INQUEST

Health and Social Care Committee
House of Commons
London
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hsccom@parliament.uk

06 October 2023

Dear Steve Brine MP,

I am writing to make you aware of INQUEST's concerns regarding support for people with mental ill health, autism and learning disabilities.

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 was a long-standing member of the Independent Advisory Panel on Deaths in Custody and represent INQUEST on the Ministerial Council on Deaths in Custody. In recent years, INQUEST has dealt with a large proportion of cases involving mental ill health, learning disability and autism: 29% of our current cases involve individuals who died while in the care of mental health services.[1]

There are distinct issues arising out of mental health deaths. A review of recent coroner's Prevention of Future Death (PFD) reports following deaths in mental health settings has evidenced, inter alia, a lack of adequate mental health training, issues regarding risk assessments for leave and the national shortage of acute psychiatric beds.[2]

It is also noteworthy that multiple PFDs issued recently have raised concerns about inadequacies in mental health trust investigations into deaths. As you will be aware, there is no independent body responsible for conducting investigations into mental health related deaths as there is for police related deaths or deaths in prison. Instead, NHS trusts or, occasionally, private companies will carry out an investigation into a death. As evidenced in INQUEST's recent Family Consultation Day report, many bereaved families doubt the independence and impartiality of those tasked with conducting the investigations. As one family member said about the trusts, "they're marking their own homework".[3] Families also called into question the extent to which trusts welcomed or valued family involvement over

[1] INQUEST, Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767, April 2023
[2] For more information, see the Courts and Tribunals Judiciary page on Prevention of Future Death reports, https://www.judiciary.uk/?s=&pfd_report_type=&post_type=pfd&order=relevance, including the reports on the deaths of [I/S] , [I/S] and [I/S] .
[3] INQUEST, Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767, April 2023

the course of an investigation, even though they were often crucial witnesses to the care on offer and had become experts in supporting their relatives' mental health, learning disability and autism.

Good quality investigations can aid a coroner's inquest and help facilitate better evidence gathering. Yet as highlighted in the aforementioned recent PFD reports, there continues to be problems with trust investigations being delayed, a failure of the investigation to meaningfully and critically analyse the events leading up to a death, and a lack of involvement of the bereaved family during the course of the investigation.[4] The absence of automatic, independent investigations into mental health related deaths, and the impact this has on learning across the sector, needs to be better understood. I believe your committee could provide valuable additional scrutiny to this issue, particularly to examine its effect at a national level.

Autism is also an increasingly prevalent issue in our casework. INQUEST has recently worked on a concerning number of self-inflicted deaths involving autistic children and young people. These deaths often involve vulnerable people who have struggled with their mental health and were subject to lengthy waiting lists for autism diagnoses, who were not able to access suitable autism-specific support or appropriate care from mental health services (including CAMHS), educational settings and/or their local authority. I believe the committee could have a role to further examine the trends coming out of inquests and report on the systemic issues related to the treatment of autism which is leading to deaths.

Finally, we would ask the committee to further examine the available data on mental health related deaths. While the CQC publish data on the deaths of people detained in mental health settings, INQUEST have found it difficult to ascertain whether this data includes informal or voluntarily held patients in mental health settings. We have also found it difficult to determine the numbers of children who have died in mental health settings that are both public or privately owned.[5] The Rapid Review into mental health data recommended more work be done "to map the full range of data on deaths, including what is collected by which organisation and what can be done to improve it."[6] It would be helpful for the committee to look at what progress has been made against this recommendation, given the Review stated follow up should be completed no later than Autumn 2023.

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[4] For more information, see the PFDs into the deaths of [I/S] [I/S] [I/S] and [I/S]

[5] For more information, see the answer to a Parliamentary Question tabled by Fleur Anderson MP on the number of children who have died while detained under the Mental Health Act and in the care of a mental health settings as a voluntary patient, https://questions-statements.parliament.uk/written-questions/detail/2022-06-20/21301. While the answer provided by the government provides a total figure of 21 deaths of children and young people, this figure is not disaggregated to show the numbers of deaths of children only.

[6] Rapid review into data on mental health inpatients settings: final report and recommendations, https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations, June 2023

Given the vital scrutiny your committee provides I believe the above issues could greatly benefit from further examination, particularly given reports that reform of existing mental health legislation may be delayed.[7]

Best wishes,

Deborah Coles

[I/S]

INQUEST Executive Director

[7] The Times, Thousands 'will be betrayed' if mental health reforms ditched, https://www.thetimes.co.uk/article/thousands-will-be-betrayed-if-mental-health-reforms-ditched-gvlbnc0zp, August 2023