Written evidence submitted by the Independent Advisory Panel on Deaths in Custody (IAPDC) (MHB0083)

Executive summary:

The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can meet their human rights obligations to take active steps protect lives, prevent deaths, and keep those in the care of the state safe. The IAPDC welcomes the opportunity to submit evidence to the inquiry of the Joint Committee on the Draft Mental Health Bill. For our response, we have provided answers relevant to our single purpose of preventing all deaths, both natural and self-inflicted, in custody.

Our findings and recommendations are as follows:

- The Panel welcomes the Draft Bill. However, none of the Bill's provisions will make any impact on reducing deaths in mental health settings if significant healthcare resource – often in the form of more hospital beds – is not made available to those in need. At present, it is often the lack of available beds or other facilities that leaves those in mental health crisis at such serious risk. As Sir Simon Wessely stated in his Independent Review of the Mental Health Act (MHA), "all these powers are illusory if no bed is available and that is frequently the case."

- The Panel welcomes the proposed ban on the use of prison as a 'place of safety' as well as proposals to end the use of 'protective' bail on mental health grounds. Strong guidance, more available hospital beds, and more health-based places of safety are needed to ensure these provisions prevent vulnerable individuals from being held in prison as they await hospital care. Without this, the real risk to life posed by this use of prisons will remain.

- The Panel welcomes the proposed introduction of an overarching 28-day period for those awaiting transfers from prison to hospital for mental health treatment. However, we remain concerned that without stronger drafting or guidance, and an increase in available hospital beds, this 'backstop' time-limit will risk similar delays to those which take place now. We also recommend DHSC commit to conducting a review of the operation of the new time limit one year after its enactment, and to monitor thereafter, to identify how it is working in practice and its impact.

- The Panel welcomes the proposed ban on the use of police custody as a 'place of safety' but has serious concerns about the level of resourcing available to implement it. While we have identified examples of policing best practice in dealing with individuals in mental health crisis – including de-escalation, deployment of health professionals as first responders, use of Liaison and Diversion (L&D) services, and designated health-based places of safety – more needs to be done to ensure this good practice is strongly embedded and widely adopted across the 43 forces in England and Wales. The Panel urges Government to ensure that a lack of healthcare resource does not leave police officers continuing to detain those in mental health crisis, despite the proposed ban.

- While the Panel welcomes many of the provisions in the Draft Bill, there is much that it does not address. We urge the Committee, and Government, to increase focus on those detained under the MHA. Serious outstanding issues include:

    - The high rate of deaths of those detained under the MHA.
    - The lack of adequate, disaggregated data to properly understand those deaths.
    - The lack of adequate independent investigation into those deaths and effective follow-up to ensure they do not happen again.

The use of prison as a 'place of safety' and for 'protective' bail

1. The IAPDC welcomes Clauses 41 and 42 of the Draft Bill to end the use of prison as a 'place of safety' and end the use of bail for an individual's own protection where they are in mental health crisis. The IAPDC remains deeply concerned that the use of prison in such circumstances poses serious risk to mental health and therefore places lives in danger.

2. While it is unclear how many individuals are held in prisons as 'places of safety' or on protective bail, unpublished statistics suggest the numbers may be low. However, inspection reports relating to individual prisons suggest the numbers may nonetheless be significant in some areas and particular establishments, notably women's prisons. As found by the Criminal Justice Joint Inspectorates, Care Quality Commission, and the Healthcare Inspectorate of Wales in their joint thematic report on mental health in the criminal justice system from November 2021:

    "Despite the significant risks they posed to vulnerable individuals, prisons continued to be used as a place of safety from court. The scale of the issue was unclear as data was not collected and incidents were not reported centrally. However, during our inspection, we were made aware of one women's prison where the problem was so frequent that the prison's senior managers had recorded 24 incidents of their prison being used as a place of safety in the previous 12 months."[i]

3. In the IAPDC's 'Keeping Safe' consultations with prisoners, practitioners, and policy-makers, one man in prison said, "Jail is not a mental hospital. Well, it shouldn't be. But it is at present."[ii] Individual cases demonstrate the serious risks this use of prisons pose. Sarah Reed was a young woman whose self-inflicted death took place three months in to being held on remand in prison as she awaited psychiatric assessment. The inquest jury found that the healthcare treatment she received while in prison on remand was inadequate and that this contributed to her death.[iii]

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[i] Criminal Justice Joint Inspectorates, Care Quality Commission, and Healthcare Inspectorate Wales, 'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders', November 2021, p. 96, available here.

[ii] The IAPDC Keeping Safe Conference, February 2020, available here.

[iii] INQUEST, 'Jury concludes unnecessary delays and failures in care contributed to death of Sarah Reed at Holloway prison', 20 July 2017, available here.

4. Dean Saunders was a young man whose self-inflicted death took place while being held on remand in prison, where he suffered a severe mental health crisis. The jury found that the "neglect" he suffered while detained there contributed to his death.[iv] Speaking at the IAPDC Keeping Safe conference in February 2020, Dean's father, Mark Saunders, said: "Dean was a 25-year-old young man just starting his life. Had a young child. Had a loving partner and they just got their first flat together. And all of a sudden he went ill with a mental illness, ended up in prison as a holding pen because they didn't have a secure bed for him. He was meant to be on constant suicide watch. But, as we found out, it turned out to be a money saving exercise to take him off that suicide watch. And that gave Dean the time and the equipment to take his life."

5. The Panel therefore welcomes Clause 41(2) of the Draft Bill, which amends the definition in section 55 of the MHA to provide that *only* hospitals may serve as places of safety for the relevant provisions of Part 3 MHA, such as the use of places of safety pending admission to hospital on remand for mental health assessment under section 35.

6. The Panel also welcomes Clause 42, which introduces changes to the Bail Act 1976 to remove the ability of courts to refuse bail to a person for their own protection and remand them to prison, where the sole grounds for doing so relates to concerns around their mental health. Under the Draft Bill, for those accused or convicted of (and awaiting sentencing for) non-imprisonable offences, the 'protective' bail exception, where concerns only relate to mental health, is entirely removed. Where the individual has been accused or awaiting sentencing for imprisonable offences, and there are mental health concerns about them, they may be denied bail for their own protection *only* where they are remanded to hospital under section 35 MHA. In addition, since prisons will have been removed from the definition of 'places of safety' under the MHA, by Clause 42 of the Draft Bill, such individuals cannot be held in prison as a 'place of safety' pending admission to hospital under section 35.

7. We support the aim of these provisions, which add significant new safeguards to the use of 'protective' bail for those in mental health crisis. However, the Panel has concerns about how this new exception to bail on combined 'protective/section 35' grounds will operate. As amended by Clause 42, the original 'protective' exception to bail will remain in paragraph 3 of Schedule 1 to the Bail Act. Even with the above amendments, it seems to leave individuals liable to being denied bail on 'protective' grounds provided it is not for mental health reasons alone.

8. Where the reasons for an individual's need for protection arise solely in respect of their mental health issues, the process will be clear. But what if a court decides there are not only mental health-based reasons to remand them for their own protection? For example, a court may view that an individual's homelessness and mental health condition together give rise to concern that they should be held in custody for their own protection. Would a court be permitted to remand them for their own protection, under the (amended) 'old' exception to bail, rather than the new exception introduced by the

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[iv] INQUEST, 'Jury concludes neglect contributed to death of Dean Saunders at HMP Chelmsford', 20 January 2017, available here.

Draft Bill, since the reasons that satisfy the court that they should be held in custody for their own protection may be deemed to not *only* relate to their mental health?

9. The language of the Draft Bill is not clear. Where healthcare provision is scarce, and so individuals are unable to be admitted to hospital or health-based place of safety, courts will be concerned to ensure individuals do not come to harm. They may then seek to rely on the remaining 'protective' ground of bail to hold them in prison, relying on a non-mental health-related reason to do so. If this were to take place, the changes introduced by Clauses 41 and 42 would be seriously undermined.

10. These problems will be severely exacerbated if these changes are not properly resourced. At present, it is the lack of available healthcare resource which leaves vulnerable people being placed in prison. The time spent waiting for a transfer is necessarily linked to the time spent waiting for a hospital bed to become available. As Sir Simon Wessely stated in his Independent Review of the Mental Health Act, "all these powers are illusory if no bed is available and that is frequently the case."[v] Additional healthcare resource to free up beds for patients detained in prison custody, as well as new commissioning of health-based places of safety, is urgently needed.

11. Given what may be the low numbers of individuals detained in prison in this way each year, it may not be especially onerous or difficult to ensure adequate healthcare provision is available. The need to cater safely for what may be small cohort of patients is particularly acute considering the high risk of harm they currently face otherwise by being placed in prison.

12. Section 35(4) MHA makes clear that the individual cannot be remanded to hospital unless the court is satisfied that arrangements have been made to admit the individual to hospital within seven days of the date of remand. If individuals cannot be remanded to hospital for want of a bed within seven days, and so no section 35 order can be made, they will have to be released. While it is never appropriate for individuals in mental health crisis to be held in prison, it cannot be right that a lack of adequate provision means that they are released without the care they need.

13. Further, for those who are not held on remand, either since they are not ordered to hospital under section 35 or are not accused of or awaiting sentencing for an imprisonable offence, they will be released, potentially on conditions relating to mental health treatment. While release will be the only suitable option for those whom it is not appropriate to remand to hospital under section 35, rather than imprisonment, proper resourcing will be needed to ensure that those who are released receive the treatment they need in the community.

14. <u>Recommendation</u>: The IAPDC would urge the DHSC and MoJ to work together to introduce guidance to ensure that individuals in mental health crisis do not continue to be held in prison on remand using the remaining 'protective' exception to bail. At the same time, we urge the Government to ensure that these changes are properly provisioned to ensure individuals needing treatment receive it promptly in a community

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[v] 'Modernising the Mental Health Act: Increasing choice, reducing compulsion', Final report of the Independent Review of the Mental Health Act 1983, December 2018, p. 32, available here.

healthcare or hospital setting. We also urge the Government to collect and publish data on the use of prison for 'protective' remand and as a place of safety, so the problem can be understood and the effective implementation of these bans monitored.

A time-limit on mental health transfers from prison to hospital

15. The Panel welcomes Clause 31 of the Draft Bill to introduce a time-limit on mental health transfers from prisons to hospitals. Lengthy waiting times ahead of transfer can lead to the serious deterioration of unwell prisoners' mental health, potentially leading to them being segregated, placed on constant watch, and at risk of suicide. HMIP's annual report for 2020-2021 suggested transfers to hospital under the MHA rarely took place within the 14-day time-limit for a transfer decision under section 47, with one prisoner in Leicester waiting 266 days.[vi] As found by the Criminal Justice Joint Inspectorates, Care Quality Commission, and the Healthcare Inspectorate of Wales in their joint thematic report from November 2021:

    "Acutely unwell prisoners who required urgent transfer to a secure mental health inpatient hospital for treatment continued to experience long waits in prison. Delayed mental health transfers continue to be the reality for prisoners who are extremely vulnerable or a potential risk to themselves or others, or who require treatment for their condition that An inspection of the criminal justice journey for individuals with mental health needs and disorders 100 cannot be provided in prison. For example, at one of the sites we visited, 17 prisoners had been transferred to hospital in the last 12 months and only one had met the national guideline of being transferred within 14 days. The longest took 375 days. At another, 23 prisoners had been transferred to hospital in the previous 12 months and only five had been transferred within 14 days. The longest took 91 days. This results in mentally unwell prisoners being held in conditions that are in no way therapeutic and in many cases clearly exacerbate their condition."[vii]

16. As the Panel understands the new section 47A MHA, introduced by Clause 31 of the Draft Bill, a new time-limit for transferring prisoners to hospital will be added to the existing process of transfer directions under section 47. Under new section 47A, a health provider within a prison will make an initial request (from a registered medical practitioner) for a report under section 47 that an individual meets the criteria under section 47(1). After that, new section 47A requires that 'as soon as practicable' the health provider must make a 'referral notice' to the Secretary of State, as well as many bodies as it considers are likely to be involved in the care of the prisoner, such as the relevant NHS Trust.

17. The Secretary of State will then decide whether to make a transfer direction under section 47 as normal. Provided the Secretary of State makes a transfer direction, new section 47A(4) provides that a 28-day time-limit will be deemed to have started from the

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[vi] HM Chief Inspector of Prisons for England and Wales, Annual Report 2020–21, 20 July 2021, p. 43, available here.

[vii] Criminal Justice Joint Inspectorates, Care Quality Commission, and Healthcare Inspectorate Wales, 'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders', November 2021, pp. 99-100, available here.

date of the initial request for a report at the start of the process. Importantly, the time-limit will only run from initial requests which have led to a report under section 47 and where the Secretary of State is satisfied that the detention criteria have been met, rather than from any and all such requests.

18. It is important to note that transfer directions, by section 47(2), have an expiry date of 14 days from the date of issue, reflecting the recommendations of the 2009 Report of Lord Bradley that the NHS should have 14 days as their "minimum target" in which a prisoner is to be transferred.[viii] Nothing in Clause 31 alters this. We hope that this process will lead to those within prison healthcare teams being strongly incentivised to make initial requests under new section 47A, which will essentially 'kick off' the process for ensuring the 14-day transfer direction is started, and that the entire process does not finish later than 28 days, the time-limit functioning essentially by way of a 'backstop'.

19. At present, reports for transfer directions under section 47 are often not made at the earliest opportunity – when the healthcare need arises – so as to avoid a transfer direction expiring pointlessly, since resource problems will mean the prisoner cannot be transferred in time. If the 28-day 'backstop' means transfers take place more promptly, and acts to contain the process leading up to and completing the 14-day transfer direction window, then this may help ensure more transfers take place when they are needed.

20. Further, it is significant that Clause 31(2) changes the detention criteria in section 47 to ensure that a transfer direction can still be made even if a hospital bed is not yet available. We welcome this change, provided the 28-day time-limit does result in beds that were not available at the start of the period becoming available by the end of it.

21. However, there is a fundamental problem with the proposed time-limit. We welcome that new section 47A provides that shortages of hospital beds and staff cannot amount to 'exceptional circumstances' to justify a failure to meet the time limit. But it is the lack of access for prisoners to available hospital beds that has given rise to this systemic problem: patients in prisons across the country continue to face serious, unacceptable delays in accessing the care they need as soon as they need it. Prisons and healthcare providers may do all they can to 'seek to ensure' that prisoners are transferred, but if additional investment is not made to make more hospital beds available faster, prisoners will not be transferred within 28 days. While we welcome this new time-limit, on its own it does not, and indeed cannot, solve this fundamental problem; additional investment is necessary.

22. Additionally, the Panel has concerns about the drafting of the time-limit. The language of new section 47A(4) does not appear to require any authority involved to actually ensure it takes place within 28 days. Rather, they must 'seek to ensure' that the individual is transferred within that time. With numerous agencies involved in ensuring an individual is transferred, it may be that placing strict statutory duties on all involved may not be effective or feasible. We have concerns that placing no stricter duty on

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[viii] 'The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system', April 2009, p. 106, available here.

anyone to actually effect transfer may leave the time-limit significantly less likely to be met.

23. Further, it is important to ensure the addition of this further 28-day time limit does not create perverse incentives that adversely impact those needing mental healthcare in prisons. We believe further review will be needed, after a year from the time limit's enactment, to assess how it is working in practice. This would also provide an opportunity to determine whether it has made a significant impact on health outcomes for those needing transfer to hospital from prison.

24. Recommendation: To make real change in this serious, systemic problem that is leaving so many prisoners at such risk, relevant bodies should be under stronger obligations than simply 'seeking to ensure' prisoners are transferred to hospital within 28 days. But most fundamentally, greater resource is urgently required to ensure more hospital beds are made available, without which the new time-limit will be wholly ineffective. We also recommend that DHSC commit to reviewing the operation of the time limit one year after its enactment and to monitor its impact annually thereafter.

Banning the use of police custody as a 'place of safety'

25. The IAPDC welcomes the proposed ban on the use of police custody as a 'place of safety' in Clause 41. Many vulnerable members of the public find themselves in contact with the police during or following a mental health crisis. A high proportion of deaths that occur in police custody, as well as during or following police contact, involve people who are experiencing mental health and and/or substance misuse issues. In 2020/21, 12 of the 19 people who died were identified as having mental health concerns and 14 people were known to have a link to alcohol and/or drugs.[ix] Both factors are also prevalent among the 92 people who died in 2020/21 after some form of contact with the police.[x] Ensuring that such individuals are swiftly diverted to the treatment they need, rather than police custody, is important to preventing these tragic deaths from occurring.

26. This cannot be achieved without banning the use of police custody as a 'place of safety', as well as significant investment in practice and healthcare resource, in the form of beds in hospital and health-based places of safety. As part of an ongoing project, the Panel has identified significant best-practice for police in responding to individuals in mental health crisis, examples of which we believe will be essential to ensuring this ban on the use of police custody as a 'place of safety' is made to work.

27. In February 2021, the IAPDC, along with the then-Policing Minister the Rt Hon Kit Malthouse MP, sent a joint letter to Police and Crime Commissioners (PCCs). Among other things, we asked for examples of good practice, as well as gaps in practice, relating to responses to those in mental health crisis and learning lessons following deaths relating to custody.

[ix] Independent Office for Police Conduct, 'Deaths during or following police contact: Statistics for England and Wales 2020/21', July 2021, available here.

[x] Independent Office for Police Conduct, 'Deaths during or following police contact: Statistics for England and Wales 2020/21', July 2021, available here.

28. We were encouraged to find instances of proactive and conscientious initiatives to ensure that individuals in mental health crisis were not detained but diverted swiftly to mental health services. This included the use of 'street triage', involving an assessment as to whether a person should be held under Section 136 MHA and, if not, what follow-up is needed from services in the community. To provide this, Devon and Cornwall police, for example, rely on support from a mental health professional relayed from a control room, while Leicestershire and Hampshire forces use mental health response vehicles to transport a mental health worker with another emergency worker (such as a police officer or paramedic) to incidents that require their input.

29. We also received good examples of the use of Liaison and Diversion (L&D) teams. These are trained healthcare professionals (sometimes referred to as 'trusted assessors') who comprise standalone teams or are based in custody suites and provide support by proactively screening for vulnerable individuals in custody. They provide clinical oversight, undertake assessments, make referrals into local services, give staff training to officers, and, in some cases, where there is an identified risk of self-harm or suicide, provide post-custody follow-up. We understand all forces have commissioned services which include L&D within police custody.[xi]

30. Responses we received highlighted the apparent successes of these initiatives. For example, Hampshire police have witnessed a reduction in police deployments to calls concerning poor mental health, which goes against the national trend and may be attributed to strong partnerships with health and social care. In addition, Nottinghamshire police commented that they have not used custody as a place of safety since March 2019, whilst Durham police reported it has only been used four times in as many years.

31. This tallies with statistics on the use of police custody as a 'place of safety', which has significantly declined in recent years. The proportion of people detained under section 136 who are held at a police station has fallen from 4% in 2016/17 to 0.4% in the year to March 2021.[xii] Of the 33,652 detentions under section 136 last year, other than that 0.4% taken into police custody, 76% were taken to a health-based place of safety and 18% were taken to Accident & Emergency.

32. These examples of police practice, if properly resourced, have the potential to ensure individuals in mental health crisis are not placed in custody. But the sharing, embedding, and wider adoption of this good practice is essential for doing so. The Panel's work, however, highlights concerns that some police forces are not doing so as effectively as they could.

33. Making the ban work effectively requires there to be sufficient healthcare resource available to give police forces real alternatives to custody. As was made clear to us in our

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[xi] Criminal Justice Joint Inspection, Care Quality Commission & Healthcare Inspectorate Wales, 'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders', November 2021, p. 36, available here.

[xii] House of Commons Library, 'Police powers: detention and custody', 19 August 2021, p. 25, available here; Home Office, National Statistics, 'Police powers and procedures: Other PACE powers, England and Wales, year ending 31 March 2021', 14 December 2021, available here.

consultation with PCCs, police cannot and do not want to be first-responders for those in mental health crisis. But lack of healthcare resource mean that the use of custody is sometimes viewed as the only option for police struggling to deal with individuals in severe crisis. This is confirmed by the most recent annual 'State of Policing' report by HM's Chief Inspector of Constabulary and Fire & Rescue Services (HMCICFRS), which found:

> "Some forces received effective advice and help from mental health professionals. This helped police officers to deal with incidents and, where possible, avoid detaining people under section 136. Instead, they found other ways of getting the necessary support for the individuals in question.
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> "In forces where help from mental health professionals wasn't so readily available, officers told us they were more likely to detain a person under section 136 and take them to a mental health facility. They said they needed to do this to manage the risks that the person posed to himself, herself or others."[xiii]

34. Indeed, it was reported by HMCIP in its annual report for 2019-20 that in many cases section 136 'place of safety' powers would not be needed at all were there sufficient healthcare provision readily available:

> "The picture was complex, and further complicated by a lack of data and poor recording. If a detainees' wait was so long that their time to be detained lawfully under PACE was running out, the police could apply section 136 to detain and then transfer them to a health-based place of safety. We judged that many such detainees to whom this applied were not well served by mental health services and should have been moved from custody sooner without the use of section 136 powers in this way."[xiv]

35. It has been made clear to us in our ongoing work that police custody is not viewed as a suitable or safe place for a person in mental health crisis, and that police officers would almost never choose to use a police cell as a place of safety if suitable alternatives were available. As the Panel warned in its response to the White Paper which preceded the Draft Bill, meeting this commitment will require mental health services to be given the appropriate funding to respond effectively.

36. Recommendation: While the Panel welcomes the ban on the use of police custody as a 'place of safety', to make these provisions work effectively the Government must now commit to a level of funding sufficient to ensure that there are satisfactory and safe alternative health-based places of safety available across England prior to the Draft Bill's enactment. (We note that separate arrangements are being made in Wales.) We also urge police, as well as their partners in healthcare and PCCs, to ensure that the good practice they have adopted to better respond to individuals facing mental health crisis is further developed and more widely shared.

[xiii] HMICFRS, 'State of Policing – The Annual Assessment of Policing in England and Wales 2021', March 2022, p. 142, available here.

[xiv] HM Chief Inspector of Prisons for England and Wales, Annual Report 2019–20, 20 October 2020, p. 89, available here.

The lack of high-quality data on deaths of those detained under the MHA

37. Innovative statistical analysis carried out by the IAPDC of recorded deaths in custody between 2016 and 2019 shows that people detained under the MHA have the highest mortality rate of those in custody.[xv] Rates ranged from 1,103 to 1,334 per 100,000 persons detained, three times higher than the mortality rate in prisons. It is perhaps unsurprising that, as the Parliamentary and Health Service Ombudsman found in 2020, one in five people treated for mental health problems reported not feeling safe during their care.[xvi]

38. But there remains a lack of high-quality data on deaths under the MHA. For instance, there remains no disaggregated data on characteristics protected under the Equality Act 2010, such as race, and it takes far longer to provide statistics on causes of death under the MHA than for any other place of detention.

39. There are also significant uncertainties over the number of those who die in healthcare settings immediately after leaving mental health detention, or the number of deaths of those who are 'de facto' detained, such as children. This is a serious problem, which the Draft Bill does not address.

40. Recommendation: We believe it is vital that Government take steps to ensure the Care Quality Commission (CQC), NHS, and DHSC work together to ensure that there is clear, high-quality, disaggregated data to properly understand the full picture of deaths of those detained under the MHA.

The lack of effective independent investigation of deaths under the MHA

41. Despite the high rate of deaths of those detained under the MHA, the investigation they receive contrasts starkly with the investigation of such deaths that occur in other places of detention. Deaths within mental health settings lack any independent system of pre-inquest investigation as is carried out by the Independent Office for Police Conduct (IOPC) for deaths in police custody or following police contact, or by the Prisons and Probation Ombudsman (PPO) for deaths in prisons or immigration removal centres.

42. Instead, coroners' inquests remain the only independent review that deaths in mental health settings receive. Unlike inquests relating to deaths connected to police or prison custody, MHA-related inquests are largely reliant on internal reviews and investigations conducted by the same trust responsible for the patient's care. This raises serious concerns about the availability of independent, impartial information following a death and the learning that should stem from it.

43. Unlike prisons or the police, mental health trusts are effectively permitted to investigate themselves following a death that may have been caused or contributed to by failures of its staff and systems. As the charity INQUEST have noted, this lack of independence

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[xv] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.

[xvi] PHSO, '1 in 5 mental health patients don't feel safe in NHS care, Ombudsman finds', 19 February 2020, available here.

mirrors discredited, and now superseded, practices within other forms of state custody. The investigations which do take place are of varying quality, and are often deficient in terms of scope, timeliness, quality, independence, and family involvement. Despite these failings, it will be these internal investigations that form a substantial part of the evidence before a coroner into that very death.[xvii]

44. Further, there remain real concerns about the extent to which organisations effectively implement the findings of coroners reports on preventing future deaths made under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009. This raises questions as to whether the existing process of investigation and reporting around deaths of those under MHA detention is adequate, relying so much as it does on the findings of coroners' inquests. (The Panel is currently taking forward an initiative to explore how these reports can be made more effective, having conducted roundtable events with senior coroners in August and September of this year, and will be releasing a report later this year.)

45. The absence of independent, searching scrutiny leaves NHS and healthcare organisations without outside voices to help it learn and respond after a death and to introduce changes to policy and practice to prevent further fatalities. The CQC is unable to play this role, since it does not conduct full, individual investigations followed deaths of detained patients. Rather, it simply reviews a sample of cases each year to identify emerging issues.

46. Recommendation: While the Independent Review of the MHA by Sir Simon Wessely did not recommend a new process of independent investigation for all deaths of those detained under the MHA, his review found that a "stronger case" could be made for such a process for certain deaths, such as those that are self-inflicted. While the Draft Bill does not cover these issues, the Panel believes there remains a strong case for Government to re-examine this issue and we urge it to do so at the earliest opportunity.

The IAPDC would welcome the opportunity to provide further information or oral evidence if required by the Committee.

23 September 2022

[xvii] See INQUEST, 'Deaths in Mental Health Detention: An investigation framework fit for purpose?', 2015, available at: https://www.inquest.org.uk/deaths-in-mental-health-detention.