INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST BRIEFING: Mental Health Act Reforms

Westminster hall debate: reform of the Mental Health Act 1983

25 July 2019, 1:30pm

INQUEST provides advice and assistance to bereaved people whose relatives have died in mental health settings, including those who are detained under the Mental Health Act 1983. Through nearly 40 years of extensive casework with families affected, INQUEST has seen repeated systemic failings leading to avoidable deaths time and time again.

Our casework has shown that the current system of investigations and oversight following deaths in mental health settings is insufficient for identifying and implementing the necessary changes in policy and practice to prevent future deaths. The following recommendations would be an important step in addressing this, ensuring improved access to truth and justice for bereaved families, and more effective implementation of important changes following deaths.

INQUEST, with the support of bereaved families and specialist lawyers, is calling for:

1. **An independent system of pre-inquest investigation** following deaths in mental health settings, equivalent to systems of investigation in other places of detention.
2. **Legal aid for inquests through automatic non means tested public funding for bereaved families,** for specialist legal representation immediately following a death.
3. **The creation of a national oversight mechanism** tasked with the duty to collate, analyse and monitor learning outcomes and their implementation arising out of deaths in custody and detention and other state related deaths.

In December 2018 *The Independent Review of the Mental Health Act,* chaired by Sir Simon Wessely, echoed INQUEST's demand that 'families of those who have died should receive non means tested legal aid' joining the widespread calls for change. [1] The review also endorsed the need for an 'Independent Office for Article 2 Compliance', which would act as a national oversight mechanism to monitor recommendations and report on implementation.

For more information contact INQUEST on 020 7263 1111 or lucymckay@inquest.org.uk

Amy El Keria and her family's struggle for justice and change

"For 14 years we kept Amy safe. In less than three months under the care of the Priory she was dead. The only thing that has kept me going since her death has been the need to achieve justice for Amy and to stop other families going through the torture we have endured."

– Tania El Keria, Amy's mother

Amy was a child with complex needs associated with multiple mental health diagnoses. She died in 2012 aged just 14 years old, whilst an NHS funded patient in a specialist children's unit in a private psychiatric hospital run by the Priory Group (Ticehurst House in Sussex). Following her death, the Priory refused to undertake an independent investigation. As Amy was classed as a voluntary inpatient, though she was effectively detained, the Priory argued against an enhanced 'Article 2'

[1] Wessely, S. (2018) *The Independent Review of the Mental Health Act 1983*. London: Department of Health and Social Care. Download. Both these recommendations also made in Angiolini, E. (2017) *Report of the independent review of deaths and serious incidents in police custody*. London: Home Office. Download.

inquest, opposing an inquest jury. Only with the assistance of INQUEST and a specialist legal team were Amy's family able to challenge this.

All six other interested persons in the proceedings received automatically funded legal representation, including the Priory, West London Mental Health NHS Trust, and London Borough of Hounslow Social Services. Yet the family were forced to go through a stressful and demanding appeal process to access legal funding.

Thanks to the support they received, in 2016 the inquest jury concluded finding gross failings contributed to Amy's death. Her mother Tania said, *"I knew the Priory's investigation following death was a whitewash and the inquest proved that."* Following the publicity arising from the critical inquest, the Health and Safety Executive were alerted to the circumstances and undertook a criminal investigation. This led to the Priory Group being found guilty of breaching the Health and Safety Act in relation to Amy's death.

This rare accountability came despite the failings of the current system. It relied on the perseverance of this family with the support of INQUEST and dedicated lawyers. Too many deaths like Amy's are not properly investigated and families cannot access legal support. Even despite the publicity and prosecution, a recent undercover documentary on Ticehurst House uncovered ongoing risks due to the lack of oversight on and follow up from deaths.

1. The importance of independent investigations

There is currently a glaring disparity between the way deaths in mental health settings are investigated pre-inquest, compared to deaths in other forms of state detention. If a person dies in a prison or following contact with the police there is an automatic, external investigation by the independent national bodies, the Prison and Probation Ombudsman (PPO) and Independent Office for Police Conduct (IOPC). They publish the final report, have oversight on all deaths and policy issues, and share and publicise regular thematic reports.

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. The investigations which do take place are of varying quality, and are often deficient in terms of scope, timeliness, quality, independence and family involvement. Ultimately, even when there is an independent investigation commissioned, the healthcare provider in question has control and oversight of the final report.

"When our son died, having been in the care of mental health services, we expected a full and thorough investigation of the circumstances of his death to uncover any failings which contributed to his death. At the inquest we discovered that the investigation, written by an expert consultant psychiatrist, had been edited to remove and amend key findings around failings by the Trust's senior management and staff. This was carried out without the consent of the author of the report, and indeed of our family.

As the report excluded key information, we were forced to pay for legal representation to challenge the Trust management's actions and the amended report. Without any external oversight or proper independence, the system of investigation lets down families like ours. We cannot trust investigations to identify the real failings behind deaths. This is not only disappointing but can lead to poor, uninformed inquests and prevent essential learning from deaths." - ***The family of Harry Whiteman, who was 22 when he died a self-inflicted death in the care of NHS mental health services.***

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The current system of internal investigations in mental health settings do not allow for meaningful learning, or national oversight on issues which may be widespread. This mirrors the discredited practices of the past, with police investigating police and internal prison service investigations, prior to the establishment of the Independent Police Complaints Commission (now IOPC) and PPO.

The current lack of truly independent investigations into deaths in mental health settings does not inspire public confidence or the confidence of bereaved families (as our CQC family listening day evidenced). INQUEST casework continues to demonstrate that the lack of a pre-inquest independent investigation impacts on all aspects of the response to deaths in mental health settings. An inquest is limited in scope, often occurs a long time after the death and, in practice, relies heavily on the investigation that precedes it. A conflicted and limited investigation inevitably impacts on the quality of the inquest, framing events and limiting evidence in ways that can be difficult to roll back.

The current system is simply not good enough and allows for repeated failings, which can be fatal. Consideration of changes to this system was promised during the passage of the Mental Health (Use of Force) Bill (now Act) through parliament but are yet to be seen.

For more information and case studies see*:*
***Independent investigations: the current system is not enough, Full Briefing* (June 2018)**

2. Legal Aid for Inquests

"Funding should be available for the families of those who have died unnaturally, violently or by suicide whilst detained, to receive non means tested legal aid. This would be to help families to understand the processes, their rights, and what steps they can take. This would include funding to attend the inquest, but should also be available to support families immediately after the death of the patient."

- Independent Review of the Mental Health Act (Dec 2018)

The INQUEST campaign on Legal Aid for Inquests is calling for automatic non means tested legal aid funding to families for specialist legal representation immediately following a state related death, such as those in mental health settings, to cover preparation and representation at the inquest and other legal processes.

In the past 20 years every review and public inquiry considering this has recommended that the inequality of arms between bereaved families and state parties at inquests be urgently addressed. Yet the Ministry of Justice has disregarded the evidence and ignored the voices of bereaved families, in their Review of Legal Aid for Inquests (Feb 2019).[2]

Inquests are intended to be inquisitorial, non-adversarial processes. However, in reality bereaved families regularly face combative legal teams, instructed to defend state policies and practices, rather than learn from individual and systemic failings. Currently, state bodies involved in a death have immediate and unlimited access to the best legal teams and experts, at public expense. In contrast bereaved families, who come to these processes through no fault of their own, do not.
Some bereaved people are granted legal aid after going through protracted and intrusive processes. Many get nothing or are required to pay large contributions towards legal costs. Others have no choice but to represent themselves in complicated legal hearings, or resort to crowdfunding.

[2] *Ministry of Justice rejects widespread call for automatic legal aid for bereaved families following state-related deaths*, INQUEST Media Release (7 February 2019). Available: www.inquest.org.uk/moj-legal-aid-review

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Removing the barriers to accessing legal representation will not only create a fairer and more just inquest system, it will protect lives.

Learn more: www.inquest.org.uk/legal-aid-for-inquests #LegalAidForInquests

3. The case for a national oversight mechanism

"One thing that we heard time and again is that where there are lessons to be learned following a serious or fatal incident, these lessons are not being shared nationally so that everyone can benefit, and to prevent similar incidents elsewhere. We think it is crucial that mechanisms are put in place nationally to make sure this happens." - ***Independent Review of the Mental Health Act*** (Dec 2018)

A lack of any national system for monitoring and oversight on deaths in places of detention, and any arising recommendations, is allowing dangerous systems and institutions to go unnoticed and unchecked. Properly conducted inquests and investigations can save lives, but a national oversight mechanism is required to maximise their preventative potential.

The current mechanisms for learning lessons from deaths are diffuse, inconsistently applied and lacking centralisation and standardisation.

- Recommendations arising from deaths are not monitored or followed up in any systematic way.
- Inquest jury findings are not collated, published or even shared between coroner's courts.
- Whilst coroners' Prevention of Future Death (PFD) reports are now mostly published online, there is no audit or follow-up to ascertain the impact of these reports at a national or local level and coroner's have no power to ensure action has been taken.
- Even if change is achieved, it is often not sustained. Actions peter out only to be raised again several years later at different inquests.

National oversight on state related deaths is something INQUEST has long campaigned for throughout our existence, and was a call endorsed by Dame Elish Angiolini QC in her 2017 report on deaths in police custody[3], which recommended the creation of an Independent Office for Article 2 Compliance, relating to the UK's duties under the human right to life.

This recommendation for a body with oversight, tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level, was seconded in the recent Mental Health Act Review.

An oversight body is required to annually review and monitor reports and recommendations arising from deaths, such as the Record of Inquest or PFD, to track issues and trends. All relevant bodies (such as inspectorates and investigative bodies) should be required to feed into this process, and there must be a role for bereaved families and community groups to voice their concerns, providing a mandate for its work.

For more information see: *Deaths in Mental Health Detention: An investigation framework fit for purpose?* (2015)

[3] Angiolini, E. (2017) *Report of the independent review of deaths and serious incidents in police custody*. London: Home Office. Download.

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