

Independent investigations: the current system is not enough

Mental Health (Use of Force) Bill, INQUEST Briefing, June 2018

Through extensive casework with families affected, INQUEST has seen that the current system of investigations following non-natural deaths in mental health settings is not sufficient. We believe that a system of truly independent, pre-inquest investigation (equivalent to other detention settings), with a mechanism for national oversight and learning, is absolutely necessary to reduce deaths and serious incidents such as those involving use of force.

It is iniquitous that institutions responsible for the treatment and care of mental health patients should not be subject to the same scrutiny as other institutions of detention such as police, prison and immigration detention. This risks ongoing injustices for bereaved families.

Currently Level 3 investigations, part of the 2015 Serious Incident Framework, are the only mechanism of independent investigation and scrutiny, prior to a coroner's inquest. The issues with this mechanism are as follows:

- Level 3 investigations are inconsistently used and rarely take place. INQUEST has seen many cases where given the seriousness of the death we would have expected an independent investigation to take place within the framework, but there has been a failure to do so.
- It is firmly INQUEST's view that a restraint related death is cause for significant concern, therefore the presumption should be a level 3 enhanced investigation into the death and broader circumstances.
- While the Serious Incident Framework may provide for an independent team to conduct an investigation, commissioning and management of the 'independent' process is not institutionally and practically independent as it continues to sit within the NHS management structure. There is also no oversight outside of the NHS on whether investigations take place, and no oversight or external assessment as to the quality of these investigations.
- The investigations which do take place are of varying quality, and are often deficient in terms of scope, timeliness, quality, independence and family involvement. There are also concerns about the lack of publication of investigation reports and the methods of identifying learning beyond that of the individual Trust/private provider. The internal nature of the investigations means that there is no visibility or oversight around the implementation of recommendations, and identification of common themes or issues which may be of relevance nationally.
- Trusts, Clinical Commissioning Groups and NHS England can all argue that an independent investigation is not needed as the coroners' process will satisfy the need for independence. However, there are many issues with relying on inquests, such as:
 - The nature and extent of the investigations carried out before the inquest are critically important as they can impact on the subsequent inquest regarding its remit, the issues requiring scrutiny, as well as the witnesses to be called.
 - Coroner's inquests can take up to a year or more to take place. If you rely on the inquest for learning and change, which is the primary aim of NHS investigations, there will be a significant delay which may risk future deaths occurring.
 - Coroners do not have the resources or scope to undertake their own investigations and are reliant on the investigation undertaken by the Trust or private provider.

CASE STUDIES

Janet Muller

21 years old, Sussex Partnership NHS Foundation Trust, homicide after absconding whilst under section, 13 March 2015

Janet was found dead in the boot of a burnt-out car on 13 March 2015. She was a sectioned inpatient at the Mill View Hospital, when she climbed over a wall and absconded. This was the second time she had absconded that day. A man not previously known to her was convicted of her manslaughter in February 2016.

When it came to the trust carrying out an investigation into her death, despite the seriousness of what happened, they categorised this investigation as level 2. The investigation was not independent. Their findings did not go far enough, as highlighted by the highly critical inquest conclusion.

The level 2 investigation found poor record keeping and mechanisms around entry and exit to the ward, management issues and educational issues around dual diagnosis. The family and lawyers reported that the trust was obstructive throughout the inquest process, including initially objecting to the opening of the full inquest. The trust failed to provide full disclosure, delaying the inquest proceedings and causing significant upset.

When the inquest was finally heard, the jury found failures by the trust had contributed to Janet's death. This was in stark contrast to the trust's own investigation, which only identified two contributory factors. The inquest additionally found that there was: a the lack of communication regarding Janet's risk of absconding, incomplete, insufficient and at times contradictory risk assessments and care plans, and a lack of urgency in replacing the garden fence over which she and others were able to abscond multiple times.

Following the critical findings at the inquest, the Chief Executive of the trust apologised to the family and admitted failings; an apology the family said arrived three and half years too late. Janet's death was one of a number of concerning deaths of patients on wards run by the same trust. More info: www.inquest.org.uk/janet-muller-inquest-conclusions

Laura*

22 years old, Elysium Healthcare/Gloucestershire Hospitals NHS Trust, self-inflicted death whilst sectioned, 20 February 2017

Laura had a long history of serious mental health problems. She was a prolific self-harmer, and had made multiple suicide attempts from age 14 onwards. As such she had numerous spells as an inpatient in mental health institutions, mostly due to her serious self-harming which had caused multiple admissions to A&E.

In June 2016, Laura was admitted to Wotton Lawn Hospital under the care of 2gether trust. She was subsequently detained there under the Mental Health Act. She and her family had concerns about the care she received there, and made various complaints including those on the use of restraint.

Laura was transferred to Arbury Court in November 2016, which was part of Partnerships in Care and subsequently Elysium Healthcare. Her placement was funded by the NHS. Throughout her time there she continued to regularly commit serious self-harm, using various items. On the day she died there were two prior significant incidents of self-harm but no action was taken to increase

observations. In contravention of the hospital's policy, Laura was given a plastic bag and was later found with that bag over her head and a cord around her neck on and could not be saved.

Despite the circumstances of her death, Elysium Healthcare carried out an internal investigation which was not independent. The family felt that their concerns were not properly considered and they did not agree with all the conclusions in the report, which were weak and not always supported by the evidence. 2gether NHS Foundation Trust also investigated Laura's care. An internal investigation was undertaken, which was unsatisfactory and as a result, the trust informed the family that they would commission an independent investigation.

Niche Consult were commissioned to carry out the independent investigation. However, after the Trust were notified that one of the leading members of Niche Consult was previously a director of nursing at Partnership in Care, there was significant backtracking by 2gether Trust who then stated that a further internal investigation would be undertaken.

So far, the evidence provided to the family and legal team shows extremely serious failures in relation to Laura's care, especially on the day she died, and supports the family's concerns that her death could have been avoided. The inquest is not yet listed.

**Surname removed as the case is pre-inquest*

Sabrina Walsh

32, Sussex Partnership NHS Foundation Trust, self-inflicted death whilst sectioned, 31 October 2016

Sabrina had a long history of mental ill health and self-harming behaviour. After suffering a serious deterioration in her condition, she was taken to A&E by her mother on 30 October. She absconded, deliberately ran into oncoming traffic and was detained by the police for her own safety.

Sabrina was taken to the Eastbourne Section 136 ('place of safety') suite where, on the morning of 31 October, she tied a ligature around her neck whilst in the bathroom, but was interrupted by nursing staff. She was constantly observed, assessed as being at 'high risk of suicide' and detained under section 2 of the Mental Health Act.

That afternoon Sabrina was transported in a secure ambulance to the Woodlands ward in Hastings, run by Sussex Partnership NHS Foundation Trust. She was found dead just under 4 hours of being taken there. Despite her high risk of suicide, Sabrina was only formally checked every hour, and when Woodlands carried out a check at 8pm, she was not in her room. When staff returned to attempt to find her five minutes later, Sabrina was found with a ligature around her neck tied to the bathroom door.

The jury concluded that her death was contributed to by neglect, continuing: *"Overall if correct procedures were followed they would have had a positive effect on Sabrina and the level of care received. By not following procedures this has had a clear and direct effect on her passing. This is a gross failing of medical care from staff at Woodlands"*.

The trust apologised to the family about their failures. The investigation by the trust was a level 2 one and was chaired by an independent external investigator. The findings did not go nearly as far as the inquest. More information: www.inquest.org.uk/sabrina-walsh-inquest-conclusions

Abbi Sian Mcalister

23, Birmingham and Solihull Mental Health Trust, died whilst sectioned on 16 April 2015

Abbi had struggled with borderline personality disorder and depression from the age of 16, and had been admitted as a sectioned inpatient on several occasions. Two months prior to her death she had gone to the top of a car park with the intention of jumping but was prevented from doing so by the police. During the next seven weeks, whilst still an in-patient, Abbi continued to self-harm, express suicidal thoughts, and speak about her wish to go back to the top of the car park and jump.

On 16 April 2015 Abbi attended an external therapy appointment accompanied by a healthcare assistant. When her appointment ended she asked to go to the city centre and, although though she was asked to go back to the hospital, she phoned a taxi, went to the Birmingham City centre and jumped to her death.

The trust carried a level 2 investigation, despite the seriousness of what happened, and attempted to finalize their report without meeting with the family. A consultant clinical psychologist led this investigation and interviewed the staff involved in Abbi's care. The trust agreed to meet the family but objected to them being represented at this meeting. Even though the trust made some admissions about their failure of duty of care towards Abbi, their findings did not go far enough. The inquest which took place in January 2016 found that Abbi's death was contributed by the failures that were so serious they amounted to neglect.

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