

Preventing Deaths in Detention of Adults with Mental Health Conditions

An Inquiry by the Equality and
Human Rights Commission

Contents

Foreword	Page 3
Chapter 1: Executive summary	Page 4
Chapter 2: Setting the scene	Page 11
Chapter 3: Recommendations	Page 19
Chapter 4: Human rights and the Human Rights Framework	Page 23
Chapter 5: Dignity and respect	Page 27
Chapter 6: Risk and assessment	Page 35
Chapter 7: Access to treatment and support	Page 45
Chapter 8: Investigations and preventing future deaths	Page 53
Chapter 9: Scotland	Page 66
Appendix 1: Glossary	Page 74
Appendix 2: Organisational landscape across settings	Page 80
Appendix 3: Terms of Reference for the Inquiry	Page 81
Contacts	Page 82

Foreword

Professor Swaran P. Singh and Evelyn Asante-Mensah, OBE Lead commissioners to the Inquiry

Between 2010 and 2013 367 adults with mental health conditions died of ‘non-natural’ causes while in state detention in police cells and psychiatric wards. Another 295 adults died in prison of ‘non-natural’ causes, many of these had mental health conditions. Since 2013 that number has risen considerably. Each of them left behind loved ones who have suffered as a result of these deaths.

The Equality and Human Rights Commission’s role is to promote and enforce the laws that protect everyone’s rights to fairness, dignity and respect. We launched this Inquiry to ensure that the human rights of some of the most vulnerable members of society – those with serious mental health conditions – were being protected as far as possible.

Our Inquiry reveals that despite many reports and recommendations, serious mistakes have gone on for far too long. The same errors are being made time and time again, leading to deaths and near misses.

Yet it also shows that making improvements is not necessarily complicated or costly: openness and transparency and learning from mistakes are just about getting the basics right.

By listening and responding to individuals and their families organisations can improve the care and protection they provide and prevent further unnecessary and avoidable harm.

During the course of our work, we consulted with and were helped greatly by several organisations, including the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW), Her Majesty’s Inspectorate of Constabulary (HMIC), Her Majesty’s Inspectorate of Prisons (HMIP), the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO).

We also met with the National Offender Management Service, Welsh Government, Department of Health, NHS England, NHS Wales and the Home Office.

We received evidence from individuals and organisations affected by the topic of our Inquiry. In the course of this Inquiry, the team was able to spend time talking to some of the families of those who died in detention and their experiences are central to our report. We would like to thank all of those involved, in particular the family members, for their help and support. We would also like to thank the Commission’s Inquiry team for their hard work.

We hope that this report provides valuable insights and recommendations which can bring about real change in the way that adults with mental health conditions are treated in detention. Our aim is to help prevent further unnecessary tragedies.

Chapter 1: Executive summary

Overview of the Inquiry

Our Inquiry was launched in June 2014 to examine how compliance with human rights obligations can reduce ‘non-natural’ deaths of adults with mental health conditions in state detention. We looked at deaths in three state detention settings – prisons, police cells and hospitals – consulting with inspectorates, regulators and others with responsibilities in this area. The Terms of Reference for the Inquiry are at Appendix 3.

The Equality and Human Rights Commission’s (the Commission’s) Inquiry examined the available evidence in relation to the deaths of 367 adults with mental health conditions who died of ‘non-natural’ causes while in police cells or as detained patients over the period 2010-13, plus a further 295 who died in prison custody, many of whom also had mental health conditions.

This is a large number in itself, yet for each individual who died there are family members and other loved ones who suffer as a result of these deaths. Previous inquiries, investigations, inquests and court cases have established that, too often, the circumstances

surrounding deaths in detention involve breaches of people’s most basic human rights – including the right to life. We wanted to establish whether a focus on increased compliance with Article 2 of the European Convention on Human Rights, including the State’s positive obligation to protect people’s life, would reduce avoidable deaths.

One in four British adults experience at least one mental health condition,¹ and one in six are experiencing a mental health condition at any given time. Some people will experience more than one mental health condition.² While many people continue to lead productive and fulfilling lives with very little involvement from the State, the Government recognises its role to provide specific care for people experiencing mental health conditions at a time of vulnerability.

We wanted to establish whether a focus on increased compliance with Article 2 would reduce avoidable deaths

1 For the purpose of this Inquiry the Commission will define a mental health condition as any disorder or disability of the mind. This definition is identical to the definition of a ‘mental disorder’ in section 1 of the Mental Health Act 2007.

2 *The Fundamental Facts 2007*, p. 7. Available at: http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard

A small number of those with mental health conditions will be detained by the State either because of an offence they have committed or because they are judged to be a threat to themselves or others.

In 2012/13 there were over 50,000 detentions in psychiatric hospitals, and this number is increasing. The prison service does not currently record the number of prisoners with mental health conditions. The most recent national data relates to 1997, where 92 per cent of male prisoners were reported to have one of the following five conditions: psychosis, neurosis, personality disorder, alcohol misuse and drug dependence. Seventy per cent had at least two of these.³ Statistics for England show that police cells were used as a place of safety 6,028 times in 2013/14.⁴ That equates to 115 occasions each week when someone was held by the police because of their perceived risk to themselves or to others.

Human rights give essential protection to everyone. Our rights are protected under the Human Rights Act 1998, by the European Convention on Human Rights, and by other key obligations of the State to uphold the Optional Protocol to the UN Convention against Torture. In the UK the National Preventive Mechanism (NPM) is charged with carrying out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment.

In 2012/13 there were over 50,000 detentions in psychiatric hospitals, and this number is increasing

They not only protect individuals from the acts and omissions of the State and public authorities acting on its behalf but also oblige those authorities to take steps to protect them in certain carefully defined circumstances.

Recommendations

We make four major recommendations which, if implemented, we believe would reduce deaths and give families, government and institutions a greater assurance that human rights obligations have been met and all has been done to protect the lives of those the State has detained.

Our recommendations are addressed at government, regulators and inspectorates and the leaders and managers of individual institutions. These are included in more detail in Chapter 3 of the report.

Recommendation 1: Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions.

³ Singleton N. et al (1998) *Psychiatric Morbidity Among Prisoners*, 1997. London: ONS.

⁴ HSCIC, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England 2013-2014*, Annual figures. October 2014.

As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

Recommendation 2: Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.

Recommendation 3: In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour which applies to NHS bodies in England. If it proves to be effective this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

Recommendation 4: The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014

with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

Main findings

For **detained patients in hospitals** we were not able to access much of the information that follows a non-natural death, such as individual investigation reports. Detained patients are a particularly vulnerable group in the UK who are being held in order to keep them, and others, safe. The care given to them must reflect their specific needs and it is incumbent on society to monitor this care.

There is no body charged with ensuring that investigations take place or that learning is identified (including at other hospitals), as in the prison and police settings. The inevitable conclusion is that this is an opaque system where families of those who die in psychiatric hospitals are shut out of the care preceding and the investigation following a death.

In healthcare settings, a Coroner's inquest into the death of a detained patient is compliant with Article 2. However, we would like to see a model in place similar to the role of the investigatory bodies in the police and prison settings. The Government should take steps to ensure it can be confident that independent investigations are indeed taking place, that staff are supported to speak candidly about events and there are no deaths in psychiatric hospitals that could have been prevented. The Commission considers this to be such an immediate opportunity to reduce the deaths of detained patients that we intend to take this forward with those responsible for providing and regulating psychiatric care in hospitals.

An important and recent change is the introduction in November 2014 of a statutory duty of candour⁵ which applies to NHS bodies in England and will apply to all other care providers registered with the Care Quality Commission (CQC) from 1 April 2015. The duty means that care providers must ensure they are open and honest with people when something goes wrong with their care and treatment, in particular staff must be candid when taking part in interviews relating to investigations. This has potential for driving significant improvement and should be monitored closely – if effective it should be applied to other settings including prisons and police.

In relation to **prisons** the debate about how people are detained needs to go beyond the minimum standards that keep people alive. Those responsible for detention must ensure that people are not punished for behaviours that are viewed as disruptive but in fact are symptomatic of illness. Prisons need to monitor the numbers of prisoners with mental health conditions and their severity so that they can reflect on them and make appropriate arrangements for treatment and support.

It is impossible to talk about the high levels of people with mental health conditions in prisons without questioning whether imprisonment is the appropriate place. When an individual has committed a crime, they rightfully pay penance for that crime; as many others have previously stated we remind the Government that the aim of the penal system should be about rehabilitation as well as punishment.

Statistics for England show that police cells were used as a place of safety 6,028 times in 2013/14

For some people the need for tailored rehabilitation that meets their particular needs might be better served within the community or psychiatric hospitals. This would also mitigate the pressures on prison resources.

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014. HM Inspectorate of Prisons (HMIP) have cited their concerns about the increase in people being imprisoned. They and the Prisons Probation Ombudsman (PPO) have also voiced concerns about staff reductions, tougher regimes and less resources and possible links between the deaths and these factors. Any link between these factors and the increase in non-natural deaths since 2013 is complex and needs to be better understood. Therefore those responsible for keeping prisoners safe should work together to understand and address these issues. Any deterioration in conditions of detention and adverse impact on those with mental health conditions should be monitored and remedied.

In the course of our Inquiry we have come across cases from PPO investigation reports where deaths have resulted from the failure to identify a prisoner's mental health condition and where concerns were

⁵ Care Quality Commission, Guidance for NHS bodies: Regulation 5: fit and proper persons: directors and Regulation 20: duty of candour, November 2014.

identified but not shared with colleagues. These deaths could have been prevented if prisons got the basics right.

There are very few deaths within **police custody**, however every year a number of people with mental health conditions die while being detained. The role of the police is not to provide clinical care to people in need of support however they are often the first on the scene so they cannot ignore the need to be able to respond appropriately while minimising the use of restraint. This should always be done in partnership with local health providers (including ambulances).

There is a considerable amount of work being done nationally and locally, including the Crisis Care Concordat.⁶ These should help ensure quicker assessments and access to clinical care and that people are not being held inappropriately within police cells. Due to be reviewed in 2015 this should ensure that the deaths in this setting will continue to decrease.

The police should record and publish the use of restraint in order to allay concerns that there is discriminatory use against people with mental health conditions and people from ethnic minorities.

Context of the Inquiry

The Independent Advisory Panel on Deaths in Custody collects information in relation to all deaths across detention settings. The Panel is clear that there are gaps in the data. There is a detailed table in Chapter 2 (Setting the scene).

The numbers of deaths in or following police custody have fallen over the past

10 years. Rates of non-natural deaths in prisons similarly fell after 2004 and remained at a lower level between 2008 and 2012; in 2013, however, there was an increase. This suggests there is a need for continued scrutiny to avoid preventable deaths.

Evidence base and gaps

Our Inquiry examined the evidence that is currently available. Much of this is collected by the Independent Advisory Panel on deaths in custody, although we also contacted central government to ensure they recognised the figures we used.

One of our early conclusions was that improvements are needed in the collection and availability of information in order to provide assurance of the State's compliance with its Article 2 responsibilities. This should include all information necessary to provide an overview of the number and features of the deaths. This should include race, gender, age and location of death.

The right to life

Our Inquiry focused on Article 2 of the European Convention on Human Rights which obliges the State to protect by law everyone's right to life. This obligation includes a positive duty on the State to ensure preventative measures are taken to protect life in certain circumstances and to carry out a proper investigation into deaths for which the State might be responsible. It also means that the unintentional taking of life by public authorities is prohibited. Other key aspects of the rights which protect

⁶ See <http://www.crisiscareconcordat.org.uk/>

us all include the Optional Protocol to the UN Convention Against Torture and the role of the NPM.

Article 2 case law focuses on minimum standards of protection which the State is obliged to provide to those within its care. Those responsible for detaining individuals should take appropriate steps to foster good mental health across all three settings in order to be comparable with community-based mental healthcare.

The right to non-discrimination

Article 14 of the Convention prohibits discrimination in the enjoyment of the Convention rights. This means that the State must ensure that the right to life of people with mental health conditions is given equal protection to that of other people.

Our approach

Our Human Rights Framework

We constructed a Human Rights Framework based on the right to life and the right to non-discrimination. This Framework translated the legal requirements into practical steps organisations in the three settings should take to ensure their obligations under Articles 2 and 14 are discharged so that the lives of adults with mental health conditions are properly protected while in state detention.

The Framework covers four main areas:

Dignity and respect. To comply with their obligations under Article 2, all of those responsible have a duty to ensure the provision of a safe and respectful

environment to minimise risk for vulnerable individuals in detention.

Risk and assessment. An effective risk assessment is critical in ensuring that measures are identified and put in place to reduce risk. Information about risk needs to be communicated and shared between staff to enable agencies to fulfil their duty under Article 2 to protect people in detention.

Treatment and support. To comply with their obligations under Article 2, agencies should provide and be equipped and funded to provide appropriate and timely medical and mental health treatment and support for detained people with mental health conditions.

Investigations. Article 2 imposes a procedural obligation to initiate an effective public investigation by an independent official body into any death for which the State may have some degree of responsibility. This will include deaths from non-natural causes of individuals in state detention.

Collecting evidence

We engaged with the key organisations in the three settings to determine their perspectives on the protection of detained adults with mental health conditions. We reviewed existing evidence, including reports and statistics. We also sought additional evidence which was not already in the public domain where we had identified gaps and we invited submissions from individuals and organisations.

We met with families of those who had died in the three settings and were moved by their stories, the honesty they shared with us and their commitment to honouring the loved ones by ensuring lessons are learned.

There were some cases we were unable to include in our analysis because there is ongoing legal action, including in relation to the use of restraint by staff from the settings.

We met with the National Offender Management Service, Welsh Government, Department of Health, NHS England, NHS Wales and the Home Office. We received evidence from individuals and organisations affected by the topic of our Inquiry, including focus groups of frontline workers organised by Unison and Black Mental Health UK.

All of the above provided us with invaluable understanding into the settings and have helped shape our findings and recommendations.

Additionally, we reviewed a small sample of guidance on protecting detained individuals produced by statutory organisations in the three settings. Most of the guidance covers the obligation to protect. While there is a strong focus on obligations under the Equality Act we found much less reference to human rights obligations, particularly Article 2.

Involving and consulting others

Many organisations work in this area and we acknowledge their expertise and commitment to reducing the deaths of people in detention settings. There are some major initiatives taking place to action these commitments. It was agreed that by consulting with others we could jointly have a greater impact.

In recognition of the independent examination provided by regulators and inspectorates, the Inquiry team had regular meetings with counterparts at the Care Quality Commission (CQC),

Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Prisons (HMIP), the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO).

We are not the only organisation producing reports of relevance in this area. The current Home Secretary ordered a specific thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. This work includes those with mental health conditions, those from ethnic minority backgrounds and children. The Harris Review has examined the deaths of 18-24-year-old prisoners and will be published later in 2015.

INQUEST and Black Mental Health UK provide the support to the families of people who have died and their tireless campaigning keeps the issues in both political debates and the media.

Chapter 2: Setting the scene

Who is being detained?

The vast majority of people who live with mental health conditions will never be held in detention, however a number will spend some of their life in the custody of the State.

When an individual is detained in a hospital, the legal authority comes from the Mental Health Act 1983. In 2012/13 in England and Wales, the number of detentions under the Mental Health Act was over 50,000.⁷ This number has been increasing.

The prison service does not record the number of people with mental health conditions. The most recent data relates to 1997, where 92 per cent of male prisoners were reported to have one of the following five conditions: psychosis, neurosis, personality disorder, alcohol misuse and drug dependence. Seventy per cent had at least two of these.⁸

When someone is in crisis in a public space, the Mental Health Act currently allows them to be held in police custody as

In 2012/13, there were 7,761 occasions when the Act was used and resulted in people being held in police cells

a ‘place of safety’ when there is insufficient health-based support available locally. In 2012/13, there were 7,761 occasions when the Act was used and resulted in people being held in police cells (section 136 of the Mental Health Act). The Care Quality Commission (CQC) and Her Majesty’s Inspectorate of Constabulary have raised concerns about the continuing practice of people being held in police custody, including children as young as 11.⁹

In January 2014, the Home Secretary, the Rt Hon Theresa May ordered a specific thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. This work includes ‘those with

⁷ Care Quality Commission (2013) *Mental Health Act Annual Report 2012/13*. Available at: <http://www.cqc.org.uk/content/mental-health-act-annual-report-201213>

⁸ Singleton N. et al (1998) *Psychiatric Morbidity Among Prisoners, 1997*. London: ONS.

⁹ Care Quality Commission (2013) *Monitoring the Mental Health Act in 2012/13*. Available at: http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

mental health problems and those from black and minority ethnic backgrounds'.¹⁰ The Home Office also published a review of section 136 in December 2014,¹¹ one of the key aims of which was to 'remove barriers preventing a person in mental health crisis from accessing help wherever they are while protecting human rights and civil liberties'.¹²

Deaths in detention settings

Data used by the Inquiry

Statistics are published across all the settings on an annual basis by the Independent Advisory Panel on Deaths in Custody who report 'there continue to be problems gathering population data on those in custody across all the sectors both in terms of overall population and breakdown by characteristic. Lack of this information makes it harder to analyse the figures for deaths in custody and in particular to draw any comprehensive conclusions or provide context to the number of deaths'.¹³

Prisons

Statistics relating to prison deaths are published quarterly in the Safety in

Custody reports on the Ministry of Justice website. The Prisons and Probation Ombudsman (PPO) publishes an investigation report after each death and this is produced in preparation for the Coronial process – although it cannot be published until the inquest is complete. Prisons do not collect data in relation to the mental health of prisoners.

Police

The numbers of those who die in police custody are low and the Independent Police Complaints Commission (IPCC) shared the investigation reports for many of those in our time period. However, the Inquiry was only able to consider those cases where the investigation was

The IPCC has accepted that each death in police custody has an impact on trust and confidence in the police, particularly in people from ethnic minorities

10 HMIC (2015) *HMIC's 2014/15 inspection programme*. Available at: <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/03/inspection-programme-2014-15.pdf>

11 Available at: <https://www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act>

12 Ibid.

13 Independent Advisory Panel on Deaths in Custody (2014) *Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2012*. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/IAP-Statistical-analysis-of-recorded-deaths-2000-to-2012-Publication.pdf> (p2)

complete. There are several important cases which we were unable to examine due to ongoing legal action.

The IPCC published a 10-year review in 2011 of deaths in or directly following police custody.¹⁴ The IPCC has accepted that each death in police custody has an impact on trust and confidence in the police, particularly in people from ethnic minorities.

Hospitals

Service providers of healthcare are required to notify the CQC in England and the Healthcare Inspectorate Wales (HIW) whenever there has been a death of a service user detained under the Mental Health Act. The CQC hold a spreadsheet which is updated on notification of a death but have no statutory duty to update this after the inquest with the final details or to disseminate the information. CQC and HIW share the information they hold with the Independent Advisory Panel on Deaths in Custody and also with the Equality and Human Rights Commission (the Commission) for this Inquiry.

NHS England is currently reviewing its guidance to clarify how trusts should undertake investigations following the death of a detained patient and the Commission has fed into this process. In our response to the consultation about this guidance we stated that the non-natural death of a detained patient should be treated as a serious incident. As such

those responsible for commissioning the healthcare should ensure there is always an independent investigation with the aim of obtaining an objective assessment of the nature and causes.

National context

Inquests

The Coroner's inquest is the primary means by which the State fulfils its Article 2 obligations. An inquest is an inquisitorial fact-finding procedure to find out the circumstances that led to the death. It does not deal with issues of blame or responsibility for the death, or with issues of criminal or civil liability.

Previously, there had been criticism of the effectiveness of the coroner systems. Reforms which came into force in 2013 aim to ensure all 96 coroners in England and Wales work to the same standards, and are overseen by the first Chief Coroner of England and Wales.¹⁵ Coroners now have a legal power and duty to write a report (Preventing Future Deaths report) following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. The report is sent to the people or organisations that are in a position to take action to reduce this risk and to the chief coroner. Organisations must reply within 56 days to say what action they plan to take. The reports, which include the names of the people and organisations receiving the report are posted on the Courts and Tribunals

¹⁴ Independent Police Complaints Commission (2010) *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09*. Available at: https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

¹⁵ The Coroners And Justice Act 2009.

Judiciary website, so it becomes a matter of public record that they have had to answer a report.¹⁶

In December 2013, the Chief Coroner published his first summary report to Prevent Future Deaths for the six months up to 30 September 2013. Further summary reports are expected and will be important for bringing

together the information relating to deaths in detention to improve learning in the settings.

Article 2 inquests will ascertain the circumstances in which an individual died. Inquests by jury must be held when an individual dies in detention and the death is violent or unnatural or the cause is unknown.

Table 2.1 Numbers of deaths in detention, England and Wales, 2010-13

	Deaths of people with mental health problems in or following police custody			All deaths in prison custody			Deaths of in-patients who were detained under the Mental Health Act		
	Total	Natural	Non-natural	Total	Natural	Non-natural	Total	Natural	Non-natural
2010	7	3	4	198	126	72	297	209	88
2011	8	1	7	192	122	70	288	204	84
2012	5	1	4	192	123	69	324	233	91
2013	6	4	2	215	131	84	266	179	87

Sources: IPCC; MoJ Safety in Custody Statistics; CQC.

¹⁶ See <http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/>

Ministerial Board on Deaths in Custody

The Ministerial Board on Deaths in Custody brings together decision-makers responsible for policy and issues related to deaths in custody in the Ministry of Justice, Home Office and Department of Health. They are supported by the independent advice of the Independent Advisory Panel (IAP), members of which were selected for their expertise in matters connected with deaths in custody.

International context

National Preventive Mechanism

The UK has ratified the International Covenant on Civil and Political Rights (ICCPR) which bans the use of torture or cruel, inhuman or degrading treatment or punishment. It has also ratified the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (commonly known as CAT).¹⁷ This international human rights treaty requires State parties to take measures to prevent, investigate and punish anyone who commits these practices, including those in detention settings.

The UK has also ratified the Optional Protocol to CAT (OPCAT). OPCAT recognises that people deprived of their liberty are more vulnerable to the risk of torture and other forms of ill-treatment. Whilst CAT contains an obligation to prevent torture, OPCAT provides for the independent monitoring of places of detention in order to prevent torture and other cruel, inhuman or degrading

treatment or punishment. It obliges every State party to establish one or more national preventive mechanisms who visit places where people are detained by the State, or are under the State's control or jurisdiction. For example, prisons, secure mental health units, secure children's accommodation, military detention settings and immigration detention settings. In the UK, HM Inspector of Prisons coordinates the National Preventive Mechanism which is made up of 22 member organisations.

Outside our Terms of Reference

During the evidence gathering for this Inquiry, we became aware of certain areas which would merit further investigation.

Increase in deaths in prisons from 2013 onwards

The Terms of Reference for our Inquiry cover deaths that occurred between 2010 and 2013.

The Prisons and Probation Ombudsman recorded a 64 per cent increase in self-inflicted deaths in prisons in England and Wales in 2013-14 from the previous year. This increase has not been reflected in Scottish prisons. Many of these deaths have been too recent for the inquests to confirm the cause of death so the numbers are not conclusive.

The Chief Inspector of Prisons has discussed prisoners 'being held in deplorable conditions who are suicidal, they don't have anything to do and they don't have anyone to talk to'.

¹⁷ Article 7 of ICCPR bans torture, see <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx> Ratified on 20 May 1976.

In the same interview he said ‘this is a political and policy failure – this is not the fault of staff’.¹⁸

He concluded that ‘increases in self-inflicted deaths, self-harm and violence cannot be attributed to a single cause, they reflect some deep-seated trends and affect prisons in both the public and private sectors. Nevertheless, in my view, it is impossible to avoid the conclusion that the conjunction of resource, population and policy pressures, particularly in the second half of 2013-14 and particularly in adult male prisons, was a very significant factor in the rapid deterioration in safety and other outcomes we found as the year progressed and that were reflected in the National Offender Management Service’s (NOMS) own safety data. The rise in the number of self-inflicted deaths was the most unacceptable feature of this. It is important that the bald statistics do not disguise the dreadful nature of each incident and the distress caused to the prisoner’s family, other prisoners and staff. It is a terrible toll. “The total experience of imprisonment affects suicidal behaviour” is a valid conclusion today, just as it was when the inspectorate first addressed the issue back in 1999. Then, as now, it requires acknowledgement, action and accountability for doing so from top to bottom.’

The Rt Hon Chris Grayling, the Lord Chancellor and Secretary of State for

Justice said that he is ‘absolutely clear there is not a crisis in our prisons’.¹⁹

In September 2014, the Government committed to ‘a national system of liaison and diversion services being built which would mean the mental health condition of an offender could be identified during the court process and a decision taken at that stage on where to detain him’.²⁰ The Minister has committed to ‘every prisoner who needs it to have access to the best possible treatment. I want mental health to be the priority for our system’.²¹

NOMS is reviewing the increase in deaths in prisons. This needs to be carried out in conjunction with the inspectorates and ombudsman to ensure the changes can be made to decrease the numbers of prisoners dying. There should also be immediate implementation of the commitments made by the Secretary of State to improve mental health services in prisons, after a consultation process to ensure the most effective initiatives are implemented.

Natural deaths in hospitals

According to statistics from CQC, there were 825 deaths from natural causes amongst patients detained under the Mental Health Act in the time period of our Terms of Reference.

¹⁸ See <http://www.bbc.co.uk/news/uk-28233294>

¹⁹ See <http://www.ft.com/cms/s/0/4b37cd8a-2777-11e4-be5a-00144feabdco.html#axzz3PYUVPaDe>

²⁰ See <http://www.theguardian.com/society/2014/sep/16/chris-grayling-mental-health-prisons>

²¹ See <http://www.theguardian.com/society/2014/sep/16/chris-grayling-mental-health-prisons>

Side effects from anti-psychotic drugs

A number of deaths are classified as being from natural causes but may be related to anti-psychotic drugs.

In 2012 the Chief Pharmaceutical Officer in Wales sent a letter to health bodies, prisons and inspectorates agencies specifically about the adverse side effects of the anti-psychotic drug clozapine.²²

There is a need to ensure that staff are made aware of and monitor the side effects of anti-psychotic drugs. The fact that some deaths since then have been linked with the prescription of such medication indicates that this is an issue that requires more detailed investigation.

Deaths post-detention

In all three settings, we are aware of high – and in some cases increasing – numbers of deaths shortly after leaving detention. In police custody, while there has been a steady decline in all deaths in or following custody, there has been a significant increase in apparent suicides following custody from 39 in 11/12 to 65 in 12/13.²³ This should be addressed.

The NHS in England has taken steps to address the matter in hospitals with a mandatory follow-up within seven

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days for post-discharge from psychiatric hospitals. This should be replicated in all detention settings and there must be effective pre-release assessments which will support people in the transition from detention. For individuals leaving prison there should be referrals to mental health services which are followed up within seven days.

Numbers of beds in psychiatric hospitals

The Commons Health Committee noted in 2013 that there was severe pressure on beds in psychiatric hospitals.²⁴ More recently, the shortage of psychiatric admission beds was highlighted in an investigation by community care and BBC news. This found that, in 30 of England's 58 NHS mental health trusts, the number of patients sent to out-of-area hospitals

²² Chief Pharmaceutical Officer for Wales, Clozapine and Gastrointestinal obstruction, Cpho (2012)1, 2012.

²³ Independent Police Complaints Commission (2014) *Deaths during or following police contact: Statistics for England and Wales 2013/14*. Available at: https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1314.pdf

²⁴ House of Commons Health Committee (2013) *Post-legislative scrutiny of the Mental Health Act 2007: First Report of Session 2013-14*. Available at: <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf>

rose 33 per cent during the previous year and had more than doubled since April 2011, with some patients being sent up to 300 miles for care.²⁵ The lack of in-patient provision needs to be addressed.

Community mental health services

Better provision of crisis services in the community could prevent some people from being detained in psychiatric hospitals. Recent government initiatives to improve parity of esteem between physical and mental health should ideally result in improved mental health services and a reduction in detentions; however, resources continue to be under considerable pressure in mental health services. Further progress is needed as our evidence highlights that a lack of available beds in hospitals has led to deaths in the community where individuals have been formally assessed as requiring hospital admission under the Mental Health Act. A recent investigation by community care²⁶ and BBC news identified seven suicides and one homicide linked to bed pressures since 2012.

Our evidence also shows that people may enter the criminal justice system as a result of their mental health condition not being adequately treated beforehand. Further measures to improve access to appropriate healthcare at an earlier stage in people's lives should result in fewer detentions and deaths.

²⁵ See <http://www.communitycare.co.uk/2014/05/06/rise-mental-health-patients-sent-hundreds-miles-care-nhs-overwhelmed-demand/>

²⁶ See <http://www.communitycare.co.uk-linked-mental-health-beds-crisis-cuts-leave-little-slack-system/>

Chapter 3: Recommendations

We have grouped our recommendations under four broad headings.

Recommendation 1

Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

All settings:

- Responsible agencies in all three settings should ensure that recommendations from investigations are followed up and lessons are learned.
- Investigatory bodies need to continue to improve (or monitor and review) the quality of their investigations and their involvement with the bereaved families.
- We recommend that the review of the role of the Independent Advisory Panel

on Deaths in Custody (IAP) in 2015 should reflect the impact of their work to date and consider how they could ensure their initiatives are integrated into the working practice of detention settings. The Equality and Human Rights Commission (the Commission) will feed into this review.

Prisons:

- The setting up of new institutions (such as Secure Training Centres²⁷ and the North Wales prison in Wrexham) must incorporate policies which explicitly address human rights obligations and incorporate the Commission's Human Rights Framework.
- The Government should consult on their proposed improvements to mental health services within prisons. These improvements should be matched with sufficient resources.
- A thorough review should be conducted to understand the increase in non-natural deaths from 2013 in order to implement recommendations in 2015, either by a thematic review by HMIP or other urgent means.

²⁷ See <http://www.equalityhumanrights.com/legal-and-policy/our-legal-work/parliamentary-briefings/criminal-justice-and-courts-bill-2014-use-physical-restraint-secure-colleges>

Recommendation 2

Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.

All settings:

- Organisations which do not deliver to the standards outlined in the Equality and Human Rights Commission's Human Rights Framework risk being in breach of human rights obligations.
- Risk assessments need to be carried out, be effective, be reviewed regularly and shared with all relevant agencies and staff.
- Training in mental health awareness should be mandatory and ongoing for all frontline staff so they are better able to identify and appropriately support people with mental health conditions.
- There needs to be a clear process which sets out how the implementation of recommendations from investigations into a death (including the inquest) will be followed up. This is the joint responsibility of those who run individual institutions and the regulatory and inspectorate bodies which make those recommendations.
- We recommend increased statutory obligations on institutions to publically

respond to recommendations (for example through action plans) from inspectors and regulators in relation to deaths in detention.

- We recommend that the IAP principles for safer restraint are fully implemented in the three settings. Restraint should only be used when all other options to keep detainees and others, including staff, safe have been exhausted.

Prisons:

- Prisons should set up a system which alerts staff of possible events or dates which may trigger increased vulnerability for a prisoner (for example anniversary of imprisonment, bereavement or trial date).
- Segregation²⁸ should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance. An 'exceptional circumstance' should be clearly defined and understood by prison staff. Where prisoners with mental health conditions are segregated, their level of risk and the requirement to be segregated should be regularly reviewed.

Police:

- Each police force needs a dedicated senior lead and resources on mental health (as in South Wales) to ensure appropriate support (including diversion routes) to people in custody.
- The Government to continue the financial commitment to ensuring the provision of sufficient mental health

²⁸ For the purpose of our report segregation is when a prisoner is kept apart from other prisoners and they may be kept in another part of prison called the segregation unit.

crisis care so that people receive appropriate treatment when it is needed and police cells are not used as a place of safety.

Recommendation 3

In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour which applies to NHS bodies in England. If it proves to be effective this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

All settings:

- Families should be fully involved in the investigations process and given appropriate information and support.
- The Chief Coroner to continue to produce summary reports (as outlined in the Coroners Act 2009) from preventing Future Deaths Reports, particularly to ensure there is the opportunity for learning from non-natural deaths in psychiatric hospitals.
- The use of force/restraint²⁹ should be recorded, monitored and the data made

publically available in all detention settings, including where the police use force on detained patients in a hospital setting.

Psychiatric hospitals:

- The Secretary of State for Health should establish responsibility for ensuring oversight of investigations in psychiatric hospitals and national collation of data. The government should reconsider appointing an independent body to investigate deaths of detained patients in psychiatric care.
- NHS Wales and Healthcare Inspectorate Wales data should be systematically collected, analysed and made publically available with full breakdowns by protected characteristics as defined in the Equality Act 2010.

Prisons:

- Each prison establishment to ensure it has a staff member responsible for identifying and implementing learning from investigations and work to prevent deaths being undertaken in other prisons. They should ensure there is accurate data relating to the numbers of prisoners with a mental health condition to enable appropriate resource planning.

The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings

²⁹ Independent Advisory Panel on Deaths in Custody (2013) *IAP Common Principles for Safer Restraint*.

Recommendation 4

The Equality and Human Rights Commission’s Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions. The following points explain how the Framework can support those responsible for the detention of people.

- All 12 steps in section A must be taken to prevent otherwise avoidable deaths.
- It should be used to inform and shape policy decisions in all three settings at national and local level.
- It should be used as a practical checklist by individual institutions to measure Article 2 compliance.
- It should be used as a practical checklist for those tasked with investigating deaths in detention.
- It should be used as a flexible measurement tool which can be adapted by individual institutions to tailor the steps required to be taken to secure Article 2 compliance.

Chapter 4: Human rights and the Human Rights Framework

The legal framework

What are human rights?

Our shared human rights are protected by the European Convention on Human Rights (ECHR) which was made part of our UK law by the Human Rights Act 1998 (HRA), and a number of other treaties which the UK has ratified such as the UN Convention Against Torture. They not only protect individuals from the acts and omissions of the State and public authorities acting on its behalf but also oblige those authorities to take steps to protect them in certain carefully defined circumstances.

In the context of this Inquiry, the police, prisons and hospitals are public authorities.

An individual who believes their rights under the HRA have been infringed can bring a case in the courts against a public authority. However, if their claim fails, the person could bring a human rights claim against the UK in the European Court of Human Rights.

Article 2 of the ECHR

At the core of this Inquiry is Article 2 which states that 'Everyone's right to life shall be protected by law'. This means that public authorities must not take life. The unintentional taking of life is

prohibited, for example where the use of force, such as restraint, is more than absolutely necessary.

In addition Article 2 imposes two positive obligations:

1. An obligation to protect individuals in state detention whose life is at risk, whether from the acts of others or from suicide.

This obligation comprises:

- a) A duty to put in place appropriate systems designed to protect lives (the 'systems' duty), and
- b) A duty to take reasonable steps to protect individuals from a real and immediate risk to life which the institution is or should be aware of (the 'operational' duty).

2. An obligation to effectively investigate any death for which the State may have some degree of responsibility. This will include deaths from non-natural causes of individuals in state detention.

These obligations are also subject to the obligation under Article 14 of the ECHR that the State must ensure that there is no discrimination in the enjoyment of these Article 2 rights. This means that public authorities must not treat individuals

differently on any grounds such as their race, language, religion, political or other beliefs, sex, disability, age, sexual orientation, transgender status, or any other personal status, unless this can be justified objectively.

The Human Rights Framework

We have constructed a Human Rights Framework based on the requirements of Article 2 emanating from domestic and European case law. The evidence collected by this Inquiry has been evaluated against this Framework to identify areas for improvement and of existing good practice.

Section A sets out the steps required to be taken to meet the obligation to protect and not to take life.

Section B sets out the steps required to be taken to meet the obligation to investigate.

Section A – obligation to protect and not to take life

The overarching obligation is to provide a safe and respectful environment for detainees. This obligation comprises the four principal responsibilities of the State, each one sub-divided into the practical steps which should be taken.

The overarching obligation is to provide a safe and respectful environment for detainees

Dignity and respect

To maintain an environment that provides:

1. Freedom from physical abuse by staff or other detainees
2. Freedom from bullying, threats and disrespectful treatment by staff and other detainees
3. Freedom from neglect by staff or external professionals
4. Freedom from unlawful use of physical restraint

Steps 1 to 4 will involve ensuring that effective systems are in place to report and to tackle abuse, bullying, neglect and disrespectful treatment.

A safe environment will include, where necessary, the provision of safe cells and rooms and arrangements for emergency responses.

Risk and assessment

To provide:

5. An effective risk assessment before initial detention or as soon after as is reasonably practicable
6. An effective review of that risk assessment at regular intervals thereafter
7. Dissemination of those assessments to relevant agencies within and outside of the setting

Steps 5 to 7 may require a two-stage process. Firstly, an initial assessment to identify those at potential risk of suicide or loss of life and, secondly, a more comprehensive assessment of those so identified to determine level of risk and specialist support/individual safeguards

required. It will also involve ensuring that effective systems are in place to implement the safeguards.

Treatment and support

To provide:

8. Access to timely and appropriate medical and mental health treatment and support
9. Access to appropriate social support, such as listeners, insiders and regular family contact, for example
10. Information and advice in an appropriate format on how to access this treatment and support
11. A right to treatment for drug and alcohol abuse and protection from access to them

Individualised protection

To provide:

12. Proportionate individualised protection where the detainer knows or should know that there is a real and immediate risk to the life of a detainee. Effective risk assessment will make it easier to identify when this obligation is triggered.

When determining what actions are proportionate, it is necessary for agencies to consider a number of factors including the seriousness of the risk, the steps that could reasonably be taken to reduce or eliminate the risk and the relative ease or difficulty of taking those steps. Sufficiently trained staff will be required to identify risk and determine the appropriate measures and systems that should be put in place.

Section B – obligation to investigate

This obligation comprises the three principal responsibilities of the State to make sure that there is an effective investigation into every death from non-natural causes in state detention.

1. To conduct an effective investigation, which:

- The state initiates itself.
- Appoints an investigator independent of those implicated in the death.
- Begins promptly and concludes as quickly as is reasonable.
- Takes all reasonable steps to secure relevant evidence relating to the death.
- Takes all reasonable steps to uncover any discriminatory motive behind the death.
- Makes the investigation and its conclusions open to public scrutiny.
- Involves the next of kin and ensures that their interests are protected.

2. To make arrangements to secure legal accountability for those responsible for a death.

An effective investigation will hold to account anyone found to be at fault as a result of the investigation. Depending on the degree of culpability, this may lead to disciplinary action and criminal proceedings against either an individual or an organisation, for example under the Corporate Manslaughter and Corporate Homicide Act 2007.

3. To take appropriate measures to prevent future deaths.

An effective investigation should have identified any systemic or training defects, any defects in the planning, management or control of the incident and any defects in instructions to staff.

A consequence of this should be that lessons are learned and shared. This is to ensure that, so far as is possible, steps are then taken to minimise the risk of similar deaths in the future.

Findings and recommendations

Organisations which do not deliver the standards outlined in the Equality and Human Rights Commission Framework risk being in breach of the European Convention on Human Rights.

Our Inquiry makes **two key findings** specific to the Framework:

- If all the practical steps set out in Section A are taken, the number of non-natural deaths of individuals detained by the State will decrease.
- If appropriate measures are taken following an effective investigation carried out in accordance with Section B, Article 2 compliance will be enhanced and future deaths will be prevented.

Our Inquiry makes **five key recommendations** specific to the Framework:

- All 12 steps in section A must be taken to prevent otherwise avoidable deaths.
- It should be used to inform and shape policy decisions in all three settings at national and local level.
- It should be used as a practical checklist by individual institutions to measure Article 2 compliance.
- It should be used as a practical checklist for those tasked with investigating deaths in detention.
- It should be used as a flexible measurement tool which can be adapted by individual institutions to tailor the steps required to be taken to secure Article 2 compliance.

Chapter 5: Dignity and respect

Human rights obligations

To comply with their obligations under Article 2, agencies should ensure the provision of a safe and respectful environment to minimise risk for vulnerable individuals in detention. This involves ensuring that effective systems are in place to report and tackle abuse, bullying, neglect and disrespectful treatment by staff or other detainees, as well as self-harm. Unnecessary and unsafe physical restraint techniques must not be used against detained individuals.

Agencies in all three settings have undertaken work to improve standards and ensure there are fewer incidents of deaths resulting from a failure to provide a safe environment. There is evidence of ways to address bullying and disrespectful treatment in the three settings. An example is a toolkit to improve suicide prevention of detained patients and there are a number of initiatives in the police setting to monitor police use of restraint and reduce its use (including its use against people with mental health conditions).

There are problems in providing dignified and respectful protection for detained individuals in all three settings. There are reports of ongoing bullying and disrespectful treatment by other detainees in prisons. There are some instances of failings in providing a safe environment for detained patients, including failures

to observe patients at risk and a few investigations where the Coroner identified negligence.

Article 2 imposes a negative duty on the state to refrain from taking life intentionally. This duty will be triggered where a death is as a result of the use of force, for example restraint, by agents of the state in circumstances where its use is more than is absolutely necessary.³⁰

There are different definitions of restraint in the three settings.

It is a concern that the use of restraint is a direct or indirect cause of some non-natural deaths in the three settings. Where these deaths occur, significant lessons must be learned to ensure there is no repetition of preventable faults in future incidents. Data on the use of restraint should be collated, published and monitored in the three settings, to enable the identification of any inappropriate use to reassure the public that the State is committed to transparency even behind closed doors.

It is a concern that the use of restraint is a direct or indirect cause of some non-natural deaths in the three settings

³⁰ *McShane v the United Kingdom* (2002) 35 EHRR 23 para 93.

This was recently acknowledged by the Rt Hon Theresa May, the Home Secretary, who announced³¹ in October 2014 that a review of the use of force by police will be carried out, following concerns that physical restraint and Tasers are being used too often on people with mental health conditions as well as people from ethnic minorities. Police forces should also look at how this relates to their use of stop and search powers and to ensure that officers are appropriately trained and supervised, and that any misuse of powers is identified and tackled. In the prison setting, data on restraint is centrally collated on a monthly basis and this is analysed to identify trends but this data should be made publically available to aid transparency. Collecting and analysing data on the use of restraint is very important.

The Independent Advisory Panel on Deaths in Custody³² (IAP) has worked with agencies in the three settings to agree and develop a set of common principles for safer restraint. These principles were published in July 2013 and IAP³³ reported in November 2014 that feedback from agencies in the three settings ‘suggests they will be complying with the common principles on the use of physical restraint’.

The IAP principles for safer restraint should be fully implemented in the three settings and there is need for more oversight and monitoring of the use of restraint.

Providing a safe environment

Vulnerable adults who are in custody or detained have a right to freedom from neglect by staff or external professionals and a right to a safe and respectful environment. Failing to provide this environment increases likelihood of non-compliance with Article 2 of the European Convention on Human Rights (ECHR). A safe environment should also provide for mental wellbeing and trying to reduce the person’s level of distress with appropriate treatment and therapeutic activities.

Individuals who have been detained in a psychiatric hospital are there because they need assessment or treatment for their own safety or to protect the safety of others. Where someone is known to be at risk of suicide the operational duty is triggered (see Obligation 12, section A of Chapter 4 – The Human Rights Framework). In this context, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness³⁴ recommended that there

31 See <https://www.gov.uk/government/speeches/home-secretary-at-the-policing-and-mental-health-summit>

32 Independent Advisory Panel on Deaths in Custody (2013) *Common Principles for Safer Restraint*.

33 Independent Advisory Panel on Deaths in Custody, November 2014 bulletin. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/12/Independent-Advisory-Panel-on-Deaths-in-Custody-e-bulletin-November-2014.pdf>

34 Five year report of the national confidential inquiry into suicide and homicide by people with mental illness, *Avoidable Deaths: summary of findings and recommendations* (2006).

should be no access to ligature points for patients within psychiatric hospitals. Progress is being made in removing ligature points, including the implementation of a suicide prevention toolkit which was developed by the former National Patient Safety Agency,³⁵ and this progress needs to continue. The continued existence of ligature points should not be tolerated.

The provision of a safe environment is not limited to a ligature-free environment. It also includes the provision of appropriate medical and mental health treatment and support – see Chapter 7.

There have been some instances where there has been a failure to monitor detained patients at risk, including patients who managed to take their own lives despite their records noting that they should have been under constant or frequent observation.

Bullying and disrespectful treatment

As set out in our Human Rights Framework, the European Convention on Human Rights requires that detained adults are free from bullying, threats and disrespectful treatment by staff and other detainees. This can have a detrimental impact on their mental health and increase their level of risk. To demonstrate compliance with Article 2, agencies

responsible for managing the prison estate should be doing everything they reasonably can to ensure detained adults are not being bullied by other prisoners.

Our analysis of evidence highlighted work to address bullying in prisons. Evidence in some prison inspection reports highlights some strategies to challenge and address bullying before it escalates and share information among staff. Yet a consistent theme from our analysis of evidence is that bullying, threats and disrespectful treatment by other detainees can be a precursor to someone taking their own life.

Both the Prisons and Probation Ombudsman (PPO) and HM Inspectorate of Prisons (HMIP), which has a statutory role to inspect individual prison establishments, have highlighted bullying in the lead up to non-natural deaths. In a sample of 80 PPO³⁶ investigation reports into the self-inflicted deaths of young adults in prison between 2007 and 2014, 20 per cent were recorded as having experienced bullying from other prisoners in the month before their death, compared to 13 per cent of other prisoners. This mirrored a previous finding of PPO³⁷ from an earlier sample of self-inflicted deaths.

The following case study highlights the risk of a prisoner taking their own life as a result of bullying.

³⁵ NPSA, Preventing suicide: A toolkit for mental health services: The suicide prevention toolkit.

³⁶ Prisons and Probation Ombudsman, Learning Lessons bulletin: Young Adult Prisoners, April 2014.

³⁷ Prisons and Probation Ombudsman, Learning from PPO investigations: Violence reduction, bullying and safety, October 2011.

Case study

X was new to prison and told reception staff that he was scared about being in prison. After a week he was transferred to a prison closer to home, but he was verbally abused and physically assaulted by other prisoners. He was moved to another unit, but no-one checked on his welfare or asked if the move had helped stop the bullying. Before a transfer was arranged to another prison, he took his own life in his cell. He left a note indicating he couldn't bear the verbal abuse.

Disciplinary action was taken against the prisoner who physically assaulted him but the Ombudsman identified concerns that there was little further investigation and no action taken regarding the prisoners who were verbally abusive. They said that while staff took the risk he faced from other prisoners seriously, they did not consider whether he was at risk of suicide or self-harm as a result

and that it was depressingly similar to another death in a different prison and the learning highlighted in a previous report.

(PPO (2014) Learning lessons bulletin Fatal incident investigations issue 6: Young adult prisoners)

A particular problem in Young Offender Institutions is bullying and disrespectful treatment by other detainees. The published response of the Howard League for Penal Reform³⁸ to the Harris Review³⁹ into Self-Inflicted Deaths in National Offender Management Service (NOMS) Custody of 18-24-year-olds highlighted the widespread extent of this problem in the young adult estate. We hope this concern will be taken forward by the Harris Review as it reflects on the findings of this Inquiry.

To comply with human rights legislation, prison staff should take all reasonable steps to identify vulnerable prisoners who are being bullied and share relevant information between staff.

38 See https://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Consultations/Response_to_HoL_Select_Committee_on_the_constitution_regarding_the_office_of_Lord_Chancellor__2014_08_29.pdf

39 On 6 February 2014 the Justice Secretary announced an independent review into self-inflicted deaths in National Offender Management Service custody of 18-24-year-olds. The purpose of the review is to make recommendations to reduce the risk of future self-inflicted deaths in custody. The review will focus on issues including vulnerability, information sharing, safety, staff prisoner relationships, family contact, and staff training and will explore these through this call for submissions alongside existing and commissioned research and meetings with stakeholders and people affected and interested more broadly. The terms of reference of the review are available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/11/Harris-Review-Terms-of-Reference1.pdf>

Yet PPO⁴⁰ found that staff responses to allegations of bullying, assaults and other related incidents could be better and highlighted the importance of recording and sharing information and protecting prisoners at specific risk of victimisation.

Bullying and disrespectful treatment can include a wide range of behaviours. NOMS does not use the term ‘bullying’ in the context of adult prisons however it has produced guidance⁴¹ which sets out the effective management of violent prisoners. This guidance should be implemented as thoroughly as is required by prisons.

Restraint

Detained patients

There are some initiatives to reduce the use of restraint on detained patients.⁴² However, evidence from published reports highlighted problems with different definitions of restraint in use and wide variation in the use of restraint on detained patients.

IAP analysis of data on restraint indicates that there has been a reduction in the number of deaths of detained patients directly caused by restraint. It reported that there have not been any such deaths in the period 2010-13. It is possible that

the variability of reporting may mean that some restraint-related deaths are not reported as such. Statistics from the Care Quality Commission (CQC) show that restraint was used in 43 cases in the previous seven days in the period 2010-12. Additionally, the IAP report noted that in 15 deaths of detained patients in 2012, restraint was used in the previous seven days but may not have been the primary cause or a secondary cause of death. This is the highest number of restraint-related deaths since 2000 and is an area of concern.

IAP has raised concerns about the broad definition of restraint-related deaths used by the CQC, which may be a factor in the variation in reporting of the use of restraint by health trusts. A report by the mental health charity Mind⁴³ noted that mental health trusts use different definitions and that it was not confident that all instances of physical restraint were effectively recorded.

Published reports and investigation reports highlighted concerns about the deaths of some detained patients through the use of face-down restraint in previous years, which can be particularly dangerous as it can lead to suffocation. There are developments in England and Wales to address the use of this method of restraint.

40 Prisons and Probation Ombudsman, Learning from PPO investigations: Violence reduction, bullying and safety, April 2011.

41 National Offender Management Service, Prison Service Instruction 64/2011 Management of Prisoners at Risk of Harm to Self or Other, April 2012.

42 All Wales Violence and Aggression, Training Passport and Information Scheme (September 2004).

43 Mind (2013) *Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England.*

In April 2014, the Department of Health published guidance⁴⁴ for health trusts in England on the use of face-down restraint, which advises that it should not be used. This guidance also recognises that initiatives to reduce the use of restraint and seclusion involve a change in culture and relationships within services, including working in partnership with people using services and their families/friends.

There are a number of schemes which aim to de-escalate situations and move away from the use of restraint on detained patients. Examples of these include the Safewards intervention model, Implementing Recovery through Organisational Change (ImROC) and the Respect Training programme in Sheffield. The sharing of learning and wider implementation should take place in all hospital trusts.

Prisons

According to the evidence presented to this Inquiry there was one restraint-related death in a prison in 2010.

All prisons submit a central monthly return to the NOMS to provide information on the frequency and type of force which has been used in the prison. This allows for data to be analysed and the identification of any concerns but this data is not published. IAP held a cross-sector restraint workshop in May 2010⁴⁵ and

found that Ministry of Justice guidance on the use of restraint provides an effective mechanism to ensure the continued safety of prisoners. IAP also recommended that other custodial sectors could learn from this policy as it provides a very clear command structure during the use of restraint.

Police

Police forces in England and Wales do not centrally record the use of restraint against detainees. This is a problem because we were unable to assess whether there is a disproportionate use of restraint against people with mental health conditions. We support the initiative announced by the Home Secretary, the Rt Hon Theresa May MP, at the joint event by the Home Office and Black Mental Health UK to ‘conduct an in-depth review of the publication of Taser data and other use of force by police officers’.⁴⁶ This should look particularly at the claims of the discriminatory use of restraint against men from ethnic minorities.

Police forces should record data on their use of force/restraint against individuals in every setting and this should include the recording of race and whether the individual restrained has a mental health condition. This will increase their knowledge of how widely restraint is being used and allow the identification of any inappropriate or discriminatory use against people

⁴⁴ See <https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions>

⁴⁵ Independent Advisory Panel on Deaths in Custody, Report of the Cross-Sector Restraint Workshop held in May 2010.

⁴⁶ See <http://www.gov.uk/government/speeches/home-secretary-at-the-policing-and-mental-health-summit>

with mental health conditions and people from ethnic minorities.

Having had access to the final reports from Independent Police Complaints Commission (IPCC) investigations, we have identified that restraint was a factor in eight of 15 deaths in or following police custody in 2010-13 where the person was recorded as having a mental health condition (this includes deaths where restraint was identified as a primary or secondary cause). We received evidence of two deaths involving police restraint on a detained patient in a psychiatric hospital.

There has been recognition among police forces that restraint should be used only in exceptional circumstances and with limited use of force on people with mental health conditions. The Police Federation of England and Wales⁴⁷ in their evidence to the Home Affairs Select Committee stated that the police are trained to restrain violent criminals, not people with mental health conditions. The College of Policing is currently working to reduce the use of restraint by the police, aiming to make the restraint of someone with a mental health condition a 'rare' event.

A number of submissions and published reports raised concerns about an increasing call-out of police officers to restrain detained patients on psychiatric hospital wards, although there are no reliable figures to substantiate this. Restraint should only be used in

exceptional circumstances. Once police officers are on a hospital ward they control the situation and may use restraint techniques which have been deemed unsafe to be used by hospital staff. This has potentially very serious consequences as police techniques, including the use of face-down restraint and Tasers, are generally not appropriate for detained patients. Two deaths involving police restraint took place in psychiatric hospitals.

If police call-outs to hospitals are increasing, then it is not clear why there has been an increase, although submissions to the Inquiry suggest that this has happened since the publication of new Department of Health guidance which prohibits face-down restraint.⁴⁸ Submissions to the Inquiry suggested that a reason for the increasing call-out of police officers to psychiatric hospitals may be health staff interpretations of the guidance, leading to staff calling in police officers more frequently. This warrants further investigation. In some geographical areas progress has been made and new protocols have been agreed with local police forces stating that restraint should not be used by police forces in a hospital setting unless there is risk to life. This has greatly reduced the number of police restraints of detained patients in these areas. The IPCC and the College of Policing are both looking at this problem and we will monitor the outcomes of this work.

⁴⁷ Written evidence submitted by the Police Federation of England and Wales to the Home Affairs Select Committee inquiry on policing and mental health, published 20 May 2014.

⁴⁸ See <https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions>

Recommendations

To support agencies in the three settings to comply with their legal responsibilities we make the following recommendations:

For all settings:

- We recommend that the IAP principles for safer restraint are fully implemented in the three settings. Restraint should only be used when all other options to keep detainees and others, including staff, safe have been exhausted.
- The use of force/restraint⁴⁹ should be recorded, monitored and the data made publically available in all detention settings, including where the police use force on detained patients in a hospital setting.

Prisons:

- The setting up of new institutions (such as Secure Training Centres⁵⁰ and the North Wales Prison in Wrexham) must incorporate policies which explicitly address Human Rights obligations and incorporate the Equality and Human Rights Commission's Human Rights Framework.

⁴⁹ There is no universal definition of the use of restraint. We refer to the Independent Advisory Panel on Deaths in Custody, IAP Common Principles for Safer Restraint, published in July 2013.

⁵⁰ See <http://www.equalityhumanrights.com/legal-and-policy/our-legal-work/parliamentary-briefings/criminal-justice-and-courts-bill-2014-use-physical-restraint-secure-colleges>

Chapter 6: Risk and assessment

Human rights obligations

To enable agencies to fulfil their duty under Article 2 to protect people in detention it is crucial that they identify, regularly assess and monitor the risks to individuals. Everyone in detention should be protected through a well-informed and effective risk assessment which is managed and reviewed on a regular basis and shared with all relevant agencies.

Cross-sector findings

Evidence drawn from reports, submissions, investigations and bereaved families has revealed the following cross-sector findings.

Inadequate risk assessments contributed to some non-natural deaths in hospitals and prisons. Inadequate risk assessments have also been recognised as a contributory factor in one non-natural death in police custody.

The management of risk includes the needs to communicate and share information among staff and between agencies. A recurring theme which contributed to non-natural deaths in all three settings is poor communication and information sharing between staff. We have evidence which reveals failures to update risk assessments following key incidents. There are instances when staff appear not to have understood that

information can be shared and that the duty to protect confidentiality must be balanced with reducing the risk of harm.

This problem has been highlighted by inspectorate bodies and has been the subject of recommendations following investigations into non-natural deaths in detention of adults with mental health conditions. Yet evidence shows incidents where these recommendations were not being acted upon and investigations after deaths continue to uncover this shortcoming.

The challenges of sharing information across the three settings and between agencies also need to be addressed.

The Chief Coroner's summary report⁵¹ identified poor communication and the lack of procedures and protocols or the failure to follow them as a recurrent theme amongst non-natural deaths in the six-month span of his 2013 report.

A recurring theme which contributed to non-natural deaths in all three settings is poor communication and information sharing between staff

⁵¹ See <http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/summary-of-reports-to-pfds/>

Families of individuals can provide crucial information about the risks facing their family member and where appropriate should be an active part of the risk and assessment process. Yet evidence from some bereaved families is that they did not feel actively involved in this process. Families highlighted instances where they raised concerns but the risk assessments were not updated.

Families of individuals can provide crucial information about the risks facing their family member and where appropriate should be an active part of the risk and assessment process

Detained patients

In relation to detained patients, evidence points to failures to update risk assessments for detained patients and also of poor communication between staff. In some cases this has resulted in a failure to establish appropriate and timely measures for patients who were at risk, which in some cases has resulted in avoidable self-inflicted deaths. In some of the most severe cases patients had previously attempted to take their own lives but the risk assessment had either not been updated or had not been shared between staff. This finding is supported by Care

Quality Commission (CQC) inspections of hospitals, which found that over a six-month period in 2012-13, care plans and risk assessments in 11 per cent of wards had not been updated following incidents or changes to care needs.⁵²

The importance of reassessing risk

Evidence from published reports and formal responses to the Inquiry demonstrated failures to identify potential triggers which may increase the risk of suicide for detained patients. In such circumstances, it is crucial that risk levels are reassessed as part of an ongoing process and additional flexible, personalised support is provided to the patient. Examples of potential triggers which may heighten risk include receiving bad news and the cancellation of temporary visits or trips for detained patients under Section 17 of the Mental Health Act, which allows a detained patient out of hospital temporarily on leave of absence. Recently published evidence from CQC⁵³ found that Section 17 leave is being increasingly cancelled due to staff shortages.

Information sharing

Internal inquiries and investigations into individual non-natural deaths of detained patients highlight staff failing to pass on important concerns in relation to detained patients in the lead up to their death. Coroner's investigations highlight an over-reliance on electronic data when there may be an additional need for staff to communicate verbally where the level of risk has been updated. NHS

⁵² Care Quality Commission (2013) *Mental Health Annual Report 2012/13*. Available at: <http://www.cqc.org.uk/content/mental-health-act-annual-report-201213>

⁵³ Ibid.

Wales informed us that, after recognising weaknesses in sharing information, basic guidance for frontline staff on sharing information and confidentiality is in the process of being developed.

The following case study highlights problems about staff not communicating known risk about a detained patient to other staff.

Case study – Communicating risk

X had been heard by staff discussing his desire to take his own life, and there were signs of previous attempts. These attempts had been noted in his medical records, but not discussed with his doctor despite opportunity at two team meetings.

X was granted unescorted leave, but then took his own life in the grounds of the hospital. At the inquest, the Coroner found a contributory factor in his death was the ‘neglectful’ decision by the hospital to grant the patient unescorted leave as a result of the doctor not being aware of all of the facts. The Coroner raised concerns about the absence of a system to check that all correct staff had been given full and up-to-date information and to ensure family members were invited to be involved in decisions about care, particularly as they often have information which if known about might decrease the risk of harm or self-harm.

(from Coroner’s Preventing Future Deaths report)

Removal of ligature points

Failure to remove ligature points which have later been used by detained patients in non-natural deaths is a critical weakness within some psychiatric hospital settings according to investigations and reports. In some cases the need to remove specific ligature points had been identified but not followed up.

Case study – Not removing risk

A mother told us that a unit had not removed bin liners from her daughter’s room despite her having tried to self-harm using this method on multiple occasions:

‘X was on 15 minutes observations, despite the fact that she had made six attempts on her life in the week leading up to her death. ... they put her back in her room, despite the fact that she had attempted to take her life in that way six times in the week. She always used the same, it was a method told to her by another patient as well, so she was able to learn that.’

The inquest jury found that not removing bin liners from X’s room, the level of observations not being increased and not making a referral to the Psychiatric Intensive Care Unit contributed to her death.

(Mother of detained patient – families listening day)

Absconding⁵⁴

A theme from the information we were able to access related to detained patients who were able to abscond, despite indicators of vulnerability, and then took their own lives. A study by the National Confidential Inquiry into Suicides and Homicides by People with mental illness found that having policies in place to prevent patients absconding was one of the service changes associated with the largest reduction of suicides of detained patients.

Training

A consistent theme from the evidence is that an increasing use and turnover of agency and NHS in-house agency⁵⁵ staff may be resulting in some unsafe practice due to a lack of training and knowledge about risk and assessments. Additionally, agency and in-house agency staff do not always know the history of detained patients or have an existing rapport with them. In one example an in-house agency

member of staff discovered a dying patient but, instead of acting immediately, left the scene to get a substantive member of staff, with a vital loss of time.⁵⁶

Prisons

Identification of risk

The prison service has introduced a range of measures to ensure the safety of detained prisoners which had contributed to a reduction in the number of non-natural deaths from 2007. Despite this progress, reports, investigations and submissions to the Inquiry highlight the ongoing themes of poor identification and management of risk.

Prisons and Probation Ombudsman (PPO) investigation reports and a recent thematic report on risk factors⁵⁷ found that ‘too often too much weight was placed on judging how the prisoner “presented” rather than on indications of risk, even when there had been very recent acts of

Having policies in place to prevent patients absconding was one of the service changes associated with the largest reduction of suicides of detained patients

54 For the purpose of this Inquiry, absconding is any absence without leave of a person detained or liable to be detained under the MHA 1983, for example: on Section 17 leave from hospital, or held under short-term powers of Section 5, 135 or 136 in England and Wales.

55 Also known as ‘bank staff’.

56 Submission from Unison.

57 Prisons and Probation Ombudsman, Learning from PPO investigations: Risk factors in self-inflicted deaths in prisons, April 2014.

self-harm or suicidal ideation (having suicidal thoughts).’ Additionally, the report stated that in some cases prison officers were not clear about their responsibilities for assessing risk. The result of this is that too often prisoners are not recognised to be at risk.

Management of risk

Even where risk is identified the processes put in place to address this are frequently insufficient according to evidence from investigation reports and submissions. Prisoners identified as at risk must be assessed using Assessment, Care in Custody and Teamwork (ACCT) procedures. A PPO⁵⁸ sample of 60 investigations involving prisoners who were subject to ACCT processes when they died found that in only half of the cases the ACCT was correctly implemented or monitored at the time of death.

Transfer of information

The transfer of prisoners is a key stage in the communication of risk about an individual. The Personal Escort Record (PER) captures essential information about an individual’s vulnerabilities and mental health condition. A recent Independent Police Complaints Commission (IPCC) review of this form following an investigation into a death found it not fit for purpose. The College of Policing is reviewing the

form as part of its review of detention and custody guidance. A recurring theme from our analysis of PPO investigation reports was of crucial information being lost or delayed during the transfer of prisoners, so that staff at the receiving prison did not have access to vital information about known risk factors. Additionally, there were some cases where information had not been shared when a prisoner moved to a different wing in the prison.

Similar concerns have been highlighted by PPO⁵⁹ following a review of investigations into the self-inflicted deaths of 18-24-year-old prisoners. This identified the need to incorporate information provided by police, court escort services and the courts into risk assessments on reception into prison to ensure no loss of important information in the transfer of prisoners.

To remedy this problem in July 2012 the Independent Advisory Panel (IAP) issued an Information Sharing Statement (ISS)⁶⁰ to criminal justice agencies reminding custodial staff of the need to share information on a detainee’s risk of self-harm and/or suicide. However, a later preliminary evaluation⁶¹ of the impact of the ISS by a University of Greenwich consortium found that it was quite likely that ground level prison staff had not seen the ISS.

58 Prisons and Probation Ombudsman, Learning from PPO investigations: self-inflicted deaths on ACCT, April 2014.

59 Prisons and Probation Ombudsman, Learning lessons bulletin: Fatal incident investigations issue 6, July 2014.

60 Independent Advisory Panel on Deaths in Custody, IAP information sharing statement, 2012.

61 Independent Advisory Panel on Deaths in Custody, Impact of the Information Sharing Statement, July 2014.

Communication and information sharing

In situations where there is a real and existing (that is, present and continuing) risk to life, staff have a duty to tell relevant professionals; a failure to do so can result in unnecessary deaths. However, evidence from several organisations suggested that staff misunderstandings about and fear of breaking data protection legislation, and lack of access to and availability of medical records, can lead to failures to share information.

It is crucial that changes which may increase an individual's level of risk are picked up on and addressed. Prisons need to be aware of a range of risk factors, which could include anniversaries of crimes, sentencing dates, bereavements, relationship difficulties, history of self-harm, and bullying, and prison staff responsible for the welfare of individual prisoners need to use this information to review risk. Yet vulnerabilities relating to certain key trigger dates or changes in circumstances are frequently not picked up on or addressed according to evidence from investigations and reports.

Families

Families can be aware of critical changes and problems which may increase an individual's level of risk. Yet families of people who have died reported many instances where they attempted to inform prisons of critical concerns but the information was either not passed on to appropriate prison staff or it was not acted upon.

Case study – Trigger Date Database

A prisoner's risk of self-harm and/or suicide may increase in certain circumstances. HMP Gartree has introduced measures to identify potential triggers which may increase the risk of self-harm and/or suicide of individual prisoners and has identified ways to address these and reduce risk.

HMP Gartree has developed a database on trigger dates for prisoners who are, or have been, subject to an Assessment Care Custody Teamwork (ACCT) document. Trigger dates are personal and highly specific to the individual. As such, they can be very wide ranging, but include key anniversaries such as dates of offences/sentencing, bereavement, relationship breakdown, and can be an indication that prisoners are at heightened risk of self-harm and may require closer monitoring.

Trigger date information is collated by the Safer Custody Business Administrator who updates the database (spreadsheet). Information on all potential trigger dates is checked daily and given to all relevant departments prior to the date with the offer of support. The support provided depends on the individual. Some prisoners do not want to be reminded of a trigger date. The information is treated sensitively and support ranges from a phone call to a family member or friend, contacting the Samaritans or speaking to a Listener.

Using the database has ensured appropriate support is in place prior to any trigger and has resulted in the reduction in number of ACCT documents being opened. It has helped identify trends in the prison's repeated prolific self-harmers and inform prison staff prior to a potential trigger date/event. Some of the men in the prison's care self-harm as a coping mechanism therefore an ACCT will be implemented. The database is being introduced in a number of prison establishments in the East Midlands and other regions.

Police

Initiatives

The nature of policing is that the police typically do not know the individuals in a situation they are called to manage. There are concerns in relation to the assessment of risk and vulnerability within police forces but changes are being made to improve this situation.

Initiatives in relation to mental health include the piloting of new assessment models. An example is the piloting of street triage schemes⁶² in some areas, where mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health conditions. The pilots have shown that in many cases, the individuals who come into contact with the police are already known to mental health services which can improve the efficiency and effectiveness of the assessment and ensure they are referred to appropriate care.

The introduction of the Mental Health Liaison Officer role in some areas is another welcome development to help facilitate the improvement of the police response and collaboration with other agencies. Another development is the placing of mental health teams in some custodial suites to ensure that people with suspected mental health conditions can be assessed and referred for treatment at the earliest opportunity.

Case study – The effective use of mental health liaison officers

In 2011 South Wales Police reviewed the growing demand on police time of people with mental health conditions within its community and in particular those with dual diagnosis and substance misuse. The force advisor and strategic lead on mental health ensured appropriate police responses at Basic Command Unit and force level but recognised a gap in training and the need to promote organisational learning.

The advisor identified the need for four mental health liaison officers across the force to liaise with organisations, agencies and partnerships and effectively manage the increased demand from those with potential and diagnosed mental ill health in the community, hospitals and secure facilities. Any learning identified now informs future training for frontline staff, including custody staff.

⁶² See <http://www.crisiscareconcordat.org.uk/inspiration/get-inspired-2/>

Although introduced at a time of significant budget cuts, the view of South Wales Police is that the investment has led to significantly increased safeguarding of persons most at risk in the community and it has proved to be an effective use of resources. The force has recognised the valuable contribution the liaison officers make towards appropriate intervention on the frontline, including their contribution to safer detention.

Risk assessments

Recent HMIC inspection reports give a largely encouraging evaluation of the quality of risk assessments of adults with mental health conditions in police custody. However, HMIC inspections of some police forces identified a lack of understanding of assessing risk levels. An example is the HMIC inspection of police custody suites in Southwark in November 2013, which found that custody staff did not receive any ongoing mental health training to help them identify and support detainees with mental health conditions. A frequently repeated recommendation from HMIC is that all custody staff should receive regular mental health awareness training to identify and manage the care of detainees appropriately and safely.

IPCC investigations have uncovered a broader lack of clear understanding of mental health by police officers. In September 2014, Inspector Michael Brown, a serving police inspector, now

leading the development of mental health training for the College of Policing, provided evidence to the Home Affairs Select Committee inquiry into policing and mental health that most police officers initially receive only between 4 and 8 hours training on mental health-related priorities and that this is inadequate. We welcome the training programme currently being developed by the College of Policing to address this. This will be applicable to new recruits and will set a benchmark which all police forces will aim to meet.

Places of safety

Evidence highlighted people being held in police cells for up to 72 hours under section 136 of the Mental Health Act, where the police can take an individual to a place of safety when they are in a public place and it is suspected by police officers that they may be a danger either to themselves or to the public and need to access appropriate treatment. A joint report by CQC, HMIP, HMIC and HIW⁶³ published in 2013 details the serious risks involved when police cells are used as a place of safety. These risks include difficulty in accessing healthcare as well as the additional pressure on people already in distress.

[There are] serious risks involved when police cells are used as a place of safety

63 A joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales, *A criminal use of police cells in 2013? The use of police custody as a place of safety for people with mental health needs.*

The recent government review of Sections 135 and 136⁶⁴ of the Mental Health Act sets out to improve the police and health service response for those in mental health crises. It aims to significantly reduce the use of police custody as a place of safety and remove barriers to preventing a person in a mental health crisis from accessing help. A number of legislative and non-legislative changes have been proposed, including the reduction in the length of time someone can be held from 72 to 24 hours, and ensuring that Clinical Commissioning Groups (CCGs) commission sufficient health-based places of safety.

Our analysis of evidence found that some police forces have dramatically reduced the number of police cells used as a place of safety, however its use remains inconsistent across police forces, with some concerns raised about unavailability of health-based places of safety in some areas. Police cells remain over-used as a place of safety, with statistics for England showing their use as a place of safety 6,028 times in 2013 although this does represent a welcome 24 per cent decrease in its use since 2012/13 with a further fall of 25 per cent projected for 2014/15.⁶⁵

Identifying mental health conditions

Also highlighted in the evidence is the use of a mental health ‘flag’, used by police force IT systems to highlight the vulnerabilities of an individual and provide appropriate measures.

However, we received evidence from submissions that the mental health ‘flag’ is being used inconsistently and unsuitably among some police forces. Additional concerns were raised in submissions that the mental health marker category may be too broad as it does not allow for the wide range of different types of mental impairment to be categorised. This could mean assumptions are made regardless of the nature of the mental condition and tailored and personalised measures to support individuals with mental health conditions are not provided.

It has been estimated that at least 20 per cent of all demands in policing,⁶⁶ and up to 40 per cent of all demands on police time,⁶⁷ is spent on managing people experiencing mental distress. Yet evidence received has highlighted that many police forces do not have a clearly designated lead at a senior level with sufficient resources for dealing with mental health.

64 Home Office: Department of Health (2014) *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf

65 HSCIC, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014*, Annual figures. October 2014.

66 Michael Brown, the Mental Health Cop blog. Available at: <http://mentalhealthcop.wordpress.com/2013/02/13/twenty-percent/>

67 Independent Commission on Mental Health and Policing Report, May 2013.

Conclusion

When risk assessments are well-managed, involve the individual and, as appropriate, their family members, they can safeguard the individual while ensuring the institution is complying with their obligations under Article 2.

Recommendations

To support agencies in the three settings to comply with their legal responsibilities we make the following recommendations:

For all settings:

- Risk assessments need to be carried out, be effective, be reviewed regularly and shared with all relevant agencies and staff.

Prisons:

- Prisons to set up a system which alerts staff of possible events or dates which may trigger increased vulnerability for a prisoner (for example anniversary of imprisonment, bereavement or trial date).

Chapter 7: Access to treatment and support

To comply with their obligations under Article 2, institutions should provide timely and appropriate medical and mental health treatment and support to everyone in their care. They should also provide appropriate social support which will include the opportunity for regular family contact. The duty is owed to everyone regardless of whether or not they are detained.

They also have a duty to provide appropriate protection to particular individuals where they know, or should know, that there is a real and existing (that is, present and continuing) risk to that person's life. This duty does not impose an impossible or disproportionate burden on the agency but it must take all proportionate steps to reduce the risk. What is proportionate will depend on the circumstances of each case. Relevant factors will include the seriousness of the risk, the steps that could reasonably be taken to reduce it and the relative ease of taking those steps. This duty of protection is enhanced in relation to detained individuals with mental health conditions because of their particular vulnerability.

Cross-sector findings

Treatment and support

Provision exists for detained patients to receive support for mental health conditions. There are instances of good quality care and many initiatives

to continually improve the care being provided to detained patients. In the health sector, however, problems include limited access to beds, with some patients being detained long distances from families and social support.

In the prison setting, there is some provision of treatment and support for adults with mental health conditions and some peer-based support initiatives but we also found evidence of some inconsistent and inappropriate mental health treatment. Ongoing problems include access to non-prescription and illegal drugs.

In the police setting there are a range of initiatives to aid joint working between different agencies. Agencies in the other settings can learn from these initiatives. There is an ongoing problem with some unavailability of mental health treatment and support, particularly out of hours. There are initiatives to commission more health-based places and safety and an increasing recognition that a police cell is an inappropriate place for someone experiencing a mental health crisis.

As set out in our Human Rights Framework, human rights legislation requires that there should be effective communication and integration of services across agencies in all settings to ensure that adults with mental health conditions are able to access appropriate and timely

treatment and support. The Independent Advisory Panel on Deaths in Custody (IAP) carries out work to ensure that statistical data on deaths in detention is available and analysed across the three settings.

Families

Families can provide valuable support and make an important contribution to the mental healthcare their relative is receiving. Yet some families of individuals who have died in detention reported poor communication from institutions in all three settings.

Appropriate protection

There are some individual cases in all three settings where individualised protection has not been adequately implemented. Problems include insufficient support measures in place to address the cause of risk and not providing either any or sufficiently tailored treatment for individuals. Deaths of detained patients have been associated with incorrect levels of observation or an appropriate observation plan not being adhered to.

The following example shows how the provision of individualised protection can save lives. A detained patient was identified as requiring very high observation levels. During an observation the patient was found hiding with a serious self-inflicted injury. Appropriate and prompt interventions meant that the life of the patient was saved.

Hospitals

The Inquiry has had limited access to information relating to deaths in psychiatric hospitals as investigation reports are not routinely published.

Substance misuse

We have found instances where detained patients have died after misusing prescription drugs or being able to access non-prescription and illegal drugs in psychiatric hospitals.

This is a problem both on psychiatric hospital wards and when detained patients are on authorised leave under section 17 of the Mental Health Act or have absconded.

The National Confidential Inquiry into Suicide and Homicide⁶⁸ (NCISH) highlighted this problem in 2013 in relation to all hospital inpatients, reporting that not enough is known about which drugs are used by patients or where they are obtained.

Access to beds in psychiatric hospitals

Patients are being detained in hospitals far away from where they live, raising concerns about the impact on the patient's mental health due to limited contact with families (see Chapter 2). This problem has been highlighted in many reports. The recent investigation by community care and the BBC⁶⁹ highlighted that this is an increasing problem.

⁶⁸ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report, July 2013.

⁶⁹ Mental health patients forced to travel miles for care BBC News 6.5.14, see <http://www.bbc.co.uk/news/uk-27285555>

Patients are being detained in hospitals far away from where they live, raising concerns about the impact on the patient's mental health due to limited contact with families

Data they gathered from 30 trusts showed that the number of patients sent out of area in 2011-12 was 1,301, this figure was 2,263 in 2012-13 and increased to 3,024 patients in 2013-14.

Testimonies from families of detained patients who have died is that longer distances to travel meant that they saw their relative less often and made it difficult for them to provide support and input into their treatment.

Prisons

Initiatives

In the prison setting there are some initiatives aimed at improving prisoners' access to mental healthcare and social support. The review⁷⁰ of what has changed since the 2009 Bradley Report into the support offered to people with mental health conditions and people with learning difficulties in the criminal justice system found some developments. The review gathered evidence suggesting that primary

mental healthcare in prisons is becoming more robust and some prisons now have a merged primary and secondary care service. The review identified some further improvements which could be made to prison mental healthcare to recognise the multiple and complex nature of need, which could involve a greater role for current and former service users in designing and delivering care.

Other developments in prisons include access to peer-based support schemes which can provide valuable social support to prisoners with mental health conditions. Some examples include the Listener scheme, where adult prisoners are trained to provide peer-support by the Samaritans, and the Insiders scheme, which provides specific peer-support for new prisoners. The National Offender Management Service (NOMS) and the Samaritans recently won the partnership award at the Charity Times awards for joint work on the Listener scheme. Access to Listener schemes can, however, be limited in some prisons, particularly at night-time when it may be most needed. In addition, HMIP's most recent Annual Report⁷¹ stated that it had found 'too many prisoner peer supporters who lacked oversight, sufficient training or support from staff'.

Treatment and support

Prisons provide treatment and support for adults with mental health conditions, including referrals to mental healthcare professionals. However, care can be limited in some prisons and needs to be provided more consistently.

⁷⁰ The Centre for Mental Health, The Bradley report 5 years on: An independent review of progress to date and priorities for further development, June 2014.

⁷¹ HMIP Annual Report 2013-14, October 2014.

Mental healthcare in prisons

There is evidence of some inconsistent and inappropriate treatment for prisoners with mental health conditions. A theme of Prisons and Probation Ombudsman (PPO) investigation reports, for instance, concerns care plans with unrealistic and inappropriate measures, such as recommended increased contact with family when this was not possible. The measures in some care plans do not address the root cause of risk because of a tendency to adopt standardised and insufficiently tailored measures.

HMIP⁷² recognises a continuing trend to provide integrated mental healthcare but has found that care for prisoners with mental health needs is inconsistent across different prison establishments.

While training in mental health awareness is often available for prison staff, it is not mandatory and may not be taken up because of other work pressures. Such awareness, however, is essential in order to improve mental health treatment and support.

Protection for vulnerable prisoners

A particular problem in some prisons is limited access to cells on vulnerable prisoner wings. PPO⁷³ has identified a problem of newly arrived vulnerable prisoners 'lodging' on other wings because dedicated units are full resulting in instances where this has led to threats and intimidation from other prisoners and little staff support. We support the PPO's recommendations that 'vulnerable prisoners who cannot be housed in

the appropriate unit should have an equivalent regime to other prisoners and a nominated officer should check their wellbeing regularly'.⁷⁴

Family support

A recurring theme from the evidence is a lack of involvement of families in helping to inform the provision of treatment and support. Families should be included in the formulation of treatment plans as they often have information which if known about might decrease the risk of harm. Families told us that they felt excluded from inputting into treatment plans and that they felt their concerns were ignored by prisons. They also reported they had limited communication from prisons and were unaware of serious incidents involving their relative until after the death. Some families we spoke to felt that better communication on the prison's part could have resulted in actions which may have prevented the death of their relative. Families also raised concerns about a lack of understanding or personalised support towards their relative from some prison staff.

Families should be included in the formulation of treatment plans as they often have information which if known about might decrease the risk of harm

⁷² Ibid.

⁷³ Prisons and Probation Ombudsman, Annual Report 2014.

⁷⁴ Ibid.

Segregation

Segregation is when a prisoner is kept apart from other prisoners and they may be kept in another part of prison called the segregation unit. The use of segregation to manage behaviour has been deemed an inappropriate setting for prisoners with mental health conditions, as outlined in the NOMS guidance which states segregation should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance. It is therefore a concern that the most recent Annual Report by PPO (2014)⁷⁵ stated that ‘during the year there were a number of deaths in segregation units, including some prisoners who were being supported through ACCT procedures’.

HMIP has repeatedly raised concerns that segregation is used too frequently for prisoners on an Assessment, Care in Custody and Teamwork procedure (ACCT) and without full consideration of whether this is the right place to care for them. Those working in the field have informed us that, in the absence of a clear definition of ‘exceptional circumstances’, it is very much left to the judgement of individual staff.

Where prisoners with mental health conditions are segregated, their level of risk and the requirement to remain segregated should be regularly reviewed. Segregation should not be used to manage the behaviour of prisoners who are on an ACCT.

Access to ‘legal highs’ and non-prescription drugs

An increasing problem in prisons is the ease of access to drugs known as ‘legal highs’ which are not currently illegal but which can increase the risk of mental health crises and are a potential factor in some non-natural deaths, although their use is hard to detect. HMIP⁷⁶ has also raised concerns about the increased availability in prisons of new psychoactive substances, often known as ‘legal highs’, which can lead to debt and associated bullying and be a threat to health. We would welcome further research into prisoners’ access to and the use of legal highs and their potential role in non-natural deaths.

Police

The police have repeatedly raised concerns that police custody is not a suitable place for someone with a serious mental health condition particularly if they are not suspected of having committed a serious offence. The police have a limited but key role in ensuring that those with mental health conditions and other vulnerabilities are directed to appropriate and safe environments. Our analysis of evidence highlighted an ongoing issue with some unavailability of mental health treatment and support while individuals are detained in police custody.

⁷⁵ Prisons and Probation Ombudsman (2014) *Annual report 2013-2014*. Available at: http://www.ppo.gov.uk/wp-content/uploads/2014/09/PPO-Annual-Report-2013-14_FINAL_web.pdf

⁷⁶ Her Majesty’s Inspectorate of Prisons (2014) *Annual Report 2013-14*.

Initiatives

There are some initiatives aimed at ensuring that agencies in the police and mental healthcare settings understand their different roles and work together to ensure that individuals are able to access appropriate services.

The Mental Health Concordat⁷⁷ (February 2014) aims to integrate services to provide more effective treatment and support to people with mental health conditions. The Concordat is already having an impact, including new protocols to reduce the use of police custody and refer individuals to appropriate places of support and safety. These schemes are leading to quicker access to support and effective pathways of care. The Sanctuary Centre in Manchester is an example of a scheme involving a number of agencies which provides support to people before they reach crisis point and means they avoid being formally detained.⁷⁸

Implementation of the Concordat is inconsistent in some geographical areas, with some evidence that agreed protocols are not adequately reflected in working practices on the front line. We support the implementation of the Concordat in all geographical areas and welcome further analysis of its impact. Formal evaluation of the Concordat is due in 2015 and it is important that the lessons learned inform local commissioning of mental health crisis care.

As part of the Concordat a national model has been developed and some areas are piloting liaison and diversion schemes. These schemes identify vulnerable offenders when they first come into contact with the criminal justice system so that risk can be identified and appropriate treatment and support measures put in place both through early intervention where possible and throughout the process of detention. These schemes are due to be evaluated in 2015 and rolled out nationally in 2017.

Working with vulnerable and intoxicated and aggressive people

Evidence from published reports and submissions to the Inquiry highlighted an ongoing problem of a lack of agreed protocols as how to deal with intoxicated or aggressive detainees,⁷⁹ meaning that people with mental health conditions can be refused treatment in health-based places of safety. CQC reported that the exclusion of people who appear to be under the influence of drink or drugs from health-based places of safety has been a long-standing issue. There is a need for cross agency working to ensure that people in crisis are admitted to health-based places of safety.

We welcome the changes in January 2015 strengthening the MHA codes to ensure clearer understanding of responsibilities when dealing with intoxicated or aggressive detainees and

⁷⁷ HM Government, Mental Health Crisis Care Concordat, Improving outcomes for people experiencing mental health crisis, 18 February 2014.

⁷⁸ See https://www.selfhelpservices.org.uk/shs_service/the-sanctuary/

⁷⁹ Home Office: Department of Health (2014) *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf

the recommendation that police cells should only be used as a place of safety for adults if the person's behaviour is so extreme they cannot otherwise be safely managed. This is a difficult area which needs to be constantly kept under review to ensure that these changes have practical impact on the ground.

Training

Submissions to the Inquiry highlighted training initiatives which involve input from mental health professionals and service users providing training and support to police officers to improve their understanding of and attitudes towards mental health. This can help police officers to better understand how to fulfil their role and work more effectively with other agencies. We welcome developments to extend this training, with the Royal College of Nursing working with the College of Policing to progress this area.

[There is] an ongoing issue with some unavailability of mental health treatment and support while individuals are detained in police custody

Case study – Liaison and Diversion

The Dorset Liaison and Diversion team was set up in 2012 to provide ongoing support to people in the criminal justice system with mental health conditions, substance abuse or learning difficulties. As part of their work, the team provides support to the local police to help them better understand vulnerable detainees, assess their needs and de-escalate situations. The team also do joint assessments with the police to decide how best to manage the security and health risks of very intoxicated or violent individuals.

The Liaison and Diversion team operates in combination with the street triage initiative and was set up to meet the requirements of a mixed urban/rural geography. More recently it has sought to address requirements contained within the Crisis Care Concordat.

Initial feedback is that the service is highly valued by custody suite and frontline staff. Being in the same place enables rapid assessments and interventions. This frees up considerable police time, particularly where no serious offence has been committed, with quicker access to appropriate care for the detainee.

Access to medical information

Concerns have been raised about difficulties accessing medical information about individuals who have been detained in police custody. A development which is expected to take place from April 2015 is the transfer of the commissioning responsibility for all police custodial healthcare to the NHS in England. We welcome this change.

Recommendations

To support agencies in the three settings to comply with their legal responsibilities we make the following recommendations:

For all settings:

- Mandatory and regularly refreshed training in mental health awareness for all frontline staff so they are better able to identify and appropriately support people with mental health conditions.

Prisons:

- The Government should consult on their proposed improvements to mental health services within prisons. These improvements should be matched with sufficient resources.

- Segregation⁸⁰ should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance. An 'exceptional circumstance' should be clearly defined and understood by prison staff. Where prisoners with mental health conditions are segregated, their level of risk and the requirement to be segregated should be regularly reviewed.

Police:

- The Government to continue the financial commitment to ensuring the provision of sufficient mental health crisis care so that people receive appropriate treatment when it is needed and police cells are not used as places of safety.

80 For the purpose of our report segregation is when a prisoner is kept apart from other prisoners and they may be kept in another part of prison called the segregation unit.

Chapter 8: Investigations and preventing future deaths

Human rights obligations

In addition to the systems and operational duties, Article 2 imposes a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances where it appears that one or other of these duties has been breached and agencies of the State are, or may be, in some way implicated.

To be effective, the investigation should identify:

- any defects in the system
- any defects in instructions and training of relevant staff
- any defects in the planning, management or control of the incident, including the dissemination of information and the supervision of staff
- individual failings which a robust system should detect and remedy before harm is done.

To comply with human rights obligations, an effective investigation should involve the next of kin. It should also make recommendations and identify lessons which can be learned to minimise the risk of similar deaths in the future. These lessons should be shared internally and externally.

To comply with human rights obligations, an effective investigation should involve the next of kin

Learning lessons

When lessons are learned following a non-natural death in detention there are examples where this has led to real improvements, which we can link to a reduction of deaths in those settings. Measures were set up to reduce the numbers of non-natural deaths in recognition of the obligation of institutions to care for vulnerable individuals in detention. Both the number and rate of non-natural deaths reduced between 2007 and 2012.

When lessons are learned following a non-natural death in detention there are examples where this has led to real improvements

The investigative system in each setting

There are important differences between the three settings in relation to investigations. There are independent agencies in the police and prison settings to investigate non-natural deaths. There is no independent body to investigate non-natural deaths of detained patients and these investigations are the responsibility of the hospital trust that was responsible for the patient at the time of the death.

Where there has been a death in a prison establishment, the prison notifies the Prisons and Probation Ombudsman (PPO). PPO investigates all deaths in prison establishments in England and Wales. The death must also be reported immediately to the prison's Independent Monitoring Board (IMB) whose duty is to monitor that this has been dealt with appropriately and sensitively in line with local contingency plans. PPO notifies the prison of its findings and recommendations, obtains its response and for deaths prior to August 2014 published anonymised individual reports. PPO has stated that for deaths after August 2014 the name of the deceased will remain in their investigation reports, but other names will be anonymised.

According to the Independent Police Complaints Commission's (IPCC's) statutory guidance⁸¹ 'A mandatory referral must be made without delay and in any case not later than the end of the day after the day it first becomes clear that

it is a matter which must be referred'.⁸² The IPCC carries out an independent investigation into all deaths in police custody and notifies the police force of its findings and recommendations. Previously, the IPCC decided what type of investigation was required and some of these were carried out at a local level. Investigation reports are published and these identify the individual who has died.

Unlike in the other settings there is no independent body to investigate deaths of detained patients. When a detained patient dies, the hospital notifies the Care Quality Commission (CQC) in England or the Healthcare Inspectorate in Wales. The trust carries out an investigation, which can involve external input, and produces a report for the service commissioner, normally the relevant Clinical Commissioning Group, with any identified findings and recommendations.

All deaths in detention are investigated by a Coroner and there is an enhanced investigative duty in relation to non-natural deaths to ensure Article 2 compliance.

National bodies

At a national level there is a commitment to learn from previous investigations into non-natural deaths in detention.

The Independent Advisory Panel on Deaths in Custody (IAP) reports to the Ministerial Board on how lessons can be learned.

81 Independent Police Complaints Commission (2013) Statutory Guidance to the police service on the handling of complaints. Available at: https://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/2013_statutory_guidance_english.PDF

82 Ibid.

The establishment of the National Preventive Mechanism (NPM) is the means by which the UK Government fulfils its remit in terms of the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

Both the NPM and IAP recognise the importance of the voice of those in detention as part of the inspection and investigations process. The review of the function of IAP in 2015 is an important opportunity to assess where it has had an impact and where there could be improved focusing of its role as the support function to the Ministerial Board on Deaths in Custody.

The creation of the Office of the Chief Coroner (OCC) in 2013 has provided the opportunity for increased oversight of the circumstances leading to non-natural deaths in detention. This provides an opportunity for both the organisations directly concerned and for others to learn and share lessons from inquests. Since July 2013, it has been mandatory for Coroners to issue a Preventing Future Death (PFD) report to any person or organisation where, in the opinion of the Coroner, action should be taken to prevent the risk of future deaths. Prior to this change, Coroners issued Rule 43 reports which were discretionary and the change is intended to increase accountability to ensure lessons are learned to prevent future deaths.

The Chief Coroner published an analysis of trends in his first Summary of Reports to Prevent Future Deaths⁸³ in 2013.

The report says: ‘As in previous summaries, mental health-related deaths and deaths in custody feature prominently ... a common request across all categories of deaths is for lessons learned to be shared and implemented.’

The Chief Coroner should build on the analysis of trends in his first Summary Report and ensure that all PFD reports and responses to them are published on the OCC website. The Chief Coroner has developed and will be implementing compulsory training for Coroners, which will include training on decisions relating to Article 2.

Hospitals

Independent investigations are more likely to identify systemic failings in a particular institution which will enable measures to be put in place more promptly to ensure that the risk of similar deaths in the future is minimised.

A recent court judgment⁸⁴ found that, on the facts of that particular case, there is no obligation to have an independent investigation in addition to an inquest in order to comply with the investigative duty under Article 2.

Since that court case NHS England has drafted new guidance, soon to be published, which will set out a format for an investigation when a detained patient dies while in hospital care. We would expect the guidance to cover the following areas:

⁸³ See <http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/summary-of-reports-to-pfds/>

⁸⁴ *R. (Dr Michael Antoniou) v (1) Central and Northwest London NHS Foundation Trust; (2) Secretary of State for Health; (3) NHS England.*

- the circumstances in which there should be an independent investigation into a death and the factors to be taken into account in deciding who should carry it out
- the involvement of families throughout the process, including input to the Terms of Reference, being sent the report and having the opportunity to discuss it
- a clear requirement on commissioners to ensure that providers follow the guidance and monitor investigations to ensure that they are independent, objective and robust
- all reports are published and open to public scrutiny to ensure transparency.

Quality of investigations

As set out in our Human Rights Framework, investigations should be independent, identify any defects in the system and hold to account anyone responsible. The investigations should also identify recommendations and lessons which can be shared and learned within and outside the organisations directly concerned to prevent future deaths.

Concerns about the quality of initial investigations by hospitals following the non-natural death of a detained patient have been raised in Coroner's reports, by IAP⁸⁵ and by bereaved families. There are also concerns about the transparency of internal investigations into non-natural deaths, which may prevent wider learning and sharing of lessons.

There is a need for a more joined-up approach to investigating non-natural deaths of detained adults. This would involve CQC, who receive notifications of deaths from the trust and carry out reviews of them, and NHS England working more closely together.

Where investigations into non-natural deaths of detained patients have been carried out, they are of variable quality, according to reports and submissions to the Inquiry. An IAP⁸⁶ review of 18 Serious Untoward Incident Reports (SUIs) carried out by hospital trusts in England identified serious problems in quality, finding: '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.' In addition, the report stated that 'a satisfactory system does not currently exist for investigating the deaths of detained patients in an independent or open way'. We carried out our own review of a sample of SUIs in England, which confirmed the variable quality of reports. We have been unable to obtain SUI reports relating to non-natural deaths in Wales.

Sharing information and learning lessons

To ensure compliance with Article 2, our Human Rights Framework requires that an effective investigation will share and put into practice lessons learned from

⁸⁵ Independent Advisory Panel on Deaths in Custody Analysis of Serious Untoward Incident Reports, 2011.

⁸⁶ Ibid.

While individual investigations should identify lessons to be learned, wider reviews offer an opportunity to identify practice which can be applied elsewhere

the result of the investigation. This should ensure, so far as is possible, that the risk of similar deaths in the future is minimised. While individual investigations should identify lessons to be learned, wider reviews offer an opportunity to identify practice which can be applied elsewhere.

Even the highest quality investigation will fail to ensure the implementation of recommendations and the learning of lessons if the report is not published and shared both internally and externally. To demonstrate compliance with Article 2, transparency must run throughout the entire investigations process. Yet concerns have been raised about public access to reports and data from internal hospital investigations which take place before the inquest, according to evidence from reports, submissions and testimonies of families.

Unlike the police and prison settings, little information is published following an investigation, making it hard to identify any problems and trends related to non-natural deaths of adults with mental health conditions who are detained in hospitals. As a consequence, irrespective of the quality of an investigation,

individual hospital trusts may not implement recommendations, lessons may not be learned across the health setting and the lives of an extremely vulnerable group in society will not be effectively safeguarded.

There is currently no formal system in place for ensuring that learning is shared and informs practice at a national level which means the degree of systematic learning from investigations within the health sector cannot be substantiated. CQC collects data from initial notifications of non-natural deaths and carries out desktop reviews of some deaths of detained patients and any resulting recommendations should be followed up in subsequent inspections of individual providers. However this information is not used to inform wider policy or practice.

The National Confidential Inquiry into Suicides and Homicides publishes an Annual Report with data and trends on homicides and suicides of in-patients, which includes detained patients, it is not specifically focused on lessons which could be learned in relation to non-natural deaths of detained patients. The health sector would benefit from implementing learning from investigations in the police and prison settings, where thematic reports are regularly published which identify common themes and learning from investigations.

In Wales, processes have been put in place to learn from, share concerns and share approaches to prevent future non-natural deaths. The National Collaborative and the Task and Finish Group Untoward Incidents programme in Wales are examples of sharing learning from serious untoward incidents. These are at an early stage but will be developed long term.

Case study – Example of learning and sharing information from investigations

Public Health Wales holds three meetings a year with senior professionals and incident teams within mental health services from across Wales. The meetings provide a safe environment where root causes and lessons learned can be shared. Chatham House Rule apply allowing experiences to be shared honestly and openly exploring the challenges and learning.

Uncertainty about sharing information, particularly balancing data protection and the duty of care, has been highlighted as an obstacle to patient safety. Easy to read documents are being considered that set out what staff need to think about where this is a concern, for example, when and how to share information with the police when someone absconds from hospital. Networks have also been developed allowing local learning to be shared that previously hadn't been.

The Task and Finish Group Untoward Incidents programme focus is on 'closing the loop' of actions following a serious incident review, including feeding back to inspection bodies on the implementation of review recommendations. This is being tested out by a local improvement project at Cardiff and the Vale University Health Board.

Involvement of families in investigations

Our Human Rights Framework states that an effective investigation should involve the next of kin of the patient who has died to ensure their interests are protected. Guidance in the NHS Serious Incident Framework⁸⁷ clearly states the need for families to be involved in investigations. Yet families told us they were not involved in investigations and, in some instances, they felt they were actively prevented from being involved.

'And we had no contact with the hospital whatsoever, the first time was when I wrote them a letter with our complaints, our concerns, and then I got a reply from the regional director. Not from anybody in the unit, from the regional director, and with a comment of "oh we are so sorry to hear about your loss". That was the only contact we had with the hospital. We weren't involved in any internal inquiries whatsoever.'

(Quote from family member at our family listening day)

Families at a family listening day held by IAP⁸⁸ in 2011 reported that internal hospital investigations were not carried out independently and overlooked important information. They reported that they were not given full information about the process of the investigation. Our family listening day suggests that this situation has not improved.

⁸⁷ NHS Serious Incident Framework, March 2013.

⁸⁸ Report of the Independent Advisory Panel on Deaths in Custody Family Listening Day, September 2011.

Recommendations

To address our concerns about the quality and transparency of internal investigations into non-natural deaths of detained patients we recommend:

In Wales:

Data should be systematically collected, analysed and made publically available with full breakdowns by protected characteristics as defined in the Equality Act 2010.

In England:

The Secretary of State for Health should establish responsibility for ensuring there is full oversight of the investigation process as well as proper collation of information. This would enable national quality assurance and learning.

Specifically, there is a need to ensure that:

- Investigations take place in line with national guidance.
- Investigation reports reflect Article 2 compliance: they must include family representation and be open to public scrutiny.

Data should be systematically collected and analysed. The current system for the notification of deaths provides a starting-point. However, full compliance with Article 2 and Article 14 also requires more rigorous checking to ensure the data are accurate and complete, with full breakdowns by protected characteristics as defined in the Equality Act 2010. It is essential

that the data are updated following inquest verdicts and is made publicly available. Only when these measures are in place will we have confidence that we have a reliable evidence base which sets out trends and will genuinely inform decisions on how to improve policy and practice.

Prisons

The Prisons and Probation Ombudsman (PPO) investigates each non-natural death in a prison setting in England and Wales. These investigations are independent and identify defects and problems and make resulting recommendations to enable lessons to be learned. Investigation reports are published, which means they are open to public scrutiny. However, some prison establishments do not fully implement recommendations made by PPO, which prevents lessons being learned.

Sharing information and learning lessons

There is some work in individual prisons to implement recommendations from investigations into non-natural deaths and learn lessons. There are some examples of compliance with Article 2, including a prison which has a central action plan from all investigations to address recommendations and identify wider themes.

The National Offender Management Service (NOMS) has undertaken a range of work to identify lessons which can be learned at a wider strategic level. NOMS produces a quarterly statistical bulletin which, as well as reporting on the number of deaths, includes some analysis of trends. Additionally, NOMS has been exploring the reasons for the recent rise

in self-inflicted deaths in 2013 to identify patterns and trends through a review of investigation reports and work with stakeholder organisations. This work should be agreed with HMIP and PPO in order to implement recommendations in 2015.

PPO has implemented measures to identify themes from investigations into non-natural deaths in detention to help prisons to learn lessons, including thematic lessons reports. Recent reports have looked at self-inflicted deaths of prisoners on Assessment, Care in Custody and Teamwork procedures (ACCT) and prison homicides. This is a welcome approach in helping to ensure compliance with Article 2 and should enable prison establishments to identify themes and implement measures to ensure that lessons are learned from every non-natural death to reduce the risk of further deaths.

While we recognise this work to ensure compliance with Article 2 and reduce the risk of further deaths, there is some repetition of the same or similar recommendations following investigations into non-natural deaths of adults with mental health conditions. This suggests that recommendations are often only partially implemented and are not sustained long-term.

An example of this is a PPO investigation report into a death at a prison

establishment in 2012 which reported: 'It is disappointing to note that some of the issues identified, particularly relating to suicide prevention arrangements, have been found in investigations into previous deaths at [the prison].'

HMIP has highlighted prisons which have failed to implement PPO recommendations. An example is a recent inspection of a prison establishment which reported that two self-inflicted deaths in 2013 and two near misses in January 2014 had occurred and that the PPO's recommendations 'had been implemented but some had not been sustained in practice and were not consistently reinforced'.

PPO's learning lessons thematic report⁸⁹ on making recommendations highlighted that 'in self-inflicted death investigations, the biggest single category of recommendations was about ACCT (21 per cent) and those about the emergency response to the incident (16 per cent) the next most frequent. The PPO's Annual Report for 2013/14 reports there are 'continued failures of implementation' in reference to suicide and self-harm prevention procedures and 'a rising toll of despair'.⁹⁰

There are some changes aimed at improving the implementation of PPO's recommendations. HMIP has an agreed protocol⁹¹ with PPO to assess and report back to PPO on a prison's implementation of its recommendations

89 Prisons and Probation Ombudsman, *Learning from PPO Investigations: making recommendations*, July 2013.

90 Prisons and Probation Ombudsman (2014) *Annual Report 2013-14*. Available at: http://www.ppo.gov.uk/wp-content/uploads/2014/09/PPO-Annual-Report-2013-14_FINAL_web.pdf

91 Protocol on Working Arrangements Between HM Chief Inspector of Prisons and the Prisons and Probation Ombudsman (PPO), November 2013.

when carrying out an inspection. The findings are incorporated into HMIP's inspection reports. A recent change is that each prison produces an action plan which outlines how it plans to implement the PPO's recommendations and this is provided to PPO. Despite this, PPO has reported that problems with the sustained implementation of its recommendations in some prisons continue.

Although PPO may be aware that its recommendations have not been fully implemented in a particular prison, it is limited in the actions it can take to address this. PPO does not currently have the remit to return to prisons to monitor progress on recommendations.

Involvement of families in investigations

Evidence from published reports and testimonies from families highlighted variable experiences from families immediately following the death of their relative. Some families reported helpful experiences in dealing with the prison's Family Liaison Officer (FLO), including receiving good support and information, which made a difference:

'My Liaison Officer called me up, she chased up, she even found me a solicitor when I asked for one, and I ended up with a barrister and not a solicitor so I guess it depends on the area you're in.'

(Quote from family member at our family listening day)

Some families reported that they had excellent and very helpful experiences, including being involved in and informed about the investigations process. Families found it helpful that they were able to comment on the draft PPO investigation report and having a known individual to contact within PPO with any questions they had. This is encouraging in helping to comply with obligations under the ECHR and we believe this learning could be shared more widely and implemented by agencies in the other two settings.

Police

Deaths in or following police custody have decreased from 36 in 2004/05 to 11 in 2013/14.⁹² Some lessons do appear to have been learned across police forces as whole, as evidenced by falling numbers of deaths in or following police custody.

In London, there is work currently taking place in the metropolitan police service, drawing on the recommendations of a report in 2013 by the independent commission on mental health and policing (ICMHP), chaired by Lord Adebawale, into mental health and policing.⁹³ The report aimed to ensure that lessons are learned from deaths in custody or involving police contact. The report made 28 recommendations and an interim review has suggested progress is being made, including better coordination between police and health services. The report identified 176 individual recommendations from internal investigations where there was limited evidence of action having been taken to implement them.

⁹² See <https://www.ipcc.gov.uk/page/deaths-during-or-following-police-contact>

⁹³ See http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_13_report.pdf

The College of Policing intends to ensure that recommendations from all relevant Coroners' Preventing Future Deaths reports will be analysed and followed through with updating training and guidance where necessary. This will help to ensure compliance with Article 2 through learning lessons from every non-natural death of an adult with mental health conditions in order to prevent future deaths. Agencies in the other two settings could learn from this change.

The College's Authorised Professional Practice (APP)⁹⁴ on detention in custody states that 'forces must have established policies and procedures to ensure that deaths... are reported, recorded, investigated and analysed, and that the lessons learned are collated, disseminated and implemented'. This guidance is in the process of being revised and is expected to be published in spring 2015. This learning should take place in addition to the IPCC investigation process, whose recommendations now have a statutory status.

Quality of investigations

Some investigations by the IPCC have in the past had to be restarted. This has no doubt caused anxiety and upset for family members. In 2012 IPCC reviewed how it investigated deaths during or following police contact. In its report,⁹⁵ IPCC stated that its investigations 'have not always been seen as sufficiently independent of the police service'. The Anti-social Behaviour, Crime and Policing Act 2014 has led to increased powers for the IPCC

which should address these problems along with increased resources and internal changes which should lead to improvements in its investigations. All IPCC investigations will now be published, which means they will be open to public scrutiny.

The changes include a power to compel police officers to attend investigation interviews whereas previously they did not have to do so. A further change is that the status of recommendations made by IPCC is now statutory and police forces have to respond with an action plan outlining how they will address them and link to the work of other agencies. This is progress in complying with Article 2 obligations which could lead to significant improvements in the IPCC's investigations. However, in their evidence to us, IPCC expressed a frustration that they cannot compel police officers to speak at interviews and their view that this can delay the investigation process.

Sharing information and learning lessons

Police forces can sometimes be poor at implementing recommendations from investigations and applying the learning from them at both an operational and a wider strategic level.

The Independent Commission on Mental Health and Policing (ICMHP) was set up in September 2012 at the behest of the Metropolitan Police Commissioner following five deaths in police custody in the five years up to September 2012

⁹⁴ See <http://www.app.college.police.uk/detention-and-custody-index/>

⁹⁵ Independent Police Complaints Commission, Review of the IPCC's work in investigating deaths, Final Report, March 2014.

and 45 other deaths either prior to or following police contact. The ICMHP identified 176 individual unimplemented recommendations from IPCC and internal Metropolitan Police Service (MPS) investigation reports and Coroners rule 43 recommendations.⁹⁶ It found that internal investigation reports were good but that police forces did not implement the recommendations. There has been significant progress within the MPS to implement the recommendations from this report, according to evidence received by this Inquiry, the evidence for this we anticipate will be detailed when the review of the implementation of the ICMHP is published in 2015.

There remain some problems within the wider police setting in implementing recommendations and learning lessons across police forces to prevent future deaths. Where lessons are being learned, particularly in response to death, this is not systematically shared between forces, according to evidence. There is need for strategic leadership and operational capacity within each force to ensure that recommendations from investigations are implemented and lessons are learned according to reports and submission to the Inquiry. Our recommendation for a senior and sufficiently resourced lead on mental health for each force, should give each force both the capacity and strategic leadership to enable this learning to take place from internal and external sources.

Involvement of families in investigations

Testimonies from families reported negative experiences in relation to investigations. This included delays in being informed of the death of their

relative. Families reported problems in relation to the investigations process, including being interviewed very soon after the death of their relative which they felt was very insensitive.

‘We had to fight to get any information at all, we had to fight every single step of the way.’

(Quote from family member at family day)

To address problems with the implementation of recommendations and learning lessons we recommend:

That the existing senior lead role on mental health in each police force is adequately resourced to ensure this role can provide effective strategic leadership.

This role should be responsible for identifying lessons to be learned from investigations and work being undertaken by other police forces, which could be tailored to individual forces. This would involve noting progress and negative practice elsewhere and applying this internally.

Each police force should have an operationally focused Mental Health Liaison Officer (or equivalent) in each area or division, to ensure learning is implemented, training is appropriate and protocols for work with the health sector and other relevant agencies is effective. The officer in this role would be a source of knowledge and expertise, ensuring effective partnership work with agencies in other settings, and would lead on ensuring that the training of police officers on mental health involves health professionals.

⁹⁶ See http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_13_report.pdf

Recommendations

To support agencies in the three settings to comply with their legal responsibilities we make the following recommendations:

For all settings:

- Responsible agencies in all three settings should ensure that recommendations from investigations are followed up and lessons are learned.
- Investigatory bodies need to continue to improve (or monitor and review) the quality of their investigations and their involvement with the bereaved families.
- The role of the Independent Advisory Panel on Deaths in Custody; we recommend that the review of their role in 2015 should reflect the impact of their work to date and consider how they could ensure their initiatives are integrated into the working practice of detention settings. The Commission will feed into this review.
- There needs to be a clear process which sets out how the implementation of recommendations from investigations into a death (including the inquest) will be followed up. This is the joint responsibility of those who run individual institutions and the regulatory and inspectorate bodies which make those recommendations.
- We recommend increased statutory obligations on

institutions to publically respond to recommendations (for example through action plans) from inspectors and regulators in relation to deaths in detention.

- Families should be fully involved in the investigations process and given appropriate information and support.
- The Chief Coroner to continue to produce summary reports (as outlined in the Coroners Act 2009) from preventing Future Deaths Reports, in particular to ensure there is the opportunity for learning from non-natural deaths in psychiatric hospitals.

Psychiatric hospitals:

- The Secretary of State for Health should establish responsibility for ensuring oversight of investigations in psychiatric hospitals and national collation of data. The government should also reconsider the appointment of an independent body to investigate deaths of detained patients in psychiatric care.
- NHS Wales and Healthcare Inspectorate Wales data should be systematically collected, analysed and made publically available with full breakdowns by protected characteristics as defined in the Equality Act 2010.

Prisons:

- A thorough review should be conducted to understand the increase in non-natural deaths from 2013 in order to implement recommendations in 2015,

either by a thematic review by HMIP or other urgent means.

- Each prison establishment to ensure it has a staff member responsible for identifying and implementing learning from investigations and work to prevent deaths being undertaken in other prisons. They should ensure there is accurate data relating to the numbers of prisoners with a mental health condition to enable appropriate resource planning.

Police:

- Each police force needs a dedicated senior lead and resources on mental health (as in South Wales) to ensure appropriate support (including diversion routes) to people in custody.

Chapter 9: Scotland

Introduction

Matters in relation to adult deaths in detention in Scotland are primarily devolved. Scotland has its own legal and justice system, and legislates on issues to do with police, prisons and the court service. The Scottish Parliament is also responsible for the NHS in Scotland which includes mental health and public health issues such as alcohol and drug use.

Given the different policy and legislative landscape and the national approach to co-ordinate action under the Scottish National Action Plan for Human Rights (SNAP), the Commission decided to carry out an aligned piece of research in Scotland, rather than an inquiry.

Setting the scene

Scotland has seen significant organisational change since 2010 across all three settings. These changes include the establishment of a new single police force, Police Scotland, and the Police Investigations and Review Commissioner (PIRC) who investigate the most serious incidents involving the police. Prison and police custody healthcare is now the responsibility of NHS Scotland. Healthcare Improvement Scotland (HIS), the national healthcare improvement organisation, was established in 2011. Additionally, the Scottish Fatalities Investigations Unit was created in 2011 following the 2008 review into Fatal Accident Inquiries.

The current organisational landscape is shown in Appendix 2.

These changes have presented challenges in terms of informing this work as it takes time for organisations to bed down into their new structures, systems and remits, and for the benefits to be realised. This is particularly true for Police Scotland where eight different police forces were merged into one in 2013.

However, some positive developments can already be seen as a result of these changes, such as new approaches to collaborative working between the Scottish Prison Service and NHS Scotland to increase learning after the death of prisoners. We expect to see further improvements across sectors through time.

Further change is also expected after the Scottish Government reviews the submissions made to the recently closed consultation on Fatal Accident Inquiries (FAI). Specifically these changes may be around an extension of the categories of death in which it is mandatory to hold an FAI and the requirement of organisations to respond to the Inquiry recommendations.

Deaths in detention in Scotland

The Scottish Prison Service makes information on deaths in detention publically available. The information, which is updated regularly, includes name,

age, gender, ethnicity, date of admission, date of death, the establishment, length of sentence and cause of death. Information on mental health condition is not published but it is captured for internal review purposes.

Police Scotland captures information on deaths in custody but this is not collated or published as a matter of course. Police Scotland collated and shared information on deaths which occurred in custodial settings for the purposes of this research. No information on mental health conditions of detainees was available. Prior to the formation of Police Scotland, there was no central national system to collect custody information. With the creation of a new single Custody Division and the forthcoming introduction of a new IT system, there is an important opportunity to review what information can be collected and made available in the future in relation to deaths in police custody.

NHS Scotland does not routinely publish any information on the number of deaths of detained patients. Deaths of patients while subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 should be reported to the Mental Welfare Commission. In 2012-13, 78 deaths

were notified to the MWC and follow up information was received for 73 of those.

Non-natural deaths in prison

Non-natural deaths in Scottish prisons have fallen slightly since 2010. Most non-natural deaths from 2010 to 2013 were suicides (or considered apparent suicides). Of these, only one was a female prisoner. In nearly half of these suicides the person was on remand. The risk of suicide is higher in the initial period in prison – a quarter of suicides in 2010-13 occurred in the first three days in prison, over half in the first month. Prisons are also reporting increasing numbers of suicides in older prisoners.

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Table 9.1 Non-natural deaths in prison, Scotland, 2010-13

	Total	Natural	Non-natural*	Not yet Determined**	Undetermined cause of death
2010	16	4	10	2	0
2011	23	11	6	4	2
2012	21	7	8	6	0
2013	24	6	7	9	2

*Unofficial figures as includes deaths where the FAI is not yet complete but considered likely to be non-natural by the Scottish Prison Service.

**FAI is not yet complete. *Source:* Scottish Prison Service

Non-natural deaths in police custody

Non-natural deaths in police custodial settings⁹⁷ fell between 2010 and 2012. All detainees who died were male. Of the six non-natural deaths in 2010 and 2011, drugs were a factor in five deaths.

Table 9.2 Non-natural deaths in police custody, Scotland, 2010-13

	Total	Natural	Non-natural*	Not yet Determined	Undetermined
2010	4	0	4	-	0
2011	3	1	2	-	0
2012	0	0	0	0	0
2013	6	-	-	6	-

*As reported in Fatal Accident Inquiry determinations.

Source: Police Scotland

Non-natural deaths of detained patients in hospital

The number of non-natural deaths of detained patients remained constant between 2010 and 2012. All were recorded as suicides.

Table 9.3 Non-natural deaths in detained patients in hospital, Scotland, 2010-13

	Total
2010	6
2011	7
2012	6
2013	Not available

Source: National Confidential Inquiry

In 2012-13, 78 deaths were reported to the Mental Welfare Commission in Scotland where people had died while subject to compulsory treatment. Information on 73 of these deaths was provided. Over half (53) were from natural causes, 6 had no explanation or relation to mental health, 11 were suicides and 3 recorded as delirium. Of the 11 suicides, 5 individuals were in hospital at the time, 3 were subject to compulsory community treatment and the remaining 3 were in the community under suspension of detention.

⁹⁷ This is a narrower definition of custody and does not include deaths which occur once a detainee has been apprehended and is no longer at liberty or when they are being transported to or from a custody setting.

Findings

Police custody and prisons dealing with vulnerable detainees

People with mental health conditions in detention should receive appropriate and timely treatment. For this to happen, sufficiently trained staff must be in place with the right skills, facilities must be fit for purpose, and suitable protocols and procedures must be in place.

Many detainees in police custody and prisons have complex issues. Recent work by HMICS⁹⁸ found 68 per cent of detainees (in 310 police custody records sampled) declared either medical, mental health and/or substance misuse issues. Three quarters of all prisoners are thought to have a drug misuse problem⁹⁹ and there is agreement that there is significant overlap between those who have mental health conditions and those with substance misuse problems. This makes it difficult to effectively assess the level of risk and appropriate treatment for an individual, directly impacting on the obligation to protect. However, those individuals with severe mental health disorders in prisons were generally found to be transferred quickly and effectively.¹⁰⁰

Evidence repeatedly highlighted insufficient mental health training of staff in both the police and in prison

services as an area of concern, with slow and patchy progress to address this. Recent commitments to train all police officers in mental health, with priority for officers working in custody, and the development of a training strategy for prisons as part of a strategy relating to mental health and wellbeing may help to address this concern.

Our evidence highlights that levels of specialist staffing with expertise in mental health in prisons was at a level which meant it was difficult to provide continuity when staff left or were off work unexpectedly. In one such instance, prisoners did not have access to a mental health nurse.¹⁰¹

Referral and diversion schemes identify vulnerable offenders when they first come into contact with the criminal justice system so that risk can be identified and appropriate treatment and support measures put in place both through early intervention where possible and throughout the process of detention. These schemes are relatively common for substance misuse. However they are much less common for mental health. HMICS highlight the need to assess the current situation and address gaps in provision to ensure there is a coherent model of provision.¹⁰²

⁹⁸ HMICS Thematic Inspection of Police Custody Arrangements in Scotland, August 2014.

⁹⁹ National Prisoner Health Network, Mental Health Report, February 2014.

¹⁰⁰ NHS Scotland Forensic Network Prison Group.

¹⁰¹ HM Chief Inspector of Prisons for Scotland, *Annual Report 2011-12*.

¹⁰² HMICS Thematic Inspection of Police Custody Arrangements in Scotland, August 2014.

Police Scotland and NHS Scotland need to clarify processes and responsibilities to ensure people with mental health conditions who are detained are assessed and placed appropriately

The ability to access appropriate medical and mental healthcare support is dependent on organisations having clarity around what to do when they come into contact with a person in distress.

Evidence suggests that difficulties exist when police officers are dealing with people who may have mental health issues but who are also intoxicated, or where someone is at risk of harming themselves but is not accepted into the care of a mental health facility. An added frustration reported by HMICS was where police officers are required to stay with a detainee that they have taken to hospital. Delays in the detainee receiving treatment make this an inefficient use of police resources.

An evaluation of a pilot partnership agreement between NHS Tayside and Tayside Police (2009-11) found clear benefits for both organisations involved, and for those in custody. The mental health work stream within the National Co-ordinating Network¹⁰³ (for healthcare and forensic medical services for people in police care) will be considering the learning from this pilot in due course.

Case study – NHS Tayside and Tayside Police Partnership Agreement

A pilot partnership agreement between NHS Tayside and Tayside Police was instigated from 2009-2011, and evaluated in 2012. Through this agreement a dedicated team of NHS nurses were employed to operate solely within secure police custody areas on a round-the-clock basis.

The evaluation found that there were clear benefits from this approach across policing practice, healthcare practice and healthcare outcomes. The most significant benefits were for end users, and concluded that the pilot actively contributed to the prevention of a death in custody where nurses were able to administer a drug to revive a detainee suffering from an opiate overdose.

Other benefits included a decrease in transfers from custody to external NHS, a protocol making it possible to access NHS records, improved working relationships with other NHS services through nurse-led 'commissioning', increased police staff confidence in relation to risk management, better healthcare while in custody and the improved probability of continuing care beyond custody.

103 This network was established to oversee the transfer of healthcare to the NHS in 2014. The emphasis is now on sustainability and quality improvement.

Lessons learned need to be shared and actioned

In undertaking this Inquiry the Equality and Human Rights Commission developed a Human Rights Framework based on Article 2 of the Human Rights Act. This framework suggests that an effective investigation is one which is carried out promptly, is independent, open to public scrutiny and involves the next of kin. It should ensure the lessons learned from that investigation are put into practice and hold people at fault to account.

The Crown Office and Procurator Fiscal Service (COPFS) must be informed of any sudden or unexplained death across all three settings. Fatal Accident Inquiries (FAI) are a type of court hearing which publically inquires into the circumstances of a death and identifies any issues of public concern or safety, to prevent future deaths or injuries. There must be an FAI if a person dies in legal custody i.e. people in prison, people held in police cells and people subject to detention, such as people being transferred to prison. The death of a detained patient in the NHS does not automatically trigger an FAI, and in practice, it is rare for an FAI to be held in these circumstances.¹⁰⁴ There has been criticism in relation to delays in FAIs.¹⁰⁵ These delays increase distress for families and also mean that learning from these deaths can be out-of-date as systems and protocols have already been changed locally based on internal reviews.

Patients who die while subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 are reported to the Mental Welfare Commission (MWC) by the health board. If the MWC have concerns that a person may not have had the appropriate care or treatment, they may investigate further.

Internal reviews into deaths and near misses are conducted across all settings. The reports relating to these are rarely published, making it difficult to ensure public scrutiny.

A lack of a standardised approach to conducting and recording critical incident reviews across health boards in Scotland was a concern as a potential barrier to sharing learning. However it is clear that there has been, and continues to be, significant efforts to improve the review and learning culture. Healthcare Improvement Scotland is leading this work and a National Framework was published in 2013.

Other examples we found of work within the health sector to promote and share learning relevant to detained patients were the NHS Scotland Suicide Review Community of Practice and the Scottish Patients Safety Programme for Mental Health.

Similarly in the prison sector, the National Prisoner Healthcare Network (a partnership of NHS Scotland and

¹⁰⁴ Patrick, Stavert and Malcolm (2012) *The right to life, and to proper inquiries on death: A human rights perspective on the investigation of deaths of psychiatric patients in Scotland*, 1 Juridical Review 5.

¹⁰⁵ Scottish Government Consultation on proposals to reform FAI legislation Responses, November 2014.

Scottish Prison Service (SPS) and other stakeholders) formed after the transfer of prisoner healthcare to NHS Scotland. Its purpose is to provide excellence in healthcare and health improvement. The Network has an Advisory Board and a number of standing groups and short life work streams. A Mental Health Subgroup reported with a number of recommendations, and an implementation plan is now being established (2014/15).

We also heard of work underway to improve learning from deaths in prison. Death in Prison Learning, Audit and Review (DIPLAR) is a new joint review process between SPS and NHS Scotland which is under development. This will replace the current SPS Self-Inflicted Death in Custody Audit, Analysis and Review (SIDCAAR) process. DIPLAR is not limited to suicides but reviews all deaths in custody. The aim is to learn from the incident in an objective way with the focus on lessons and action.

We did not find evidence of similar 'external' groups or communities sharing learning in relation to police custody. However HMICS¹⁰⁶ concluded Custody Division within Police Scotland had both 'visible and effective leadership' and a 'genuine focus on improvement and organisational learning'. Learning from internal reviews, FAIs and HMICS all feed into the Custody Division Improvement Plan.

Case study – Learning from events

In recognition of the need to learn from incidents in 2013, Healthcare Improvement Scotland undertook a programme of extensive engagement and consultations with NHS boards, clinicians, patients and a number of national groups and organisations to inform the development of a national approach to learning. The learning should maximise the opportunities for NHS boards to learn from each other and put improvements into practice.

By having a national approach, NHS Scotland hopes to ensure that such events are not repeated by ensuring that:

- the affected person will receive the same high quality response
- any staff involved are treated in a consistent manner
- the event is reviewed in a similar way
- learning is shared and implemented across the organisation.

This is a particular issue in the health sector as deaths of detained patients in mental health wards are rarely subject to an FAI unless there has been a breach of Health and Safety legislation.

106 HMICS Thematic Inspection of Police Custody Arrangements in Scotland, August 2014.

Case study – Scottish Patient Safety Programme for Mental Health

The Scottish Patient Safety Programme for Mental Health (SPSPMH) is a four year programme centred around five work streams: risk assessment and safety planning; restraint and seclusion; safer medicines management; communication at transitions; and leadership and culture. This has been done by gathering data and running pilot studies with frontline staff to test interventions. The most effective of these will be spread across all NHS board areas.

Recommendations

- All settings should consider how they could use the Human Rights Framework to improve current processes and practices.
- Responsible agencies across all settings must ensure that their staff have the skills and resources to ensure detainees with mental health issues are treated appropriately.
- The investigative structures for the deaths of detained patients in NHS Scotland mental health wards should be strengthened in line with our Human Rights Framework and clarified. Forthcoming Scottish Government policy changes in relation to Fatal Accident Inquiries may address this and we shall monitor progress in this area.
- To ensure adequate scrutiny of deaths in detention, responsible agencies should systematically collect, analyse and make available data by protected characteristic.
- Lessons learned in relation to deaths in detention are not being shared across settings. Responsible agencies should consider how this could be achieved and put this into practice.

Appendix 1: Glossary

Definitions apply to England, Scotland and Wales, unless otherwise stated.

Absconding: Any absence without leave of a person detained or liable to be detained under the Mental Health Act 1983, for example: on Section 17 leave from hospital, or held under short-term powers of Section 5, 135 or 136 in England and Wales.

Absent without leave: When a patient is absent from the hospital in England or Wales without being given Section 17 leave, or fails to return to the hospital at the due date and time when the leave expires, or is absent without permission from an address where they have been required to live by the conditions of their leave of absence.

Adult: For the purpose of the inquiry is a person aged 18 and over.

Agency: Any organisation delivering services on behalf of the state. For example: Hospital Trusts, Prisons, NHS England, National Offender Management Service, Her Majesty's Inspectorate of Constabulary and the Independent Police Complaints Commission.

Anti-psychotic drugs: A range of medications that are used for some types of mental distress or disorder and also severe anxiety or depression.

Articles 2 and 14 of the European Convention on Human Rights (ECHR): The Convention was made part of our domestic law by the Human Rights Act 1998. Article 2 obliges the state to protect by law everyone's right to life. This obligation includes a positive duty on the state to ensure preventative measures are taken to protect life in certain circumstances and to carry out a proper investigation into deaths for which the state might be responsible. Article 14 provides that there should be no discrimination in the enjoyment of Convention rights.

Assessment, Care in Custody and Teamwork (ACCT) plans: Specify how an at-risk prisoner in England and Wales will be kept safe and what support they will be provided with.

Basic Command Unit: A local policing area in England and Wales – may also be called Local Police Unit, Division or Area.

Black Mental Health UK: A human rights campaigns group established to address the over-representation of African Caribbeans within secure psychiatric care and raise awareness to address the stigma associated with mental health.

Care Quality Commission (CQC): The independent regulator of all health and adult social care in England.

Chatham House Rule: When participants at a meeting are free to use the information received, but may not disclose the identity of participants.

Chief Coroner/Office of the Chief Coroner: Head of the coroner system, assuming overall responsibility and providing national leadership for coroners in England and Wales.

Clinical Commissioning Groups (CCGs): Commission most of the hospital and community NHS services in the local areas for which they are responsible. Services CCGs commission include acute mental health.

Commissioning: Authorising external providers to deliver services on behalf of a public body.

Coroner: An independent judicial office holder, appointed by a local authority in England and Wales who investigate deaths that have been reported to them, including: deaths in prison, police custody or while detained under the Mental Health Act 1983.

Detained patient: A person who has been ‘sectioned’ or ‘detained’ in hospital under the Mental Health Act 1983 or Mental Health (Care and Treatment) (Scotland) Act 2003 (MH(C&T)(S)A 2003). They are formal patients who are not free to leave and will lose some other important rights available to informal patients.

Family liaison officer: Police and Prisons and Probation Ombudsman (PPO) staff who provide information to and support the bereaved family in England and Wales.

Fatal Accident Inquiry (FAI): A court hearing which publically inquires into the circumstances of a death in Scotland and is presided over by a Sheriff. It cannot make any findings of fault or blame against individuals. An inquiry will normally be held if the death happened while in legal custody, for example in prison or police custody.

Healthcare Improvement Scotland (HIS): The national healthcare improvement organisation for Scotland and part of NHS Scotland.

Healthcare Inspectorate Wales (HIW): The independent inspectorate and regulator of all healthcare in Wales.

Her Majesty’s Inspectorate of Constabulary (HMIC): Independently inspects and monitors police forces in England and Wales.

Her Majesty’s Inspectorate of Prisons for England and Wales (HMIP): The independent inspectorate reporting on conditions for, and treatment of, those in prison, young offender institutions and police suites in England and Wales.

HM Chief Inspector of Constabulary in Scotland: Provides independent scrutiny of Police Scotland and inspects police custody centres to monitor the treatment and conditions for detainees.

HM Chief Inspector of Prisons for Scotland (HMIPS): Inspects prison establishments throughout Scotland in order to examine the treatment of, and the conditions for, prisoners.

Human Rights Act 1998: The statute which makes the European Convention on Human Rights (ECHR) part of our law. It requires public authorities to act compatibly with the ECHR and allows individuals whose human rights have been infringed by a public authority to bring a case in our own courts.

Human Rights Framework: A framework constructed by the Commission setting out the steps that need to be taken by prisons, hospitals and the police to meet their obligations under Article 2 of the ECHR to protect everyone's right to life.

Independent Advisory Panel (IAP): Provide independent advice and expertise to the Ministerial Board – consulting and engaging with stakeholders to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them.

Independent Police Complaints Commission (IPCC): The independent body that oversees the police complaints system in England and Wales.

Informal/voluntary patient: A person who is receiving treatment in hospital on an informal and consensual basis and who has usually agreed to admission into hospital.

Inquest or inquest hearing: A fact-finding inquiry in court conducted by a coroner in England and Wales to establish who has died, and how, when and where the death occurred. It forms part of the coroner's investigation. An inquest does not establish any matter of criminal or civil liability. It does not seek to blame anyone or apportion blame between people or organisations.

INQUEST: A charity providing free advice to people in England and Wales bereaved by a death in custody.

Legal custody: In Scotland a person is in legal custody if he is detained in or subject to detention in various settings including prison establishments and police custody (section 1 (4) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976).

Liaison and Diversion schemes: Mental health professionals in police stations and courts in England ensuring people who come into the criminal justice system with mental health conditions, learning disabilities and other vulnerabilities are recognised and promptly referred into health and other services to get the treatment or support they need.

Mental Health (Care and Treatment) (Scotland) Act 2003 (MH(C&T) (S)A):

For the purposes of this Inquiry, the law which sets out when a person can be admitted, detained and treated in hospital without their consent. It also covers their rights, how they can leave hospital and aftercare. The Act applies in Scotland.

Mental Health Act 1983 (MHA): The law which sets out when a person can be admitted, detained and treated in hospital without their consent. It also covers their rights, how they can leave hospital and aftercare. The Act applies in England and Wales.

Mental health condition: A mental disorder that may justify a person being sectioned. In England and Wales a mental disorder is ‘any disorder or disability of mind’ (section 1 MHA) and includes any mental health condition normally diagnosed in psychiatry, and learning disabilities. For the purposes of section 1, learning disability is only considered a mental disorder if it is ‘associated with abnormally aggressive or seriously irresponsible conduct’. In Scotland mental disorder is ‘any mental illness; personality disorder; or learning disability, however caused or manifested’ (Section 328 MH(C&T)(S)A).

Mental health crisis: When a person’s mental or emotional state gets worse quickly.

Mental Welfare Commission in Scotland (MWC): An independent body whose role includes investigating where they believe something may have gone wrong with the care and treatment of a person facing mental health challenges or incapacity.

Ministerial Board on Deaths in Custody: Brings together decision-makers in England and Wales responsible for policy and issues related to deaths in custody in the Ministry of Justice, Home Office and Department of Health.

National Offender Management Service (NOMS): An executive agency of the Ministry of Justice responsible for the National Probation Service and HM Prison Service, managing public sector prisons and young offender institutions within England and Wales.

National Preventive Mechanism (NPM): Designated by Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment across the UK.

Non-natural death: One of the following categories: self-inflicted/suicide, deaths caused by another person including homicide, other non-natural deaths including overdose and accidental deaths and deaths the cause of which is unknown.

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT): An international human rights treaty designed to strengthen the protection of people deprived of their liberty.

Personal Escort Record (PER): Contains information about a prisoner's vulnerabilities and mental health condition when transferred between prisons and within the criminal justice system in England and Wales.

Place of safety: Can be anywhere, but it is most commonly a designated room or suite of rooms in a mental health inpatient service, the emergency department of an acute hospital (a Health Based Place of Safety), or a police station in England and Wales. A police station should only be used in exceptional circumstances. In Scotland a police station is not a place of safety and should only be used as a last resort when no place of safety is available.

Police custody: In England and Wales for the purpose of this Inquiry, a person who is in the process of being arrested or taken into detention; has been arrested or been detained by police under the MHA.

Police Investigations and Review Commissioner: Undertakes independent investigations into the most serious incidents involving the police and provides independent scrutiny of the way police bodies operating in Scotland respond to complaints from the public.

Prison establishment: Any establishment which the Secretary of State in England and Wales or the Scottish Government may provide for the detention of adults sentenced to detention for an offence or remanded to custody. For the purpose of this Inquiry it includes prisons and young offender institutes.

Prisons and Probation Ombudsman (PPO): Carries out independent investigations into deaths and complaints of prisoners and young people in detention in England and Wales.

Protected characteristics: Are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Marriage and civil partnership is a protected characteristic, but only in relation to employment and does not apply to detention (Equality Act 2010).

Protocols: In England and Wales agreements between police forces and other agencies e.g. health regarding dealing with mental health/physical health/intoxication.

Public authority: 'any person certain of whose functions are functions of a public nature' (Section 6 HRA). This covers privately run prisons and hospitals as the company running them is exercising a public function.

Responsible clinician: In England and Wales the mental health professional with overall responsibility for a person's care and treatment in hospital. This may be a doctor but can also be some other health professional.

Scottish Fatalities Investigations Unit: A specialist unit responsible for investigating all sudden, suspicious, accidental and unexplained deaths.

Section 17 leave: In England and Wales the responsible clinician may allow a detained patient to leave hospital for a limited time – usually up to a week – either accompanied or unaccompanied.

Sections 135 and 136 of the Mental Health Act 1983: The police in England and Wales have the power to take an individual to a place of safety where he or she is in a private place (sec.135) or in a public place (sec.136) and the police think the person has a mental condition and is in need of care.

State detention: In England and Wales ‘A person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998’ (section 48(2) Coroners and Justice Act 2009). For the purpose of the Inquiry this includes: prison establishments, police custody and detention in hospital under the MHA.

Street triage: In England and Wales schemes where mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health conditions.

The Mental Health Crisis Care Concordat: An agreement between services and agencies involved in the care and support of people in crisis in England. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

UN Convention on the Rights of Persons with Disabilities (UNCRPD): An international treaty that identifies the rights of persons with disabilities as well as the obligations on states to promote, protect and ensure these rights.

Appendix 2: Organisational landscape across settings in Scotland

	Police	Prisons	Hospitals
Delivery	Police Scotland	Scottish Prison Service	National Health Service
Accountable to	Scottish Government		
	Scottish Police Authority		
Inspection	HM Inspectorate of Constabulary in Scotland	HM Inspectorate of Prisons for Scotland	Healthcare Improvement Scotland
		Mental Welfare Commission for Scotland	
	Independent Custody Visitors	Visiting Committees (from August 2015 – Independent Prison Monitoring)	
Review	Police Scotland	Scottish Prison Service	NHS Scotland
			Healthcare Improvement Scotland
Investigation	Crown Office	Police Scotland	Police Scotland
	Police Investigation and Review Commissioner	Crown Office	Crown Office
		Mental Welfare Commission for Scotland	
	Scottish Fatalities Investigation Unit		
	Health and Safety Executive		

Appendix 3: Terms of Reference

Equality and Human Rights Commission Inquiry into non-natural deaths in detention of adults with mental health conditions

The Equality and Human Rights Commission will examine the available evidence about non-natural deaths in detention of adults with mental health conditions in prisons, police custody and hospitals between 2010 and 2013. The Commission will focus on existing evidence and may contact relevant organisations to increase its understanding.

The Commission will analyse the evidence to establish the extent to which there has been compliance with Article 2, and Article 2 together with Article 14, of the European Convention on Human Rights.

The Commission will develop understanding about how organisations have implemented recommendations from previous inquiries and reports into non-natural deaths in detention.

The Commission will engage with individuals from the key organisations in the three settings to determine their perspectives on the protection of detained adults with mental health conditions.

The Commission's aim is to understand how compliance with the Human Rights Act can reduce or eliminate the risk of further non-natural deaths and make appropriate recommendations.

The Inquiry will focus its evidence gathering in England and Wales. A separate evidence gathering exercise in Scotland, aligned to the Scottish National Action Plan for Human Rights, will allow us to gather comparable data across Great Britain.

Contacts

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