



Independent Advisory Panel on Deaths in Custody

*Chair: Juliet Lyon CBE
Head of Secretariat: Andrew Fraser*

*102 Petty France
4th Floor, 4.16
London
SW1H 9AJ*

22 August 2018

www.independent.gov.uk/iapdeathsincustody

Sir Simon Wessley
Independent Reviewer – Mental Health Act

Dear Sir Simon,

The Independent Advisory Panel on Deaths in Custody (IAP) welcomes your substantive review of the Mental Health Act (1983). I am writing to provide the IAP's evidence to the second part of the review. I will start by briefly introducing the IAP.

INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

The IAP is a small, independent arms-length body developed after the Fulton review, which established the Ministerial Council on Deaths in Custody. Our role is to act as a primary source of advice to Ministers on how best to reduce deaths in state custody. The IAP is co-sponsored by the MoJ (the lead sponsor), the Home Office and the Department of Health. Prisons, approved premises, police custody, secure hospitals, establishments holding people under the Mental Health Act, and immigration centres all fall within our ambit. Panel members have considerable experience in psychiatry and human rights – as well as work within custodial environments. The IAP identifies and draws on examples of national and international good practice. We are also supported by a broad group of around 200 interested parties, including members of bereaved families and health and justice professionals. Our single objective is to help prevent avoidable deaths, natural and self-inflicted, in custody and to enable the state to fulfil its obligation to protect life. The IAP's specific mandate means that this submission will address two particular issues: the need to support the physical health of people detained under the MHA,

and the need for independent investigations of those who die while subject to the MHA.

SUPPORTING THE PHYSICAL HEALTH OF THOSE SUBJECT TO THE MHA

Between 2012/13 and 2017/2018 the following deaths of those detained in hospital were reported to the CQC:

Fig 1.

Overall summary – Deaths of detained patients - 2012/13 to 2017/18¹

Type	2012/13	2013/14	2014/15	2015/16	2016/17
Natural Causes	200	126	182	201	186
Unnatural Causes	48	36	34	46	54
Undetermined	27	36	11	19	7
Total	275	198	227	266	247
% natural deaths of total deaths	73%	64%	80%	76%	75%

Self-inflicted deaths in all forms of state custody are tragic events that the state must work to minimise as far as possible. However, in all forms of state custody – including secure hospitals – the most common cause of death is due to natural causes. In recent years at least, the number one cause of deaths of those detained in hospital was cardiovascular disease. This represents a concerning trend if some of these deaths are preventable, and an opportunity for concerted action to have a significant impact in preventing a large number of such deaths.

The IAP is concerned that many psychotropic medications have long-term and short-term cardiovascular and other physical health-related adverse effects. Unless these effects are monitored carefully and mitigated against, they increase the risk of premature mortality. Given that the state is responsible for the care of these patients, and able to compel the administration of medication, the IAP believes that the state has a responsibility to monitor the physical healthcare of those it is prescribing such medication to. The IAP would like to see the following principle considered and taken forward:

The physical monitoring of detained patients should be improved to ensure that avoidable natural cause deaths are prevented as far as possible.

The IAP would be pleased to work with the Independent Reviewer to review the Mental Health Act 1983 and the Mental Health Act Code of Practice to consider whether providing a statutory basis for physical health care and monitoring should be introduced when medication is prescribed.

¹ Source: CQC https://www.cqc.org.uk/sites/default/files/20180227_mhareport_web.pdf

INDEPENDENT INVESTIGATIONS

As you will know, all deaths in state custody should result in an inquest. In cases where the state may have been involved in the death there will be an 'Article 2' inquest. This refers to Article 2 of the European Convention on Human Rights (the right to life) and means that the inquest must decide not only the identity of the deceased and when, where and how the death occurred, but also, more broadly than a standard inquest, in what circumstances the deceased came by his or her death. For Article 2 to be engaged, there must be reasonable grounds for thinking that the death may have resulted from a wrongful act on behalf of the state.

In such a case, the state is under an obligation to initiate an effective public investigation by an independent body. The House of Lords has ruled that, while a criminal investigation and prosecution may not discharge this obligation, an inquest is likely to do so. The inquest must, however, determine not only the identity of the deceased and when, where and how the death occurred, but also in what circumstances. The limited ambit of a 'standard' inquest will not satisfy the obligation on the state.

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 persons responsible for and carrying out the investigation must be hierarchically and, institutionally and practically independent from those implicated in the events.

The investigation into deaths that engage the right to life must therefore meet minimum standards, including²:

- 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 conduct of any part of the investigation;
- lessons are learned that may save the lives of others; safeguarding the lives of the public, and reducing the risk of future deaths.

The UK government has taken the view that Article 2 responsibility is satisfied by the coronial inquest process and by jury inquests by the coroner. However, this has resulted in a clear difference 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 Office of Police Conduct (IOPC) or the Prisons and Probation Ombudsman (PPO) – no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the

² R (on the application of D) v. Secretary of State for the Home Department [2006] All ER 946 at para 9 (iii).

inquest is reliant pre-inquest on internal reviews and investigations - if an investigation is conducted at all. It has been argued for some time that the investigatory duty under Article 2 requires both that the evidence gathering phase (taking statements and collecting forensic evidence) and the formal inquiry (coroners hearing phase) both need to be independent of the institution that is being investigated.³

Recent evidence from the Mazars report⁴ into Southern Health NHS trust strongly suggests that a number of such deaths are not investigated by the trusts themselves. While the recent efforts of DHSC, NHS and the CQC to improve their investigations is welcome, such as the Learning and Candour report⁵, the issue remains that patients who die in secure hospitals do not receive the same level of scrutiny as those who die in other forms of state custody.

The lack of independent and transparent investigations pre-inquest has a number of unwelcome impacts. It makes it harder to reveal mistakes, is less transparent to bereaved families and, importantly, fails to give the appearance of credible independence. This also affects the inquest, as coroners are beholden to the investigations for much of the information they receive. There is a further problem which, while it may initially seem academic, has important implications for the state's responsibilities.

The lack of a national, independent body responsible for such investigations means that there are significant concerns over the number of deaths subject to the MHA. The Health Service Journal has reported that hundreds of patients who died while being detained under the Mental Health Act could have been denied inquests⁶. It noted that there were inconsistencies between official data on deaths reported to coroners in England and Wales and notifications sent to health regulators by NHS trusts, and suggested that coroners may not have conducted inquests into every death. The point here is not to criticise coroners, but to demonstrate that the lack of a national investigatory body means that – unlike with deaths in prisons or police custody – the numbers of deaths of detained patients are always tempered by concerns about the veracity of reporting. It is unacceptable for the state not to be able confidently to declare how many patients have died while in its custody.

The IAP recognises that the national courts have decided that internal investigations and the inquest process fulfil the requirements of Article 2. However, we would point to the credibility and benefits presented by such bodies as the IOPC and PPO and ask why patients in detained hospitals are not deemed worthy of the same degree of scrutiny if they have the misfortune to die in the state's care? The IAP would like to see the following principle considered and taken forward:

³ By the Forum for Preventing Deaths in Custody, <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>

⁴ <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf>

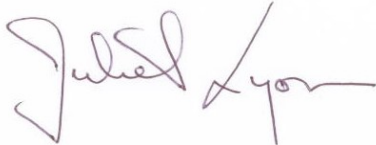
⁵ <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>

⁶ <https://www.hsj.co.uk/topics/policy-and-regulation/exclusive-trusts-fail-to-report-hundreds-of-mental-health-patient-deaths-to-coroners/7009813.article>

Detained patients who die in state custody should be subject to an independent investigation – similar to those who die in prisons, police or immigration custody.

The IAP would welcome the opportunity to discuss these points with you in more detail, if helpful.

With kind regards,

A handwritten signature in purple ink that reads "Juliet Lyon". The signature is written in a cursive style with a long horizontal stroke at the end.

Juliet Lyon CBE
Chair of the Independent Advisory Panel on Deaths in Custody

Post Point 4.16 | 4th Floor | 102 Petty France | London | SW1H 9AJ

e: Chair.IAP@justice.gov.uk

OFFICIAL/SENSITIVE/ SECRET/TOP SECRET