questioning.

### CASE STUDY

Bethan ('Beth') Smith was 31 years old when she died on 14 October 2011. She had been an informal in-patient receiving treatment at Centurion Psychiatric Hospital, Chichester.

Despite serious physical and mental health problems, including suffering from anorexia for ten years, Beth excelled academically and achieved a first-class honours degree. Having secured her first permanent job, Beth bought her own flat in 2005. However, in November 2006 she effectively estranged herself from her family and, much to their distress, had no further contact with them. The family became aware that Beth was seriously ill when the police contacted them after she had absconded from hospital and the community mental health team (CMHT) contacted the family home in error. Beth's parents attempted on two occasions to establish a link with the hospital and the local CMHT by inviting contact and offering input into Beth's care, but neither responded.

The family's first contact from the hospital was a telephone call on 11 October 2011 to say that Beth had been found hanging in her room on the ward and had been taken to intensive care. On 14 October, with the agreement of Beth's family who were at her bedside, her life support was switched off.

From the time of Beth's death, the family faced an openly hostile response from hospital staff. The hospital initially refused to share any information with the family about her circumstances or care on the grounds of confidentiality. The family eventually learned that Beth's mental illness became acute in 2009 and was characterised by prolific levels of serious self-harm and risk-taking behaviour. She had been given a diagnosis of borderline personality disorder, although this was not a diagnosis she was comfortable with. She had repeat admissions to hospital, sometimes as an informal patient and sometimes under section.

The Serious Untoward Incident investigation into Beth's death was carried out by the same trust that was responsible for the hospital where she died. The family was invited to raise their concerns and make comments on a redacted copy of what they thought was the draft report. The family later learned that at the time they met with the trust to go through their comments the report had already been signed off. The final SUI report was poor. Much of it focused on background history and a general overview of Beth's final admission and contained little detailed consideration of the care and clinical approach in Beth's case, or whether policies (including around risk assessment, observations and searches) were followed properly. Without reference to any detailed evidence or findings, it concluded nurses had done all they could and all policies had been followed correctly.

Following the *Rabone* case, Beth's death should have been a clear example of where Article 2 would apply, yet the coroner concluded initially that an enhanced inquest was unnecessary. The family made a decision to seek the help of INQUEST and instruct a specialist lawyer. Following lengthy legal arguments and the threat of judicial review proceedings, the coroner, having taken counsel's advice, finally accepted that an Article 2 inquest was the correct course.

The inquest into Beth's death was heard over eight days in June 2013. Evidence emerged from medical records disclosed to the family during the

inquest process that, in the ten days before her death:

- Beth had described her level of self-harm as “overwhelming and uncontrollable”.
- A risk assessment identified her risk of suicide and accidental death due to impulsive, deliberate self-harm.
- She was the subject of close observations; tied ligatures on five occasions; repeatedly self-harmed by cutting; and expressed chronic self-harm thoughts, including a temptation to overdose.
- A clinical decision was made that Beth should be restricted to escorted leave due to her deliberate self-harming.

The coroner returned a verdict that Beth had died from a self-applied ligature. In stark contrast to the SUI investigation findings that all policies had been followed properly, the coroner stated her intention to issue a Rule 43 report requesting that the trust conduct a review of the operation and policies applying to patient observations and searches, both central to the safe care and protection of patients

Despite the painful process Beth’s parents went through, they ultimately felt that their battle was worth it:

*All we ever wanted was the truth, a chance to meet with those who had cared for Beth and a feeling that at last someone had listened to us. This process all started with a phone call to INQUEST.*

75. Without the perseverance and hard-fought battle of Beth Smith’s family and their decision to pay for costly legal assistance they would not have received a full copy of the investigation report, nor had the documents and policies relevant to their daughter’s care disclosed to them, and neither would they have achieved the lengthy and detailed exposure of evidence concerning the circumstances of her death. The enhanced inquest led to important learning and, it is to be hoped, system changes in the unit where Beth was treated that could save future lives.



All we ever wanted was the truth, a chance to meet with those who had cared for Beth and a feeling that at last someone had listened to us. This process all started with a phone call to INQUEST. ”

## Other organisations' views on the investigation of deaths in mental health detention

69. Additionally, in 2009, the IAP's predecessor body, the Forum for Preventing Deaths in Custody, published a detailed report (<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>) concluding that the requirement for independence under Article 2 would not be met in relation to the current system of investigations of deaths of detained psychiatric patients. In December 2010, the chair of the IAP wrote to the Secretary of State requesting confirmation that they accepted the forum's recommendations. The government's reply in April 2011 re-stated that the coroner's inquest is the primary means by which the state fulfils its Article 2 obligations.

70. For an overview of the IAP's work in this area, see Philip Leach, "Investigating deaths of patients detained under the Mental Health Act in England and Wales", *Inquest Law*, Issue 24, July 2012.

71. The full report is available here: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/01/IAP-Workstream-Paper-on-Article-2-Compliant-Investigations.pdf>

72. The full report can be found here: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/06/IAP-analysis-of-Serious-Untoward-Incident-reports.pdf>

76. INQUEST, the families we work with and their legal representatives are not alone in questioning the adequacy of the current framework for investigating deaths in mental health detention. A wide range of parliamentarians, independent experts, mental health organisations and other NGOs have also raised their concerns.

77. In 2004, the JCHR's critical report on deaths in custody concluded in relation to deaths in mental health detention that "there is a case for a permanent investigatory body, with some level of overview of all cases, rather than ad hoc investigations in a few cases" (see paragraph 11).

78. The IAP has also recorded their concern that there is no central body with sufficient oversight of investigations of deaths of detained patients.<sup>69</sup> In 2011, the IAP, under a work stream led by Professor Philip Leach, conducted an examination of Article 2-compliant investigations following deaths in custody.<sup>70</sup> Key findings in relation to the investigation of deaths of detained patients included that:

- Internal investigations do not provide a satisfactory system for investigating the deaths of detained patients in an independent or open way; and it is possible that such a system may prevent full learning from the death.
- Reliance cannot solely be placed on the inquest system, as inquests take place some considerable time after a death.
- NPSA good practice guidance is insufficient to ensure an Article 2-compliant investigation and should be re-written to address the shortcomings highlighted by the IAP and to ensure consistent application by all trusts.<sup>71</sup>

79. The IAP carried out follow-up research in 2013 into the quality of investigations carried out by Strategic Health Authorities and scrutinised eighteen internal SUI reports following deaths in mental health settings. The final report was published in June 2013.<sup>72</sup> The IAP's observations included:



- None of the deaths had been investigated independently of the relevant trust. Of the five SUIs that mentioned the involvement of external reviewers, there did not seem to be a clear rationale for their involvement and none seemed to have authored the reports.

#### 40 Deaths in Mental Health Detention: An investigation framework fit for purpose?

- More generally, the SUI reports were of variable quality and consistency with unclear methodology and aims.
- The omission from eight of the reports of any reference to family liaison provides an indication that the possible contribution by bereaved families to the investigation was not considered important.
- There was a noticeable lack of focus on the cause of death in the reports and none involved a full clinical review of the patient, as would be the case when a prisoner dies and the PPO is investigating.
- None of the reports stated that it would be published or open to public scrutiny, again in contrast to investigations carried out by the PPO and IPCC following a death.

80. The National Preventative Mechanism,<sup>73</sup> a group of 18 inspectorates and visiting bodies who monitor the treatment of and conditions for detainees in the care of the state to ensure that the UK complies with their obligations under the UN Convention Against Torture, has also raised concerns about the treatment of patients in mental health settings, including: the failure of many services to involve detained patients in their own care; informal patients not being informed of their rights to freedom of movement; and a lack of attention being paid to the physical health of mental health detainees.

81. Compelling and growing evidence about deaths in mental health detention has led an increasing number of mental health organisations to raise their concerns alongside INQUEST about the adequacy and effectiveness of the current investigation system, including: Rethink Mental Illness, Mind, Liberty, JUSTICE and Black Mental Health UK.<sup>74</sup> This has resulted in heightened parliamentary concern about the problem, as illustrated by two separate debates within a month in the House of Commons where the inadequacy of investigations into the deaths of mental health patients was raised by MPs.<sup>75</sup>

 Compelling and growing evidence about deaths in mental health detention has led an increasing number of mental health organisations to raise their concerns alongside INQUEST about the adequacy and effectiveness of the current investigation system... 

73. Further details and NPM Annual Reports can be found at [www.justice.gov.uk/about/hmi-prisons/preventive-mechanism](http://www.justice.gov.uk/about/hmi-prisons/preventive-mechanism)

74. For example, see the joint letter in *The Observer* in June 2012: “The terrible anomaly of deaths in mental health detention”, [www.guardian.co.uk/theobserver/2012/jun/03/letters-deaths-mental-health-detention](http://www.guardian.co.uk/theobserver/2012/jun/03/letters-deaths-mental-health-detention)

75. See the debate in Westminster Hall on 28 November 2013 secured by a group of key MPs from each of the major parties, Madeleine Moon (Lab), James Morris (Con) and Paul Burstow (Lib Dem); and the adjournment debate in the main chamber of the House of Commons on 2 December 2013 on black deaths in custody led by Charles Walker MP.



## Conclusions and recommendations

76. “Nick Clegg calls for new ambition for zero suicides across the NHS”, [www.gov.uk/government/news/nick-clegg-calls-for-zero-suicides-across-the-nhs](http://www.gov.uk/government/news/nick-clegg-calls-for-zero-suicides-across-the-nhs)

82. The increasing priority being placed on mental health by the government and opposition is a welcome development. We note the national initiative in 2015 to call on all NHS Trusts to commit to a new ambition of “zero suicides”<sup>76</sup> and further resources which are intended to be allocated to child mental health services. However, these important objectives will not be met unless the government addresses the issues relating to the investigation framework for deaths in mental health settings that have been highlighted in this report.

INQUEST recommends the following action:

### **(1) Independent investigation of deaths**

83. Above all else, INQUEST believes there is now overwhelming evidence that the current system for investigating deaths in mental health settings is not fit for purpose. It profoundly impacts upon the understanding of and response to the deaths of mental health patients and has implications for patient safety and the prevention of future deaths.

84. Despite previous revisions to guidance, independent pre-inquest investigations are not being conducted into the individual deaths of the hundreds of detained patients who have taken their own lives. Meanwhile, the number of potentially preventable deaths in mental health detention remains the highest of all custody settings. Our perception is of a deep-seated, longstanding and widespread resistance within the NHS to arranging early independent scrutiny of deaths in mental health detention. We note that the government has, under the auspices of the new NHS England Commissioning Body, committed to updating the existing NPSA guidance on the investigation of deaths of detained patients. This should be done through consultation and the input of those with knowledge and experience of the current system. However, it is INQUEST’s view that new guidance alone is incapable of bringing about the meaningful systemic and cultural change that is needed.

**85. INQUEST recommends that a new, fully-independent system for investigating deaths in mental health settings be developed.**

Of the many reasons why this is necessary, we highlight the following:

- There is a perception that public authorities can be defensive and will close ranks if someone dies in their care. Healthcare services, whether in mid-Staffordshire or elsewhere, are just as prone to this approach.

## 42 Deaths in Mental Health Detention: An investigation framework fit for purpose?

This can result in irreparable harm to the integrity of the evidence.

- An investigation process that is neutral from the outset can achieve the confidence of the family if they are given meaningful involvement from the start. Shutting families out of post-death processes causes them deep pain and mistrust. It also denies investigators invaluable evidence from those who often knew the deceased best.
- The causes of death in mental health detention are often very similar to those in other forms of custody and can involve staff or systems failures, for example: self-harm, inadequate information sharing, risk assessments and observations, unsafe ligature points, or following the use of dangerous restraint.<sup>77</sup> It is recognised that proper independent investigations into deaths in other forms of detention are important in securing confidence in the system.
- There are no good reasons why bereaved families or the public should be any less suspicious of an internal investigation simply because the death has taken place on a locked hospital ward as opposed to in a custody suite or prison cell.
- The high incidence nationally of self-inflicted deaths on wards or following absconson makes cross-sector learning even more vital if future deaths are to be prevented. Currently, multiple trusts each investigate in disconnected and inconsistent ways and the complex framework of the NHS system makes it very difficult to see where learning and change sit. The inconsistency of approach and the diversity of policies and practices in operation across each trust inhibits the correction of dangerous practices.
- A rigorous investigation report, shared with the bereaved family pre-inquest, would assist coroners in conducting a better-quality and more focused inquest hearing by identifying the relevant issues at an early stage and ensuring that key evidence and witnesses are before the court. This is also important given the limited time and financial resources at many coroners' disposal.
- The publication of anonymised investigation reports at the conclusion of the inquest (as published by the IPCC and PPO) would ensure an important tool for visibility and learning across cases and institutions, as currently operates in the area of prison and police-related deaths.
- A single body conducting fully independent investigations into deaths and ensuring oversight would enable thematic learning to be disseminated across the NHS to help prevent future deaths.

86. Independent investigations of deaths in mental health settings may well have resource implications. However, if this reform were to lead to safer practice and fewer deaths, it would be a price worth paying. No monetary value can or should be placed on human life. However, on a purely financial basis, if this reform were to lead to safer practice, better preventative measures and therefore fewer deaths, it should also in turn result in fewer investigations, inquests and related legal costs for trusts.

77. See for example the recent report by Mind, *Mental health crisis care: physical restraint in crisis* (June 2013), [www.mind.org.uk/media/197120/physical\\_restraint\\_final\\_web\\_version.pdf](http://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf)



Independent investigations of deaths in mental health settings may well have resource implications. However, if this reform were to lead to safer practice and fewer deaths, it would be a price worth paying. ”

87. In designing a new system, we recommend that the models and experiences of independent investigation offered by the IPCC and PPO should be considered (see Appendix 1 for more details of these organisations' terms of reference, approach to independent investigations, learning and family liaison).

## (2) Collation and publication of statistics

88. The current system of publicly-available statistics concerning deaths in mental health settings has developed in an ad hoc way and fails to provide a coherent source of statistical data. The lack of uniform definitions and the difference in approach applied by each body collecting data make it extremely difficult to produce a clear analysis of the figures. The failure to collate key information concerning institution, age, gender, race or crucial features (for example, the use of force) hinders any comprehensive analytical narrative in relation to deaths in mental health settings. **INQUEST argues that an agreed, coherent set of published statistics is needed which includes all information necessary to provide an overview of the number and features of deaths of mental health in-patients.** In light of the Supreme Court judgment in *Rabone*, this must include data on the deaths of all in-patients, not just of those formally detained. An effective notification process will help to develop such datasets. One organisation with responsibility for such a system would enable consistency and more effective management and oversight.

## (3) Robust inquests and implementation of coroners' recommendations

89. Inquests into deaths in mental health detention are an important component in meeting the procedural standards of Article 2. In our experience, coroners' approaches to the conduct of these inquests vary widely across the country. In light of the implementation of new provisions in the Coroners and Justice Act, **INQUEST recommends that the Chief Coroner for England and Wales helps to address this through clear guidance to coroners, setting out the requirements of Article 2 in relation to deaths in mental health settings and clarifying what this means for the conduct of inquests.**

90. A robust, wide-ranging inquest which properly scrutinises a death can play an important preventive role and be a mechanism by which lessons can be learned. Inquests subjected to serious delay frustrate the learning process as well as placing an intolerable strain on families.<sup>78</sup> It is essential that inquest hearings into these deaths are held without unnecessary delay.

91. The continuing failure to nationally and centrally collate, monitor, audit, analyse or fully publish juries' narrative conclusions and coroners' reports to prevent other deaths is a further serious impediment to visibility and

78. An analysis conducted in July 2011 of 500 of INQUEST's death in custody cases where the death and inquest occurred between 2000 and June 2011 showed that 48% of cases took two years or more to conclude, 24% took three years or more and 9% of cases took four years or more before the inquest was heard.

#### 44 Deaths in Mental Health Detention: An investigation framework fit for purpose?

essential learning, in this area and across all deaths in state care. Such a system is essential, also to ensure public scrutiny and detailed analysis of the follow-up to these conclusions and coroner's reports. INQUEST has repeatedly called for a national accessible database of all jury conclusions and coroners' recommendations on deaths in custody to be established.<sup>79</sup> We welcome the move towards greater publication and sharing of this vital evidence base with online publication by the Chief Coroner of all reports to prevent future deaths and any responses to them.<sup>80</sup>

This is an important first step. However there is a pressing need for this information to be audited and analysed by the statutory organisations best placed to ensure any changes are implemented. **INQUEST recommends that the Care Quality Commission and NHS England should work together to collate, analyse and publish an annual report drawing together all investigation, inquest jury and coroners' recommendations that have been made in respect of in-patient deaths in mental health settings (of both detained and informal patients).** Consideration could also be given to the CQC or NHS England being able to follow up with NHS organisations as to what actions have taken place in response to coroners' reports. This too should be published as part of an annual report.

92. Finally, there is still no mechanism to compel relevant government departments, public authorities and hospitals to act on inquest findings and reports to prevent future deaths, rather than merely respond to them. INQUEST thinks there is a good case for strengthening legislation in this area.

#### (4) Enabling family engagement

93. There must be proper, meaningful involvement of families in investigations into deaths in mental health settings at all stages of the investigation process. **INQUEST recommends the development of a new approach to family involvement. This must be centred around transparency and communication, and policies and protocols should be developed to enshrine these commitments and practices.** Good practice examples can be drawn upon from the prison and police contexts. *The Family Liaison Common Standards and Principles*<sup>81</sup> developed by the IAP and accepted by the Ministerial Board on Deaths in Custody also offer an important benchmark for NHS organisations to build on.

94. Bereaved families have a vital role to play, one that serves both their and the public interest in ensuring that the full facts are established and any learning is identified in order to safeguard lives in the future. Indeed, in the context of deaths in prison and police custody, they and their legal representatives have been instrumental in exposing:

79. Coles and Shaw (2012).

80. In January 2014, the Chief Coroner launched a new website to collate all PFDs: [www.judiciary.gov.uk/about-the-judiciary/office-chief-Coroner/pfd-reports/index](http://www.judiciary.gov.uk/about-the-judiciary/office-chief-Coroner/pfd-reports/index)

81. Available from: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/02/Family-Liaison-Common-Standards-and-Principles-IAP.pdf>

*...systemic and practice problems that have contributed to deaths. Many of the changes to ... training and guidance, changes to the law ... increases in information entering the public domain ... and public awareness of the issues have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying ... for change.*<sup>82</sup>

82. Deborah Coles and Helen Shaw, *Unlocking the truth: families' experiences of the investigation of deaths in custody*, INQUEST (2007).

Skilled advocacy for the family aids the inquisitorial process and is essential to ensuring that families are supported to participate as fully and openly as possible, ensuring that their central questions and concerns are addressed and contentious evidence is brought to light. Advocacy is also important in contributing to the Reports to Prevent Future Death process. The impact of not being assisted by a skilled advocate is graphically highlighted in the individual stories in this report. **INQUEST reiterates its previous recommendation that families should automatically be eligible for non-means-tested public funding** to cover the costs of legal advice, representation and subsistence costs for inquest hearings into the deaths covered in this report.

 Bereaved families have a vital role to play, one that serves both their and the public interest in ensuring that the full facts are established and any learning is identified in order to safeguard lives in the future. 

## Appendix 1 – Other models of investigation and family engagement

INQUEST's specialist casework experience encompasses deaths in prison, police custody and following contact with the police and other state agents, in immigration and mental health detention. As such, the organisation has extensive experience of the different investigative models used to scrutinise the deaths of detainees in other custody settings.

Below is a description of the approach of the PPO and the IPCC to investigations.

### The Prisons and Probation Ombudsman (PPO)

The PPO's 2009 Terms of Reference (TOR) state that the PPO has been appointed through an open competition by the Secretary of State for Justice; and he is wholly independent of the Prison Service, the Probation Service and United Kingdom Border Agency (UKBA). Nigel Newcomen was appointed as the current Ombudsman in September 2011.

In terms of fatal incidents, the TOR explain that the PPO investigates the circumstances of the deaths of:

- 29. ... i. prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody;*
- ii. residents of Approved Premises<sup>83</sup> (including voluntary residents);*
- iii. residents of immigration reception and removal centres, short term holding centres and persons under managed escort;*
- iv. people in court premises or accommodation who have been sentenced to or remanded in custody.*

*However, the Ombudsman will have discretion to investigate, to the extent appropriate, other cases that raise issues about the care provided by the relevant authority in respect of (i) to (iii) above.*

*30. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, depending on the circumstances of the death. The Ombudsman's remit will include all relevant matters for which NOMS,<sup>84</sup> UKBA and the Youth Justice Board are responsible (except for Secure Children's Homes in the case*

83. This term is not defined in the TOR but effectively relates to probation and bail hostels.

84. i.e. the National Offender Management Service (including the Prison and Probation Services).

85. The Department for Education has since accepted the IAP's recommendation that the PPO should now investigate deaths in secure children's homes. See Bulletin 8 of the Ministerial Board dated July 2012, page 3.

*of YJB<sup>85</sup>), or would be responsible if not contracted elsewhere. It therefore includes services commissioned from outside the public sector.*

Thus, all deaths in the above institutions should be referred to the PPO for investigation. The PPO will in turn independently investigate all of these deaths. In INQUEST's experience, the extent to which the PPO will investigate some deaths (e.g. an obviously natural causes death) and the resources deployed will understandably be significantly fewer than the extent to which the PPO will investigate, for example, a suspected self-inflicted death.

In April 2013, the PPO introduced new guidance which requires that any clinical reviewer in England:

*... must not be involved in, or responsible for, the commissioning or provision of the healthcare service where the death in custody occurred (§2.9) ... The person appointed ... must make early contact with the PPO investigator before starting any work ... to agree parameters of the investigation and to discuss any interviews which should be conducted jointly with the PPO investigator. The PPO has a preference for joint interviews...*

This welcome development should improve the quality of and confidence in clinical reviews conducted as part of the PPO's investigations.

PPO investigation reports focus on a number of issues, including quality of care and symptom management, communication between prison staff and outside hospitals, issues of compassion and dignity, emergency responses and family liaison.

The PPO publishes anonymised versions of his investigative reports on his website (ordinarily post-inquest). To aid follow-up and learning, the PPO has a Learning Lessons Strategy for 2012-2015. He also prepares and publishes thematic reviews and briefings on a number of issues arising from the investigations. These publications provide important opportunities for reflection, learning and risk management.

### **The Independent Police Complaints Commission (IPCC)**

The IPCC was set up by the Police Reform Act 2002 and commenced operation in April 2004. The clearest current statement of its position in relation to independent investigations is in the referrals section of the IPCC's casework manual:

#### **Human rights assessment**

*Article 2 engaged*

*Article 2 outlines the right to life. Any case where Article 2 is engaged (for our purposes, where it is arguable that the person serving with the*

*police knew or ought to have known that there was a real and immediate risk to someone's life and failed to take steps within their power to prevent that death) necessitates an investigation that is sufficiently independent of that state. Article 2 can also be engaged where someone has suffered life-threatening injuries – these are referred to as 'near miss' cases. In practical terms, if Article 2 is engaged, this will usually mean an IPCC independent investigation or at least an investigation by a different police force to the one from which the person serves with. [emphasis added]*

The new chair of the IPCC, Dame Anne Owers, instituted a review of its Article 2 investigations to which INQUEST and the INQUEST Lawyers Group submitted detailed written evidence. INQUEST's Co-Director Deborah Coles sat on the expert reference group which advised Anne Owers to ensure that the review was as robust, transparent and thorough as possible.

In November 2012, the IPCC also commissioned an external review by Dr Silvia Casale of its investigation of the death in police custody of Sean Rigg, to which INQUEST submitted written evidence. The Casale Review<sup>86</sup> was published in May 2013 and made a number of important recommendations, which the IPCC has accepted. These are of relevance to the investigation of all deaths in detention, and include:

- The IPCC should take control of a death in custody investigation immediately after the death.
- As the Casale Review was informed by the IPCC that it has always independently investigated deaths in police custody since 2008, this change should be formally and unequivocally established in IPCC guidance.
- The family of a person who has died in custody is entitled to access to all relevant information and exceptions should only be made for compelling reasons.
- It is for the IPCC to be independent and to be seen to be independent; the perception of independence is an important factor in public confidence.

Information provided by the IPCC to the Casale Review confirms that all deaths occurring *in* police custody (as opposed to following police contact) have been investigated independently by the IPCC since 2008. Certainly the IPCC has accepted that all deaths in police custody should now be investigated independently immediately after the death. The Casale Review also considered the purpose of an Article 2 investigation and concluded as follows:

*When someone dies in custody, the public is entitled to know how and why this happened; it requires a truly independent organisation to investigate intelligently, robustly, fearlessly and effectively all the circumstances surrounding the death. The IPCC has the potential to*

86. [www.ipcc.gov.uk/Documents/investigation\\_commissioner\\_reports/Review\\_Report\\_Sean\\_Rigg.PDF](http://www.ipcc.gov.uk/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF)



*fulfil that difficult and complex role; but in the case of the death in custody of Sean Rigg in 2008 that potential was not fully realised...*

Like the PPO, the IPCC regards the dissemination of learning as an important part of its functions and regularly publishes a Learning the Lessons bulletin on issues arising from its investigations.

### **Family involvement in PPO and IPCC investigations**

The engagement between investigators and next of kin following deaths in prison or in police custody has undergone wholesale change since the setting up of the IPCC and the investigation of deaths in prison by the PPO. Both organisations now provide written information to bereaved families on what will happen in the investigation process. From the moment of death, a key stated priority for both the PPO and IPCC is to engage with bereaved families and to involve them in each stage of the investigation to an appropriate extent.

Involvement will typically consist of the following:

- A number of meetings at the outset of the investigation, including to establish trust and confidence on both sides; share the proposed terms of reference; obtain witness statements from the family; and to invite their suggestions on lines of inquiry.
- The prompt provision, in return for undertakings, of any non-contentious contemporaneous documents e.g. custody or medical records.
- An assigned Family Liaison Officer (FLO)/Family Liaison Manager (FLM).
- Written updates.
- Regular meetings to discuss developments and to provide opportunity to feed into the draft investigation report.
- Disclosure of the investigation report and its underlying documents at the conclusion of the investigation.

Full details of each organisation's approach can be found on their websites.





INQUEST provides specialist advice and a complex casework service to people bereaved by a death in custody/state detention or involving state agents and works on other cases that also engage article 2 of the ECHR and/or raise wider issues of state and corporate accountability. INQUEST's evidence based policy, research and parliamentary work is informed by its casework and we work to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths.

[www.inquest.org.uk](http://www.inquest.org.uk)



• **Advice** • **Support** • **Information** • **Policy** • **Research** • **Campaigning**

Winners of the Longford Prize 2009 and the Liberty/JUSTICE Human Rights Award 2007

- 89-93 Fonthill Road, London N4 3JH ● Tel: 020 7263 1111
- Email: [inquest@inquest.org.uk](mailto:inquest@inquest.org.uk) ● Website: [www.inquest.org.uk](http://www.inquest.org.uk)
- Inquest Charitable Trust is a registered charity, number: 1046650
- Company number: 03054853



LOTTERY FUNDED

**£10**

ISBN 978 0946858 286