Number of child in-patient mental health deaths not known

11th April 2016

Through its specialist casework with families, INQUEST has identified the absence of any coherent system in place for the recording, monitoring and publication of deaths of children receiving in-patient mental health care across England and Wales. INQUEST's research has exposed the fundamental lack of transparency and central oversight concerning the deaths of this highly vulnerable group.

INQUEST has submitted a series of Parliamentary Questions and conducted a wide scale Freedom of Information (FOI) exercise to all relevant Government departments, public bodies, NHS Trusts and private providers involved in the provision and management of Child and Adolescent Mental Health Services in England and Wales. 245 FOI requests were sent seeking information for the period 2010 to 2014. This exercise has failed to produce any clear picture of the number

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or circumstances concerning the deaths of children receiving mental health in-patient care.

Tonight BBC *Panorama* will tell the story of Sara Green, a child who died in a mental health setting. The programme will reveal the alarming evidence collated by INQUEST about the lack of accurate data on the number of child in-patient deaths in mental health settings.

Key findings from INQUEST's research include that:

- No single body is responsible for recording the deaths of children who died as mental health in-patients. This crucial information is neither collated nor analysed or made public by any one body or government department;
- At least nine children have died whilst receiving inpatient psychiatric care between 2010 and 2014. However, the true number of deaths from this period is likely to be higher as many bodies either refused to provide data or responded that they did not hold the information requested;
- Despite running 47% of in-patient child and adolescent mental health services, private providers refused to answer the FOI requests, responding that as private providers the Freedom of Information Act does not apply to them;
- There is no system in place requiring an independent investigation of child deaths, with almost all deaths investigated by the same institution where the death occurred. This prevents the additional transparency and external scrutiny which would come from an independent investigation.

Panorama follows the case of 17-year-old Sara Green who died in 2014 at the privately run Priory Group Cheadle Royal Hospital, Cheshire. INQUEST has worked with Sara's family since her tragic death. At Sara's inquest, the Coroner concluded that a lack of appropriate NHS placement and a failure to manage her discharge from the Cheadle Royal was a contributory factor to the act of self-harm that ended her life. Sara's family have courageously contributed to tonight's *Panorama* in order to highlight the poor care Sara received by Child and Adolescent Mental Health Services and the Priory. It points to serious concerns about the current state of mental health provision for children and young people.

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Deborah Coles, INQUEST Director said:

"Sara Green was a vulnerable child failed by a mental health system that was supposed to protect her. Every day we are hearing about mental health services for children and young people in crisis. The tragedy is that Sara's story is not an isolated one as we know from our casework. That the Government does not know how many children are dying in mental health settings is truly shocking. This is yet another disturbing feature of a system failing our children in mental health need.

How can we ensure learning and improvement so urgently needed across children's mental health services without the knowledge and robust examination of the circumstances of these young deaths? The Government must act now to ensure effective systems of scrutiny and accountability for the public and private bodies responsible for the treatment of vulnerable children in their care."

Jane Evans, mother of Sara Green said:

"The system both Sara and I trusted to provide the help she needed cruelly let her down, with devastating consequences. Sara's case highlights the shocking reality of a child and adolescent mental health system that is not only wholly unacceptable, but quite frankly dangerous.

INQUEST assisted us in getting a thorough inquiry into what happened to Sara and it is my hope that public exposure of Sara's story will initiate a much needed national debate and ultimately force the Government to implement necessary changes to prevent any more child deaths in mental health settings."

INQUEST has released this vital information to *Panorama* and for the first time there is an opportunity to prompt a national debate around an issue that has, up to now, escaped public scrutiny. *Panorama* will also include an exclusive interview with the Minister responsible for mental health, Alistair Burt. In response to the evidence we provided to the Minister he has now offered to work with INQUEST and we look forward to a

constructive relationship with the Department of Health that will facilitate the urgent work that needs to be done.

Ends

Notes to editors:

INQUEST is also working with the families of 14-year-old Amy El-Keria who died on 13 November 2012 while receiving in-patient mental health care at Priory Ticehurst House, Hastings and 15-year-old Christopher Brennan who died on 31 August 2014 while an in-patient at Bethlem Hospital, London. Inquests have not yet taken place on either case.

In its work on deaths in mental health settings, INQUEST has repeatedly called upon the Government to establish a system of notification which mirrors the practices in other detention settings.

INQUEST calls on the Department of Health and the CQC to assume responsibility for monitoring the deaths of all children receiving in-patient mental health care, with an automatic trigger for an independent investigation following a child's death.

Inquest of Sara Green, concluding press release.

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