INDEPENDENT ADVISORY PANEL (IAP) ON DEATHS IN CUSTODY

SECOND FAMILY LISTENING DAY – FOCUSING ON FAMILIES OF PATIENTS WHO DIED WHILST DETAINED UNDER THE MENTAL HEALTH ACT

Background

1. The IAP commissioned INQUEST, following an open procurement exercise, to deliver a second family listening event so that we could hear from families who had experience of the investigation and inquest process after their family member died whilst detained under the Mental Health Act (MHA). The aim of the event was to share details of the post death experience, investigative and inquest process, and support provided by Trusts. INQUEST's report of the day is attached, and will be published on the IAP website in due course.

Key points from second Family Listening Day – September 2011

2. INQUEST's report of the second family listening day shows there is cause for concern in terms of families' post death experience, both in terms of notification of death, access to information and support, as well as the investigations conducted by Trusts. Family members suggested a number of areas for improvement and the following recommendations take these into consideration.

Notifying families of the death

3. Practice was inconsistent in terms of informing families of their relative's death and points to the need for a family liaison lead for this sensitive role. Families described staff or police officers being not fully informed about the facts of the situation, who were unable to advise them on how to access advice and support. One family described a negative experience of liaison with clinical staff leading up to the death (for example, they did not think staff had listened to their warnings about their relative's imminent risk of suicide) after which they felt contact became adversarial because staff seemed concerned about being criticised for poor practice.

This could have been alleviated by appointing a family liaison lead who had not been directly involved in the patient's care. This could be an appropriately trained Bereavement Officer.

Access to advice and support

4. Families described being 'left in the dark' regarding the post-death process, investigations, post mortems and inquest procedure. This was described as being patchy in some cases and absent in others. There is a need for Trusts to signpost families to specialist information, legal advice, bereavement support and help.

Information about the investigation

5. Families described Trust staff as being 'insensitive and obstructive' by not providing families with information about the investigative process, what it would entail, timescales for completion and how to access the draft and final report. This damaged their confidence in the independence and rigour of the investigation. Trust policies on investigating serious untoward incidents should cover the procedures for involving families, including their contribution to the terms of reference, timescales and disclosure of the investigation report. There was one positive example where a family who was legally represented had been involved in setting the terms of reference for the investigation, were able to raise their concerns and were kept informed at important stages throughout the process. The draft report was also shared with them for comments. The Panel believes this example of good practice should be standard in all cases and we hope our recommendation, set out below, goes some way to improving the experience for other families.

6. The Panel is now aware of good practice in some Mental Health Trusts where family liaison leads are appointed to ensure families are aware of the investigation and to explain how they can contribute and receive information. The only national guidance on family liaison is the National Patient Safety Agency's document: "Being

Open"[1] document, which was re-launched in 2009. This should be referred to by Trusts when planning their arrangements for family liaison.

Recommendation: Trusts with responsibility for detained patients should have procedures in place for ensuring good quality family liaison with bereaved families. Families should be signposted to independent sources of legal advice, help and bereavement support.

Policies on investigation should be explained to families and ensure they are offered an opportunity to be involved, receive ongoing information and have sight of reports.

Access to legal advice and representation

7. All but one of the families who had obtained legal advice and/or representation reported that the process had been protracted, difficult and intrusive. For some it had come at a hugely prohibitive cost. Families also described unfairness as the Trusts legal representation at inquests was paid for by public funds. The Panel recognises the difficulties with providing resources for public funding for families given cuts to the legal aid budget. However, families who had been legally represented from the outset reported a more positive experience because they played a more active part and had some control over the process. Their lawyers were also able to access more timely information about the circumstances of their relative's death

Inquests

8. Families reported mixed experiences of the inquest into their relative's death – problems related to lack of sensitivity, inconsistent practice regarding remit and evidence, lack of disclosure of information and the impact of delays in inquest

[1] http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726)

hearings. There were some positive examples of how properly conducted inquests worked to help families' experience of the process. These included experiences of coroners who kept them involved in advance of the inquest, were thorough in their investigations and who were sympathetic to their situation when in court. Families also talked positively of those coroners who kept them informed of responses to any Rule 43 reports. The Panel believes that Trusts should also update families on action taken to implement changes to policy and practice as a result of their relatives' death.

Recommendation: Trusts should keep families informed of actions taken to learn from their relative's death including changes to policies and procedures as a result of the death, investigation or inquest.

9. The Panel has made a series of recommendations to the Ministry of Justice about reducing delays and improving the overall experience for families during death in custody inquests. The Panel recently met Ministry of Justice policy leads on coronial reform to take stock of these recommendations, and to ensure this agenda is prioritised as part of the Chief Coroner's remit.

Next steps

10. The Panel's first family listening event took place in March 2010[2] and focussed on families whose relatives died in prison or police custody. Since then the Panel convened a meeting with the custodial sectors and investigatory bodies to examine their family liaison functions. Most attendees agreed there would be value in developing a set of common cross sector principles covering the process for notifying families following a death in custody, the key sources of information and support shared with families and the importance of having procedures in place to ensure that families are informed of any changes to policy and practice as a result of

[2] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2010/09/IAP-Family-Listening-Day-Report-Aug-2010.pdf

the death. In addition, following the Panel's national stakeholder consultation event in March 2011, the Chief Executive of NOMS wrote to Governors asking them to keep families informed about the outcome of PPO investigations and inquests.

11. Implementation of the Coroners and Justice Act 2009 (section 7(2)(a)) will mean that deaths of patients detained under the Mental Health Act that are violent or unnatural or the cause of death is unknown must be held with a jury. This will be a change to current practice, where such inquests are held at the coroner's discretion, and may prompt more in-depth investigation of the circumstances of the death.

12. It is important that bereaved families are treated humanely and compassionately so their post death experience does not damage them even further at a very vulnerable time. A properly conducted investigation and inquest process in which their rights to participate are recognised and respected can even help families in the bereavement process. Such investigations also assist the public interest in establishing what happened and to identify action needed to be taken to prevent future deaths.

13. In our next term, the Panel plans to take forward work on family liaison and to re-engage with the sectors and investigatory bodies about a set of common principles to ensure consistently high level of service to families. We will consider how this can be effectively communicated to practitioners and families.

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