INQUEST

Joint Committee on the Draft Mental Health Bill
House of Commons
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Dear Baroness Buscombe,

Reform of the Mental Health Act

I am writing to you on behalf of the organisation INQUEST to highlight our ongoing concern around the lack of independent investigations into mental health related deaths. As the Joint Committee on the Draft Mental Health Bill brings its scrutiny to a close, I hope you will have had chance to consider this issue and how it can be addressed in upcoming reforms to the Mental Health Act.

INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST's specialist casework includes deaths in mental health settings, prison and police custody, immigration detention, and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. I am also a member of the Independent Advisory Panel on Deaths in Custody and am aware of the concerns they have notified the Committee of in relation to reform of the Mental Health Act.

Given the nature of INQUEST's work, we have a unique insight into some of the most pertinent issues related to the investigation of mental health related deaths. In fact, increasingly a large proportion of INQUEST's casework involves deaths in mental health settings, or of individuals in contact with community mental health services.

A consistent concern raised by bereaved families is the absence of a system for independently investigating mental health related deaths. As we have previously noted, there is a glaring disparity between the manner in which deaths in mental health detention are investigated before an inquest compared to those in other forms of state custody. Unlike deaths in police, prison or immigration detention or following contact with state agents – where the coroner's inquest is based on the independent investigation of the Independent Office of Police Conduct (IOPC) or the Prisons and Probation Ombudsman (PPO) – no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the inquest is reliant on the internal reviews and investigations conducted by the same trust or private provider responsible for the patient's care.[1] It does not inspire family or

[1] See INQUEST's report, 'Deaths in mental health settings: An investigation framework fit for purpose?' https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=92fa356f-8335-4c6a-a273-62aad802284c, February 2015; See INQUEST's report on the CQC Family Listening Day, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=244b96e0-d733-4ada-b171-897847a1adad October 2016

public confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its own staff or systems.

While the NHS have recently made changes to their investigative framework to better include families in the process, investigations are still conducted by the organisations involved in someone's death. Where independent investigations are commissioned, this is not done in a consistent manner or one that always puts the bereaved families at the centre of the process.

In our view the lack of an independent investigatory body means that there is limited opportunity to gain insight and guidance on the prevention of deaths and the meaningful change so needed, not least given that 270 people died while detailed under the Mental Health Act in 2021/22.[2] Our work with families shows us that many of these deaths are preventable and premature.

Relatedly, we continue to be deeply concerned by the lack of learning from inquests and investigations into deaths involving mental health services. While coroners continue to issue recommendations in Prevention of Future Death reports to improve the policies and practices for people detained under mental health legislation, there is no oversight body tasked with collating, analysing or following up on these recommendations. Life-saving recommendations simply go nowhere and the official regulator, the Care Quality Commission, does not review these recommendations in any systematic way. I urge you to look further at how reforming the Mental Health Act can strengthen oversight of how public bodies and private companies respond to important recommendations arising from investigations into preventable deaths.

I hope you find this information useful, and I would welcome the opportunity to discuss the matters further with you.

With best wishes,

Deborah

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Deborah Coles, INQUEST Executive Director

[2] See CQC's report 'Monitoring the Mental Health Act in 2021 to 2022', https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022, December 2022