Ministry of Justice | Home Office | DH Department of Health

Examining a sample of 18 redacted Serious Untoward Incident reports following deaths of patients detained under the Mental Health Act

Background

1. In June 2011, Professor Philip Leach presented a paper to the Ministerial Board on Deaths in Custody about Article 2-compliant investigations[1], in which he identified problems with the lack of independent investigations into deaths of detained patients. He also raised concerns about Department of Health guidance[2] as to when an independent investigation should be commissioned and gaps in the National Patient Safety Agency guidance[3], which he thought needed to be updated to:

    - clarify when an 'independent investigation' must be carried out;
    - clarify what that entails
    - clarify urgency/timings
    - clarify the nature and scope of the investigation, adequate investigatory powers, procedures, public access, and family involvement
    - establish consistent methods of identifying learning that should be shared beyond the individual Trust[4].

2. Professor Leach also recommended that "research should be undertaken to review the quality of independent investigations carried out by Strategic Health Authorities (SHAs)."

3. The Panel has since worked with SHAs, and met a range of other stakeholders, to understand how independent investigations into deaths of detained patients are commissioned. They have found such investigations are rare, and are mainly limited to investigations of homicide by mental health service users (which is a mandatory requirement, compared to the judgement that needs to be made about whether Article 2 is engaged or the SHA wishes to know more about a cluster of adverse events).

4. At the Ministerial Board on Deaths in Custody on 12 February 2013, CQC clarified their regulatory responsibilities. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 requires service providers registered with CQC to notify CQC of deaths of service users who are detained under the MHA. There is no specific statutory response to such information required by the Act, or the MHA. CQC had sought legal advice to advise their Board on options for discharging their

[1] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/01/IAP-Workstream-Paper-on-Article-2-Compliant-Investigations.pdf
[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf
[3] http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156&
[4] The sample of SUI reports contained within this analysis are from a spread of NHS as well as independent providers.

responsibilities following a death of a detained patient. CQC confirmed that their Board did not think that CQC should assume an investigatory role following the death of a detained patient but clarified that it would be expected in the exercise of its duties and powers to carry out a review of a death using its combined powers, and that this should cover all deaths (not just those viewed as unnatural).

5. CQC is developing its processes for dealing with notifications of deaths of detained patients, which includes a framework for triage and analysis with clear indicators and decision points for reviewers to determine how to escalate or follow up activity in certain cases. This may involve obtaining records from the provider; a monitoring or regulatory visit or other regulatory intervention. At a meeting between the IAP and CQC on 4 April 2013, CQC confirmed the new process would be finalised later in 2013 and agreed to keep the IAP updated on the progress. However, it should be recognised that CQC has no statutory remit or grant in aid funding to investigate deaths of detained patients, and its actions are policy commitments, not legal requirements.

6. Exploratory discussions in 2012 with an SHA Cluster lead on patient safety showed that:

- There is a great deal of patient safety data collected and acted upon by SHAs. This is being devolved back to Clinical Commissioning Groups as part of the changes to NHS governance.

- Detained patients are not identified as a specific group on the Strategic Executive Information System (STEIS) – the system for recording serious untoward incidents - in terms of suicide or other incidents. It is not possible to report on data in relation to this specific group. Therefore, CQC are the only source of information on actions taken following deaths of detained patients.

- No independent investigations had been commissioned by the SHA into the death of a detained patient[5].

Purpose of analysis

7. The Panel therefore decided to focus on assessing the quality of investigations undertaken by providers into deaths of detained patients with the aim of developing guidance that could be offered to the NHS Commissioning Board when it commences operation.

[5] Prior to NHS England assuming statutory responsibilities on 1 April 2013, the Department of Health guidance on independent investigation of adverse events in mental health services stipulated that SHAs were responsible for commissioning independent investigations. Commissioning in this context referred to determining when an independent investigation was necessary, appointing an independent investigation team, agreeing the investigation terms of reference, publishing and distributing the resultant report and ensuring a process for subsequent action to address issues raised. The guidance stipulated that an independent investigation should be undertaken when: (1) a homicide has been committed by a person who is or has been under care; (2) when it is necessary to comply with the State's obligations under Article 2 and (3) where the SHA determined that an adverse event warranted independent investigation e.g. if there was concern that an event may have represented significant systemic failures. The guidance is available to download here:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf

8. Following discussion with NHS London and the South London and Maudsley Trust (SLaM), the Panel decided to ask the CQC, as the main recipients of the reports from providers, whether it would be possible to see a sample of anonymised reports to develop the Panel's research questions. CQC agreed to support this exercise.

Limitations of the data

9. It had been the Panel's intention to use a small sample of reports to refine the criteria against which to evaluate a larger sample. However, in light of the resources required to redact 18 reports and the valuable learning that has been obtained from the smaller sample, it is no longer considered necessary to ask CQC to devote significant resources to redacting a larger sample.

Reports received

10. CQC provided redacted reports on deaths of 18 patients reported to them by providers. These were selected randomly from the information held on file; the reports received were written between May 2009 and June 2012 about patients who had died between April 2006 and April 2012 (although all but one occurred after April 2009). The Panel was provided with only the investigation reports, so there was limited management and administrative information about each of the cases – for example, it was impossible to tell from the reports whether recommendations had been accepted and implemented. It was also difficult to examine the role of external reviewers, in those cases where they were commissioned, as they were named as contributors but their particular views were not separated out from the internal investigation team.

11. Details of the patients' background and demographics are not particularly relevant to this study (the sample was not supposed to be representative of the patients and cause of death). However, for context, most reports were completed quickly after the death and very few cases had confirmed causes of death. The apparent causes were as follows: 10 self-inflicted or following self harm; five natural cause deaths; one natural cause death following an incident of restraint; one suspected overdose and one in which no information was provided. The causes of death identified in the SUI reports were broadly congruent with those determined at inquest, where held.

12. Of the 18 reports, nine had been heard at inquest, with nine outstanding. Of those yet to be heard at inquest, one had been outstanding for seven years; two had been outstanding between 3 and 4 years; two between 2 and 3 years; three between 1 and 2 years and one had been outstanding for less than a year. CQC had undertaken a paper review in 13 of the reports, three were reviewed by the MHA Operations Manager and two had not been subject to any review by the CQC[6].

[6] Currently, when a provider sends information to the CQC following a death, it will be reviewed by an Operations Manager in the MHA Operations team to determine whether or not a more detailed review is needed. If this happens, a paper review will be carried out, led by a Mental Health Act Commissioner to determine whether any further action – including a regulatory response - is required. CQC are working on a revised process for review as referenced earlier in this paper.

13. Nine reports concerned the deaths of female detained patients, seven were of male patients and two in which the gender was redacted. The age of deceased patients ranged from 20 to 58 years - the average age was 38 years. Nine patients were White British, one was mixed race and ethnicity was not stated or had been redacted in 8 cases.

14. The patients were mainly detained under Section 3 of the Mental Health Act (MHA) (10 cases), two were under Section 2, and two were under restricted transfer from prison. Two patients had been on community treatment orders (outside the Panel's terms of reference) and one was on Section 17 leave at the time of their death. No information about the patients' legal status was provided in one case.

15. Reports ranged in length from three to 68 pages, and the average length was 23 pages. Most were in the range of 20-40 pages. Other than three very short reports, the length of reports did not correlate with the quality of the investigation.

Method

16. The reports were analysed using a number of criteria under the broad descriptions of an Article 2-complaint investigation, that is it should be:

    I. initiated by the state of its own volition:
    II. independent;
    III. effective;
    IV. sufficiently open to public scrutiny;
    V. reasonably prompt and;
    VI. the next of kin/family should be involved.

17. The Panel considered whether the elements of an Article 2-compliant investigation were present – whilst acknowledging that reviews were not necessarily intended to meet those requirements.

18. The Panel considered a range of factors when analysing the efficacy of the reports, including the extent to which the following were analysed: whether the level of observations were reviewed; whether physical health provision had been of sufficient quality; whether the report establishes the factors that led to the death and significant events in the patients' history and proximal to the death were examined; use of root cause analysis (RCA) and the investigator being trained in this; reasoned conclusions followed a clear explanation of any service failings and recommendations for change that will improve practice and that logically flow from these conclusions; the use of a multi-disciplinary team to investigate the death and the involvement of service users and the family to understand the background factors.

Key findings

- **Independence**

19. All the reports were apparently commissioned and produced by the provider/Trust. The mechanism and personnel involved in setting terms of reference for the review or investigation was not clear in most reports.

20. Three reports state that families were involved in setting the terms of reference (although nine reports mention offering involvement, in general, to families).

21. Five reports specifically mention involvement of external reviewers as follows:

Case 1

This was natural cause death, but the review says the cause of death is out of scope and focuses on the organisation's response to the emergency events.

The report does not specifically state why an external reviewer was involved.

The external reviewer was a contact point for the family, and received questions from them that were fed into the scope of the review. There had been problems with family liaison by the provider, partly due to a lack of understanding of the role of the police who were present on the ward to investigate the death when the family were also in attendance. There were recommendations in the report about improving work with police to prevent confusion for families and to be clear that it is in order for the provider to talk directly to the family to whom they have a duty of care. Senior internal staff were also involved in the review and there was some public scrutiny in that they made a statement to the press.

The review took seven months to complete, which was longer than average.

Case 2

Five staff were involved in writing the report and they spoke to an external forensic psychiatrist for advice on how the patient's care had been managed. Significant events were examined clearly and one reviewer was trained in root cause analysis.

The family were involved in the review. It took three months to complete.

The review identified 14 critical issues covering a range of topics such as: medication; access to the means to take own life; use of seclusion; the relationship with the police in post-incident management; observations and staff's approach to resuscitation.

Case 3

The report does not state why an external reviewer was involved, although we could surmise it was due to the seriousness of the events as the patient died due to hanging shortly after absconding from the ward by jumping out of a window.

The report was shared with family members although it is not clear whether they were invited to contribute to the terms of reference.

Other senior internal staff were involved in the review. The reviewer was trained in RCA and provided a comprehensive review of the care in place for the patient leading up to their death. They also involved a service user in the review, although their contribution was unclear.

The review took three months to complete, which was average.

Case 4

The external reviewer was appointed due to the provider's view that the event was serious and that they needed specialist advice. The external review was a consultant psychiatrist from another Trust with experience in treatment of personality disorder. The patient died due to an incident of self harm (ligature) shortly after being moved to a specialist ward. The reviewers thought that the subtle difference in staff's approach to patient responsibility/autonomy and observation might have led to the patient feeling anxious and contributed to the fatal incident of self harm.

There were very clear terms of reference and significant events were comprehensively addressed. The internal reviewer was trained in RCA. The report took two months to complete after death, which was quicker than average.

The recommendations and lessons learned were also very clear and challenging for staff.

Case 5

An external reviewer was appointed due to the seriousness of the events – the patient had failed to return from Section 17 leave and was found dead in the grounds of the hospital. Family liaison had been positive before the patient's death and no concerns were reported about the way the provider informed them of the death. However, the review made recommendations for improvement in family liaison.

It is not clear from the report how long it took to produce, it could be either one month or one year, depending on whether there was a typographical error in recording dates.

22. The level of contribution of external reviewers was not obvious in any of the cases and none seemed to have written the reports. They were appointed because of the perceived seriousness of the events. Case 1 enabled the external reviewer to suggest specific questions that should be addressed and Case 16 made use of an external reviewer given their professional expertise in dealing with personality disorder in order to identify whether the level of care had been good enough.

23. The Panel wanted to consider whether the person undertaking the review (their seniority and professional background) affected the level of independence and quality of the investigation. The type of staff involved in the review varied from low to high seniority, their internal distance from delivery of the service and the range of disciplines. These included Ward Managers (of the ward where the death occurred), Consultant Psychiatrist, Medical Director, Corporate Governance department, Head of Nursing, Executive Director of Nursing, Patient Safety team and a service user representative.

24. Eleven reports show that the review or investigation was undertaken by a multi-disciplinary team. The number of people undertaking the review or investigation ranged from one to five – the average was three.

- **Effectiveness**

Methodology of reviews

25. Most cases involved a review of case records and policies (15 cases) and in 10 of these cases, the reviewers also interviewed staff. Four reviews considered written statements from staff (rather than interviews). Two reviews involved group interviews with staff, and one specifically mentions de-briefing staff on the findings and recommendations.

26. Eight reports specifically state that one or more of the reviewers had been trained in RCA. We considered whether this affected the effectiveness of the review. A common feature of reviews in which the author was RCA trained was a structured and systematic approach to identifying the key issues that were relevant to the patient's death and or the quality of care received. In most of these cases there were clear terms of reference as well as recommendations and learning points. These reports were rated more highly in how they approached examination of the events that led to the patient's death.

27. In the remaining cases, in which the reviewers do not state that they were RCA trained (and the reports do not follow consistent headings that were present for those where the author stated they were RCA trained), there was variable quality. Most were very short and were less structured. Recommendations were not always linked to a full exploration of the ways in which the service had performed poorly.

Physical health

28. The management and treatment of patients' physical health was examined in six cases. Five of the cases were noted as natural cause deaths, and the level of examination of the physical healthcare provided to the patient varied. None involved a full clinical review of the patient (as would be the case when a prisoner dies and the PPO is investigating).

Case 6
The death had been due to choking and there were relevant physical health problems that precipitated the incident. The reviewer checked whether regular health checks had been undertaken on the patient but did not draw any conclusions about this.

Case 7
The patient collapsed. An examination of physical health was not mentioned specifically in the terms of reference and the report contains a short discussion about the patient's lifestyle.

Case 8
Not clear whether care of physical health had been examined.

Case 9
The patient had a number of physical health problems and interventions. The reviewer checked that appropriate referrals had been made to medical services and the emergency response was analysed.

Case 10
The patient died in police custody having been taken there due to criminal charges and apprehended whilst he was AWOL – there was no meaningful review of physical healthcare.

Factors relevant to care

29. Fourteen reports clearly attempted to establish the factors relevant to the care provided in the lead up to the patients' deaths. Seven reports did this reasonably well and four did so very well. Three did so poorly.

Significant events

30. Eleven reports examined significant events during the patients' care, two did so partly, two did not cover this at all and it was unclear in three reports.

Support for staff and patients as part of review

31. Provision of staff support following the death was mentioned in 10 cases, with provision of patient support following the death mentioned in three cases.

Recommendations and conclusions from the reviews

32. Thirteen cases showed that the reviewers had reached reasoned conclusions and 10 reports had clear recommendations from improvement. Examples as follows:

Case 11
The reviewer identified 14 critical issues, key causal factors and contributory factors as well as notable good practice and then made recommendations under each heading, for example: "There should be a training event for Consultant Psychiatrists to reinforce current best practice in effective treatment of severe psychosis." "For the Clinical Director to facilitate a reflective session with the Consultant Psychiatrist in relation to this case." Others included a review of training materials; to review the use of seclusion and dissemination of learning.

Case 12
This also presented findings under headings of root causes, contributory factors and incidental factors. They were incisive and critical, for example: "The inability of teams to resolve openly differences of opinion through supervision or team consultation about their approach towards the patient." "The defensive practices of the teams and services involved with the patient as being 'too safe' which militates against required positive risk taking." "Some staff being unable to tolerate the anxiety and discomfort engendered by suicidal and self-harming behaviour." "Some staff having insufficient skills, knowledge and experience in managing personality disorder and the ability to

seek appropriate advice when in doubt." The review found no root causes for the death but identified 10 contributory causes – including a lack of leadership and high stress levels in teams. The findings were then presented as "statements of intent" and actions flowing from the conclusions, rather than recommendations. These included specific resolutions such as, "Differences of opinion will be resolved via the two senior clinicians" and "We will ensure that staff receive protected clinical supervision for all their personality disorder cases, and offered appropriate support and training before being allocated PD cases."

Case 13

The review listed the history of the patient's contact with the service and then concluded by saying the way in which she had accessed razor blades (which she swallowed and caused her death) was unclear. The reviewer said it was their role just to present the facts and to recommend areas for development flowing from this. However, no such recommendations are contained in the report.

Case 14

Review provided very little detail on the factors that led up to the patient's death, although the reviewer rated the staff response as "good with minor lessons to be learned." There were six recommendations such as, "A sign to be placed on XXX cupboard to ensure oxygen bag and emergency drugs are taken at the same time as the XXX to an incident" and "To develop the current resuscitation time trials…to include a simulated resuscitation exercise including appropriate recording of the incident."

Case 15

This review was very short and provided brief details of the patient's contact with the service and did not examine the reasons for their death. The recommendations were limited to, "The report to be reviewed at the Adult Mental Health Executive and the Clinical Risk & Safety Group."

Case 16

This report provides a structured review of causal, contributory and good practice issues. However, there are no recommendations. The author notes areas for improvement but does not present these as issues to be addressed. For example, "The communication with [the patient's] mother on the day of the incident could have been handled more sensitively. [The patient's] mother was given a phone call at work and told over the phone."

33. Positive practices were mentioned in 11 cases, with the aim of reinforcing practice that was either protective in the individual case or in general. There was no evidence that learning was shared beyond the providers.

- **Public scrutiny**

34. No reports stated that they would be published or open to public scrutiny and involvement of external reviewers (alongside provider staff) was referenced in five cases. This is in contrast to investigations carried out by the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC) following a death which incorporate independent

- **Prompt**

35. Reports were completed promptly, on the whole. The timescales from death to completion of review were clear in 14 cases – in which the average length of time was three months (10 cases took three months or less to complete). The short timescales for production of reports meant the reviews were limited to information available at the time, and most deaths were presented as 'cause unknown' pending the outcome of the inquest. Whilst this is an appropriate way of presenting the facts, it sometimes led to reviewers not exploring factors that could be viewed as causal or contributory to the deaths, and from which the providers could learn. Reports that were produced within a month of the death were also very short and of lower quality.

- **Next of kin/family involvement**

36. There was a clear offer to families of involvement in the review in nine cases. No specific offer of involvement was recorded in eight cases, although family liaison in general is noted in some of the reports. In one case the relationship between the patient and family had broken down and they declined to be involved.

37. Seven families were offered support in addition to involvement in the review and five reports specifically mentioned sending the reports to families, although there was a lack of clarity in most reports as to whether this had been done.

Conclusions

38. In January 2009, the Forum for Preventing Deaths in Custody published a report[7], which suggested that in certain circumstances, the independence requirement would not be met, particularly in relation to the investigations of deaths of detained patients under the MHA. The Chair of Joint Committee on Human Rights wrote to the previous government in May 2009 requesting confirmation of whether they accepted the Forum's recommendations. The Chair of the IAP followed this up in December 2010, and the Panel received a reply from the Secretary of State in April 2011 saying that there was no single, prescribed form for an investigation, although it should meet the minimum requirements set out in Article 2.

39. The government re-stated that the Coroner's inquest is the primary means by which the state fulfils its Article 2 obligations. The Secretary of State's letter in response to the Forum recommendations also suggested that: "in individual cases where Article 2 is engaged, the inquest alone, or in some cases the combination of inquest and NHS independent investigation should provide for an effective investigation under Article 2." Whilst the Panel agrees that inquests are the *primary* means by which the state discharges its duties to

[7] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf

investigate deaths in custody, we want to emphasise that the nature and extent of the investigations carried out before the inquest are also of critical important.[8]

40. The positive duty to investigate promptly, systematically, transparently and effectively is undertaken in certain specified custodial sectors by the PPO and the IPCC. There is, however, no such system in place for investigating deaths in a similar fashion of those detained under the MHA.

41. The Panel also has concerns that the coronial system is not sufficiently responsive or properly resourced to undertake a prompt and effective investigation into all deaths of detained patients. In addition, although non-natural cause deaths are referred to the Coroner, those detained patients who die of perceived natural causes are not routinely referred, and there is no legal requirement to do so until the implementation of reforms to the coroner system contained within Part 1 of the Coroners & Justice Act 2009. These reforms are due to be brought into force in June 2013.

42. The Panel recognises the importance of internal investigations in order to stop dangerous practices, but the available evidence indicates that a satisfactory system does not currently exist for investigating the deaths of detained patients in an independent or open way.

43. As to the sample cases considered in this paper, the Panel was provided with only the investigation reports, so there was limited management and administrative information about each of the cases. For example, it was impossible to tell from the reports whether recommendations had been accepted and implemented. The methodology and aims of the reviews were also unclear. This contrasts with PPO and IPCC investigations, where the investigative terms of reference are agreed in advance, with family input. This ensures the investigation parameters are well understood by all participants.

44. The analysis highlighted that three reports used root cause analysis in an attempt to identify any service issues that were core to the circumstances surrounding the death. Particular reports did this very clearly and demonstrated reasonable conclusions based on a consideration of a wide range of evidence. However, there is a lack of structure or process, and/or policy requirements to share learning from reviews beyond the providers and family liaison was not recorded in the reports for eight cases. However, it is not possible to conclude that contact was not offered. The omission from the reports indicates, however, that their possible contribution to the investigation was not considered important.

45. Furthermore, there does not seem to be a clear rationale for involving an external reviewer. In the cases in which an external reviewer was involved, there is some evidence of a more thorough approach to the investigation but the nature of their specific contribution is not made clear. Furthermore, the number and seniority of reviewers is variable and not predictive of quality.

[8] See, e.g., *R (JL) v Secretary of State for Justice* [2008] UKHL 68, at 42.

46. The reports - mainly labelled reviews, not investigations - were completed quickly (especially by comparison with timescales for independent investigations by PPO and IPCC) – and there was a noticeable lack of focus on the cause of death. Nearly all the apparent self-inflicted deaths were presented as self harm that had gone wrong (and caused accidental death). There are also inconsistent responses to deaths of similar seriousness. For example, the death of a patient on a community treatment was reviewed in the same depth as apparent self-inflicted deaths on the ward.

47. The variable quality and consistency of the 18 redacted reviews provided by CQC has highlighted the importance of there being clear and consistent guidance available for mental health trusts on how to conduct investigations into deaths of patients detained under the MHA. This would provide guidance to trusts, inter alia, on investigative thresholds and expectations and how they could undertake such investigations which are Article 2-compliant.

48. The Panel recommends that guidance for trusts should be produced by NHS England with input from CQC given their significant experience of undertaking regulatory visits to health and social care establishments and of reviewing Serious Untoward Incident reports. Furthermore, the Coroners & Justice Act 2009 promotes the importance of Rule 43 reports reflecting the capability of these reports to have an impact on preventing similar deaths in future. The Chief Coroner - who will oversee reforms in the Act - should also provide input to the development of the guidance to ensure that the importance of learning from deaths is embedded in the guidance.

Recommendation: NHS England – with input from CQC and the Chief Coroner - should produce guidance for mental health trusts, which provides clear and consistent guidance on how trusts should undertake investigations following the death of a detained patient (which should include guidance on how to ensure investigations are Article 2 –compliant, where relevant).