INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

Westminster Hall debate "Deaths within mental health care"

INQUEST briefing to MPs, 30 November 2020

"I am a mother who is unable to mourn the death of my only child, because I do not have the truth as to how he truly died. There is no giving up on this pathway to truth, justice, accountability and change for others and I see the only way forward is through a Statutory Public Inquiry".
Melanie Leahy, mother to Matthew Leahy who died whilst in the care of Essex Mental Health Services 2012

"Essex mental health services ignored dangerous practices that led to preventable deaths. If it were not for the dedication and persistence of bereaved families to get to the truth, these failings would never have come to light. It is time that those families are listened to." **Deborah Coles, Executive Director, INQUEST**

1. Background and context

INQUEST is the only charity working on deaths in state detention. For nearly 40 years we have developed a unique overview of investigation and inquest processes, informed by our work with bereaved families. In the last year alone we supported 388 bereaved families in relation to deaths in mental health settings or contact with mental health services. Our casework has identified a wide ranging set of concerns of relevance to this debate.

INQUEST is deeply concerned about the failing systems of treatment and care for people with mental ill health, and the inadequate scrutiny, oversight and accountability of mental health services. We have raised these previously in our 2015 report *Deaths in Mental Health Detention: An investigation system fit for purpose?* and in our 2016 evidence to the CQC review of how the NHS investigates deaths in healthcare settings.[1] The inadequacy of the current framework for investigating deaths in mental health detention has also been raised by the Joint Committee on Human Rights, the Equality and Human Rights Commission, the Independent Advisory Panel on Deaths in Custody, and in parliamentary debate.[2]

These concerns set in context the call for a public inquiry into the failings of Essex mental health services, a call which INQUEST wholeheartedly supports.

2. Failures of treatment and care for people with mental health needs

Essex mental health services: unacceptable repeated failures

The situation in Essex is a stark example of the systemic failures in the care of people with mental health needs. Since 2013, INQUEST has worked on over 28 cases involving deaths in mental health settings in Essex. These deaths are marred by failures that are repeated time and again and include: poor information sharing and record keeping, inadequate risk assessments, dangerous ligature points. There have been countless investigations, inspection reports and inquests highlighting these failures, but despite these, preventable deaths have continued.

The Parliamentary and Health Services Ombudsman (PHSO) in its review of the "missed opportunities" in the cases of Matthew Leahy and Benjamin Morris identified a "systemic failure to tackle repeated and critical failings over an unacceptable period of time" and the absence of learning or improvement.[3] In relation to the case of Matthew Leahy, the PHSO pointed to an apparent cover-

up in crucial documentation.[4] The Health and Safety Executive is currently taking legal action against North Essex Partnership Trust in relation to safety failings in the deaths of 11 patients between 2004 and 2015.

At the Linden Centre specifically, we are aware of six inpatients who were found hanging between 2004 and 2019, despite countless recommendations to make wards safer by eliminating ligature points. INQUEST and bereaved families raised concerns about this pattern of deaths and the failure to take action to prevent future deaths to the Care Quality Commission in 2016.[5] Despite repeated CQC inspections and visits, people have continued to die at the Linden Centre and in Essex mental health services.

This year alone INQUEST has been contacted in relation to the deaths of Jayden Booroff, a 23-year old who was an inpatient at the Linden Centre, and Chris Nota, a 19-year old who died under the care of Essex mental health services.

A national scandal: failing systems of treatment and care

Time and time and again, patients, their families, whistle-blowers and undercover journalists have exposed harsh, neglectful and abusive treatment of patients in mental health settings. INQUEST's casework and research illustrates some of the failures that have led to people dying.

In 2016, INQUEST reported that between July 2013 and October 2016 there had been 71 Regulation 28 ("Prevention of Future Death") reports issued in cases where inpatients in mental health settings had died. 54 of these had died due to self-inflicted injuries and 17 related to an act or omission by the NHS which had caused a patient's death. In each of these cases, the coroner had concluded that *action should be taken to prevent the occurrence to reduce the risk of death*. We identified a range of common failures across these cases, including in relation to communication, absconding, inadequate observations, ligature points and training.[6]

Yet in November 2020 our analysis of a sample of 20 recent cases of deaths in adult inpatient mental health settings, these same issues were still present, as well as:[7]

- Insufficient risk assessments and management (12)
- Poor record keeping (7)
- Inadequate observations (6)
- Lack of training (6)
- Communication failures (6)
- Not involving the family in the care of the patient (4)
- Ligature risks not being managed well (3)
- Lack of local specialist units and staff shortages (3)
- Management of leave and discharge processes (3)
- Delays in finding suitable alternative placement (2)
- Care plans failing to be updated (1)

This evidential basis of repeated failures and inaction, despite the countless recommendations of coroners among others, underscores the specific and urgent concerns of the Essex families.

3. Accountability for mental health settings and services

There are a number of specific areas where accountability for mental health settings and services is inadequate or fails.

- ***The lack of public information available about the numbers or circumstances of deaths in mental health settings***

Every year, there are around 200-250 deaths of detained patients in mental health facilities.[8] Additionally, significant numbers of mental health patients – whether in inpatient settings or receiving community services – die every year, yet there is no accessible data on this. As a result, scrutiny of the circumstances of these deaths or analysis of trends or themes is impossible.[9]

- ***The lack of independent pre-inquest investigation***

No independent investigation mechanism exists for the investigation of deaths in mental health settings. This is in contrast to deaths in prison, police or immigration detention where there is an automatic, external investigation by an independent national body. These bodies publish investigation reports, have oversight on all deaths and policy issues, and share and publicise regular thematic reports. A crucial opportunity to strengthen the framework for investigations in 2016 was missed, when CQC reviewed the way NHS trusts review and investigate the deaths of patients in England but failed to acknowledge the need for independence in investigations.[10]

The promised work to improve investigations that arose from this review has, in our experience, stalled and yielded few concrete results. In March 2020 a new Patient Safety Framework was published. However, it only applies to a limited number of NHS Trusts and work has been suspended due to the pandemic. The Serious Incident Framework being used is the one dating back to 2015. Under this framework, if a person dies in a mental health setting the trust or private provider investigates itself, or appoints another trust or individual to do so. These reports are generally delayed, kept internal and, according to the CQC itself, are of variable quality and rigor.[11],[12]

- ***The inadequacy of inspection and regulation of these settings***

The fact that concerns around basic failures in these settings are repeated time and time again raises significant questions of the bodies responsible for inspection and oversight. Despite the CQC's role in delivering the UK's international obligations to prevent ill treatment in detention,[13] it has clearly failed to prevent repeated deaths in the Linden Centre, or in forcing providers to take action to address repeated concerns.

- ***The absence of any robust mechanism for ensuring post death accountability and learning***

It is often not until their cases reach inquest that families can seek answers as to why their loved ones have died. The rigour and quality of the inquest will depend on the quality of the investigation undertaken, the approach taken by the coroner and if the family are legally represented. While the inquest process can and does play a vital contribution to the prevention of future deaths and social harms, the current system for learning and implementing changes arising from inquests is not fit for purpose. There is no framework or coordinated response required from public bodies to ensure inquest outcomes feed into concrete implementation of learning and demonstrable action. This is a significant failure of accountability.

4. The call for a public inquiry and INQUEST recommendations

It is more vital than ever that the failures in care and accountability are addressed. As shown by our analysis and the families directly affected by the failures in Essex, these are systemic and repeated concerns. It is bereaved families who have been forced to highlight the failure to take action on recommendations made in relation to the death of their loved ones, to try and get the state to act to prevent future fatalities, and now to press for this debate in Parliament. The state has a duty to prevent future deaths, and the situation in Essex shows it is clearly failing. Nowhere illustrates this more acutely than the failure to remove a dangerous ligature point after the death of Matthew Leahy.

It is clear to INQUEST that were there a framework for the independent investigation of deaths, and more responsive and robust scrutiny by the CQC and other oversight bodies this call for a public inquiry might not be necessary.[14] **However the shocking death toll of avoidable deaths shows that this is a human rights issue warranting urgent public scrutiny to try and protect lives in the future.**

On 16 October this year, Health Minister Edward Argar MP announced the intention of the Minister for Patient Safety to "commission an independent review into the serious questions raised by a series of tragic deaths of patients at the Linden Centre between 2008 and 2015".[15] It is our view that such an approach is inadequate. There have already been countless reviews, reports and recommendations, many of which have been conducted by independent bodies, but these have failed to prevent further deaths, or ensure the changes needed to improve the standard of care in Essex mental health services.

Only a public inquiry can ensure the broad ranging scrutiny needed in these cases and their broader context, by:

- **Examining systematic failings,** and ensure a thematic overview of individual deaths and other serious incidents, taking into account the evidence of patients, bereaved families, NGOs, mental health staff and the oversight and investigation bodies themselves.
- **Examining the efficacy of oversight bodies** in preventing deaths and addressing repeated failures in relation to these cases and mental health services more widely.
- **Compelling witnesses to give evidence**, as investigations to date have shown there is much still to be learned about the failures in Essex. Unless compelled to give evidence under oath it is likely that many key witnesses will not come forward.
- **Operating in public**, providing much-needed transparency and opening the opportunity for wide participation. As the campaign by Melanie Leahy and other bereaved families have shown, it is only by building public awareness has the scale of the failures in Essex come to light.

We urge you to:

1. **Support the call for a statutory public inquiry into Essex mental health services.**
2. **Support the call for independent investigations into deaths in mental health settings.**
3. **Support INQUEST's call for a National Oversight Mechanism**, which would collate, analyse and monitor learning and implementation of recommendations from state-related deaths, to ensure accountability and prevent future deaths.[16]

3rd Floor 89-93 Fonthill Road • London • N4 3JH • Telephone: 020 7263 1111 • Fax: 020 7561 0799 • Website: inquest.org.uk

[1] INQUEST, *Deaths in mental health detention: An investigation framework fit for purpose?* (2015), and Submission to CQC review of investigations into deaths in NHS Trusts (2016)
[2] Joint Committee on Human Rights (2004) Third Report, https://publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1513.htm#a76 para 335; Equality and Human Rights Commission (2015) *Preventing deaths in detention of adults with mental health conditions*, Page 54; Steve Reed MP in Westminster Hall Debate on Mental Health Act Reform on 25 July 2019, *https://hansard.parliament.uk/Commons/2019-07-25/debates/4FE061D8-70AC-4B51-BA13-F83C5CDA8438/MentalHealthAct1983#contribution-2D5CB49F-A416-4D6A-A138-B508A60E4C63*; Independent Advisory Panel on Deaths in Custody, *Report of IAP Workstream considering investigations of deaths in custody – compliance with Article 2 (2011).*
[3] See https://www.ombudsman.org.uk/sites/default/files/page/Missed_opportunities_What_lessons_can_be_learned_from_failings_at_the_North_Essex_Partnership_University_NHS_Foundation_1.pdf p8
[4] See https://www.ombudsman.org.uk/sites/default/files/page/Matthews_Case_PHSO.pdf p22
[5] INQUEST, Submission to CQC review of investigations into deaths in NHS Trusts (2016); Report on the CQC Family Listening Day (2016)
[6] INQUEST, Submission to CQC review of investigations into deaths in NHS Trusts (2016)
[7] We analysed Records of Inquests, narrative jury conclusions and Prevention of Future Death Reports relating 20 inquests that concluded between May 2018 to March 2020. The deaths occurred between April 2016 and January 2019. Within this sample, 18 deaths were self-inflicted and 2 were non-self-inflicted. They involved deaths of 15 women and 5 men, 7 of which were of people aged 24 or under. In relation to 3 of these deaths the inquest jury found that the cause of death was contributed to by neglect.
[8] CQC Monitoring the Mental Health Act in 2018/19 (Appendix A).
[9] In 2018, the Guardian suggested there had been 100,000 deaths of mental health patients in a year. https://www.theguardian.com/society/2018/nov/27/nhs-deaths-mental-health-patients-england
[10] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
[11] "they are not focused on learning but used as management tools or reports to coroners". Also "We found that analysis was often superficial, focusing on the acts or omissions of staff with little evidence of systems analysis." (https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf p39)
[12] Only a "Level 3" investigation under the Serious Incident Framework would involve any form of independent scrutiny, but these rarely take place, even in cases where they may be warranted, and they are commissioned and managed within the NHS so cannot provide full guarantees of independence.
[13] As part of the UK's National Preventive Mechanism www.nationalpreventivemechanism.org.uk
[14] We note that in responding to the petition about the death of Matthew Leahy, the Minister for Patient Safety, Mental Health and Suicide Prevention Nadine Dorries MP stated "that public inquiries do not happen for individual cases. In this case, a public inquiry is not appropriate response because we are talking about two cases" http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-administration-and-constitutional-affairs-committee/phso-report-north-essex-partnership-university-nhs-foundation-trust/oral/106331.html Q56
[15] https://hansard.parliament.uk/Commons/2020-10-16/debates/CD1E079C-FC63-40D5-89D6-97ABB1311C37/CareQualityCommissionDeathsInMentalHealthFacilities?highlight=linden%20centre#contribution-B0155084-D359-40B3-8303-656083F6921F
[16] INQUEST has been calling for the establishment of a National Oversight Mechanism: a new, independent, public body with a duty to collate, analyse and monitor recommendations and their implementation arising from post death investigations, inquiries and inquests. INQUEST's view is that had such a body been established years ago, the countless recommendations from inquests and previous inquiries into the failures across mental health services would have been implemented and these deaths prevented.