Supplementary written evidence submitted by the Independent Advisory Panel on Deaths in Custody (MHB0102)

I am writing to thank you for providing the opportunity to give oral evidence on 2 November 2022 on behalf of the Independent Advisory Panel on Deaths in Custody (IAPDC). As you know, the IAPDC provides independent advice and expertise to the Ministerial Board on Deaths in Custody with the central aim of preventing deaths in all forms of state custody. A key area of focus for the IAPDC is deaths of individuals detained under the Mental Health Act 1983 (MHA).

In recent months, there has been a growing number of reports into failings at mental health facilities, including revelations from Panorama and Dispatches documentaries about the mistreatment and abuse of patients. The widely reported deaths of three teenage girls at Tees, Esk and Wear Valley NHS Trust demonstrate the tragic consequences of inadequate care, poor risk assessment and overstretched services.[1] However, as Maria Caulfield MP, Minister for Mental Health at the Department of Health and Social Care, acknowledged in response to an Urgent Question in Parliament on 3 November 2022, she was "not satisfied" these failings were "isolated incidents at a handful of trusts".[2] Instead, they are symptomatic of system-wide failings to keep patients safe.

In light of these developments, I wanted to write to set out two clear IAPDC-recommended changes to the Draft Mental Health Bill:

A new clause to create an independent body to investigate deaths under the MHA

Deaths within mental health settings are investigated by the same trust responsible for the patient's care. The Care Quality Commission (CQC) is a regulator and does not have a role to independently investigate deaths under the MHA. Investigations under the NHS Improvement Serious Incident Framework remain *ad hoc* and insufficient. This lack of robust, independent scrutiny is in stark contrast to the investigation of deaths within other custodial settings. Deaths in prisons, immigration detention, and police custody are subject to independent investigations by the Prisons and Probation Ombudsman (PPO) and the Independent Office for Police Conduct (IOPC). A lack of dedicated, independent scrutiny creates an obstacle to effective learning and the necessary action to prevent future fatalities.

We welcome the Mental Health Minister's openness to launching a public inquiry but agree that there must be "urgent action" now.[3] As we discussed during the 2 November evidence session, there may be a range of factors which have an impact on these deaths, but the lack of progress in stopping them from taking place is deeply concerning. Sir Simon Wessely's Independent Review of the Mental Health Act noted that the case could be made for having an independent body investigate unnatural deaths under the Act and urged government to return to this issue if progress has not been made.[4] The findings of recent inquiries demonstrate that this issue must be re-examined as a matter of urgency.

Research published by the IAPDC in 2021 found that people detained under the MHA have the highest mortality rate of those in custody, including three times higher than the mortality

[1] Guardian, 'Three girls died after major failings in NHS mental health care, inquiry finds', 2 November 2022, available here.
[2] Hansard, 'Abuse and Deaths in Secure Mental Health Units', 3 November 2022, available here.
[3] Hansard, 'Abuse and Deaths in Secure Mental Health Units', 3 November 2022, available here.
[4] 'Modernising the Mental Health Act: Increasing choice, reducing compulsion; Final report of the Independent Review of the Mental Health Act 1983', December 2018, p. 102, available here.

rate in prisons.[5] The CQC reported that 363 people died in detention during the year 2020/21.[6] It must not be left to hidden cameras and whistle-blowers to uncover the failings behind these deaths. The IAPDC is now calling for the introduction of a new clause in the Bill to establish an independent body with an investigative function, similar to that carried out by the IOPC and PPO regarding deaths in police custody, prison and immigration detention.

A new clause to create a duty to produce data on deaths under the MHA

Despite their frequency, there is an alarming lack of high-quality, transparent data about these deaths, including relating to characteristics protected under the Equality Act 2010. The need for better-quality data was cited in the Equality and Human Rights Commission's written evidence to the Committee[7], and the Children and Young People's Mental Health Coalition warned against "significant gaps in available data".[8] We strongly agree.

As an example, the IAPDC's statistical analysis of recorded deaths in custody between 2016 and 2019 found that half of the women detained under the MHA in 2019 who died did not have their ethnicity recorded.[9] It is not even clear that all deaths that occur in detention are included within the numbers, such as the deaths of children who are 'de facto' detained outside the MHA or those who die while temporarily taken to a general hospital. A standard has been set by criminal justice data collection and publication, as well as clarification on the definition of what constitutes a death in custody, which could be adapted or replicated here.

We are therefore calling for the introduction of a clause in the Bill to require the publication of high-quality, disaggregated data to enable an in-depth understanding of deaths across different population groups. While agreement will be needed as to how this data is collected and published, in its absence, it will not be possible to learn lessons from these deaths in order to prevent future fatalities.

People detained under the Mental Health Act are among the most vulnerable in society, and it is the duty of the state to ensure they are given the care, rights and protection to which they are entitled. Yet patients are being systematically failed by the very institutions which are there to keep them safe. Each death is a tragedy for the individual and their family, and a catastrophe for public services and the Government. The Bill presents a vital opportunity to improve how we keep people safe and avoid the loss of life. We therefore urge the Government to ensure this opportunity is not missed.

Juliet Lyon
Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC)

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[5] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.
[6] Care Quality Commission, 'Monitoring the Mental Health Act in 2020/21', 2022, available here.
[7] Equality and Human Rights Commission's written evidence to the Joint Committee on the Draft Mental Health Bill, 14 September 2022, available here.
[8] Children and Young People's Mental Health Coalition's written evidence to the Joint Committee on the Draft Mental Health Bill, 16 September 2022, available here.
[9] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.