Equality and Human Rights Commission

Preventing deaths in detention of adults with mental health conditions: progress review

Equality and Human Rights Commission

Contents

List of acronyms

ACCT	Assessment, Care in Custody and Teamwork
ADR	Annual Data Requirement
APP	Approved Professional Practice
CQC	Care Quality Commission
CR/HT	Crisis resolution/home treatment
DH	Department of Health
ECHR	European Convention on Human Rights
FAI	Fatal Accident Inquiry
HIW	Healthcare Inspectorate Wales
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary in Scotland
HMIP	Her Majesty's Inspector of Prisons
HJIPS	Health and Justice Indicators of Performance
HSCIC	Health and Social Care Information Centre
HSIB	Healthcare Safety Investigation Branch
IAP	Independent Advisory Panel on Deaths in Custody
IPCC	Independent Police Complaints Commission
IPSIS	Independent Patient Safety Investigation Service
MWC	Mental Welfare Commission for Scotland
NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NPS	New Psychoactive Substances
OPCAT	Optional Protocol to the Convention Against Torture
PASC	Public Administration Select Committee
PER	Person Escort Record
PIRC	Police Investigations and Review Commissioner
PPO	Prisons and Probations Ombudsmen

Foreword

Baroness Onora O'Neill, Chair of the Equality and Human Rights Commission

Last year the Equality and Human Rights Commission investigated non-natural deaths of adults with mental health conditions who were detained in prisons, police custody or psychiatric hospitals between 2010-13. Our inquiry revealed that serious mistakes had contributed to this situation and had gone on for far too long, despite many previous reports and recommendations.

During our inquiry we were able to meet with family members whose loved ones had died, and their testimony provided a crucial part of the evidence to the inquiry. We also consulted with and received evidence from several organisations and other individuals affected by these unexpected deaths. Our analysis of this evidence led us to make a number of recommendations that could bring about real change to help prevent avoidable deaths in the future.

In this follow-up report we have looked for evidence of the steps taken by the various agencies responsible for implementing these recommendations. We hoped to be reassured that changes were being made in the areas of concern, the more so since many of these improvements are neither complicated nor costly.

We contacted the inspectorates and regulators that worked with us during the inquiry to give them the opportunity to tell us about the progress being made, and are grateful for the updated information we received. We also reviewed data, reports and other publications.

Our review of data on non-natural deaths in detention shows some differences between the three settings. The number of deaths of detained patients in psychiatric hospitals continues to fall.

However, the trend for non-natural deaths of those held in prisons shows a year-on-year increase, and data for 2015 reveal the highest number of deaths since 2007. The number of deaths of adults with mental health conditions in police custody is low, and continues to fluctuate at around the same level.

So we are able to report some progress and some improvements since our inquiry report, but are also disappointed to have to report some areas where little or no progress has been made.

There remains a clear need for changes that ensure independent investigations following deaths of detained patients. Our most pressing concern for prisons is that action is taken to reduce the increasing number of non-natural deaths. Our central recommendation for those held in police custody is for sustained commitment to improve access to appropriate care and treatment.

The changes we are recommending are not complex, but they do require commitment. We hope this report will provide new momentum to ensuring that these changes are made and that further avoidable deaths are prevented. This will help to ultimately ensure that the human rights of people with mental health conditions in detention are protected.

'During our inquiry we were able to meet with family members whose loved ones had died, and their testimony provided a crucial part of the evidence to the inquiry.'

Chapter 1: Executive summary

Background to our progress review

The Commission reviewed progress against the recommendations made in our inquiry report into non-natural deaths in detention in prisons, police custody and psychiatric hospitals in the years 2010–13, which published in February 2015. Our analysis of evidence in our inquiry led us to conclude that basic errors were being repeatedly made and there was a critical need to learn lessons to prevent unnecessary deaths and near misses. Through conducting this review we wanted to establish whether steps were being taken to implement the recommendations we made to bring about real change to the way adults with mental health conditions are treated in detention.

Our approach to gathering evidence for this review

We examined available evidence, including reports and statistics. We also wrote to the key regulators and inspectorates to invite them to tell us about the work they are undertaking to address our concerns and implement our recommendations. Gaps in data remain a problem in relation to deaths of detained patients and we have brought together the key stakeholders to agree a way forward to address this.

Main findings

Fresh analysis of evidence shows that changes are being made in some areas where we had concerns in our inquiry, but some key areas still need to be addressed.

Data on the number of non-natural deaths in the three settings shows that the overall trends are:

- For **detained patients,** the number of non-natural deaths is continuing to decrease.
- For **prisons,** the number of non-natural deaths has continued to increase year on year.
- For **police custody,** the number of non-natural deaths is low, but numbers are fluctuating.

Detained patients in psychiatric hospitals

Further evidence about the variable quality of investigations into non-natural deaths of detained patients reaffirms our previous finding that there is a need for the Government to take steps to provide reassurance that independent investigations are taking place and that they are of sufficient quality. This should be in the form of establishing an independent body to oversee independent investigations into the deaths of detained patients.

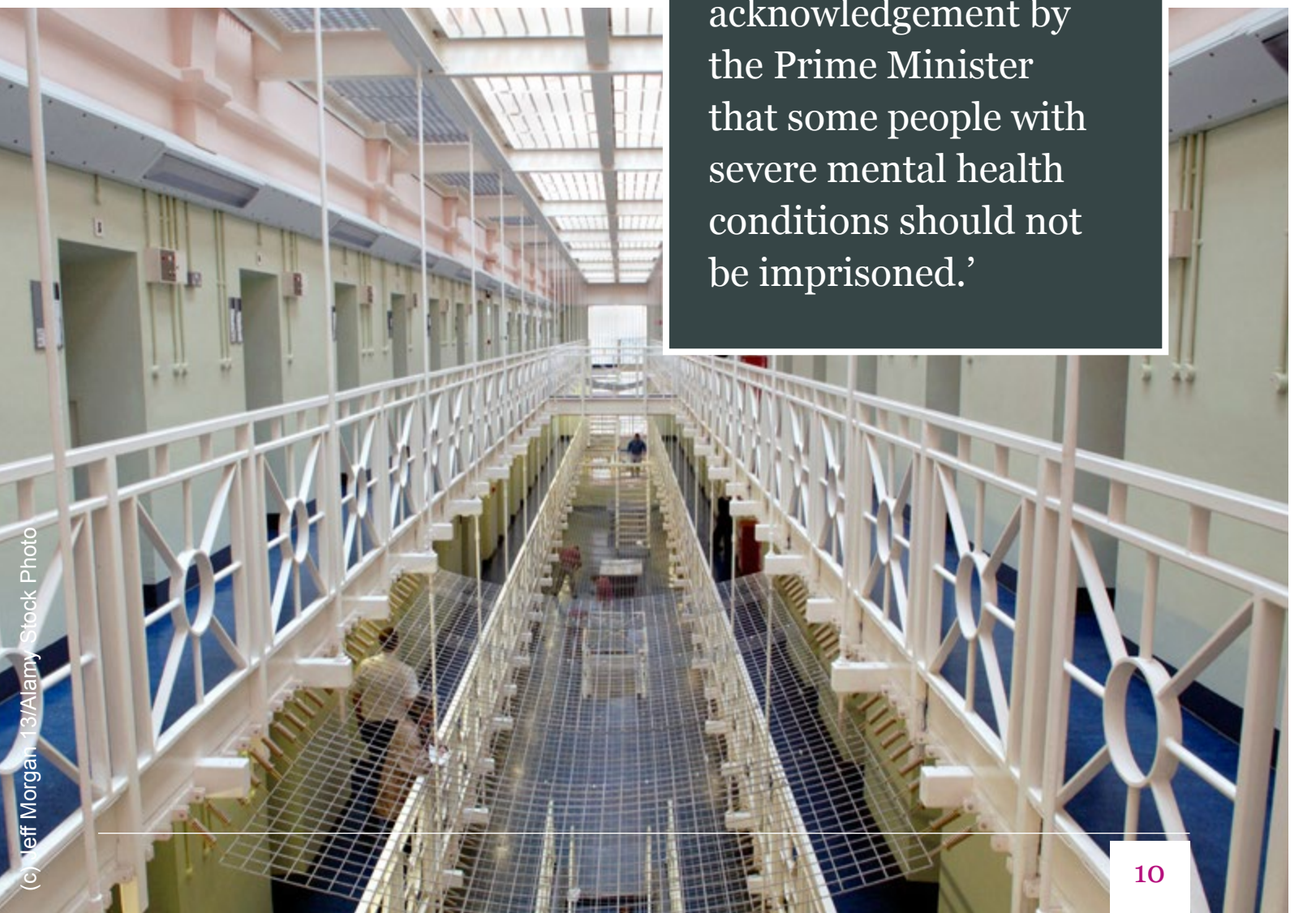
The Equality and Human Rights Commission's view is that the establishment of the Healthcare Safety Investigation Branch (HSIB), which will offer support and guidance to National Health Service (NHS) organisations on investigations and carry out certain investigations itself, could be a significant opportunity to incorporate this oversight role within its remit. Consideration should also be given as to whether any other groups with protected characteristics, such as learning disabilities, would benefit from HSIB having specific accountabilities in relation to them.

Prisons

Our most significant concern in relation to prisons is the increase in non-natural deaths, amid evidence of declining levels of safety and increasing violence.

Data for 2014 and 2015 shows that non-natural deaths of prisoners continue to rise year on year, reaching levels last seen in 2007, despite initiatives aimed at reducing these deaths. Analysis of the investigations into some of these deaths in 2013/14 by the Prisons and Probations Ombudsman (PPO) revealed that this increase is due to a complex range of factors. What was clear to the Commission in our inquiry report was that changes needed to be implemented as a priority to address the factors leading to the high number of non-natural deaths in prisons.

‘We welcome the recent acknowledgement by the Prime Minister that some people with severe mental health conditions should not be imprisoned.’



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Due to these concerns we made a number of recommendations in our inquiry report to improve support for prison detainees with mental health conditions. Our progress review leads us to conclude that more needs to be done to improve access to specialist mental health services.

Evidence from investigations into non-natural deaths of prisoners with mental health conditions continues to show weaknesses in the identification of risk for prisoners with such conditions and in the provision of treatment where risk has been identified. Some changes are being made by the Ministry of Justice, including a review of the case management system for managing and supporting prisoners at risk of suicide or self-harm.

Our view is that there remains a need to make further changes, particularly in relation to the provision of specialist mental health treatment in prisons. Indeed we continue to question whether prison is the most appropriate place for people whose needs may be better served within the community or psychiatric hospitals. We welcome the recent acknowledgment by the Prime Minister that some people with severe mental health conditions should not be imprisoned (Cameron, 2016). The Prime Minister also announced that, as a matter of urgency, Michael Gove, the Secretary of State for Justice, and Jeremy Hunt, the Secretary of State for Health, will be looking at what alternative provision can be made for more humane treatment and care for people with mental health conditions. This Ministerial Review needs to be matched with resources that will ensure people with severe mental health conditions receive appropriate specialist care.

‘...Michael Gove, the Secretary of State for Justice, and Jeremy Hunt, the Secretary of State for Health, will be looking at what alternative provision can be made for more humane treatment and care for people with mental health conditions.’

Police

While the number of deaths in police custody is low, our analysis of data shows that this continues to fluctuate at around the same level.

Although a large number of people pass through police custody, most remain there for only a short time. The fact that there were 17 deaths in or following custody in 2014–15 is cause for some concern. There is no room for complacency. It has been estimated that between 20 to 40 per cent of police time is spent on mental health-related matters. The police are often the first on the scene and they therefore need to be able to respond appropriately. This is recognised by those working in this field and there are initiatives to try to ensure this is the case.

We welcomed the announcement by the Home Secretary in May 2015 that an extra £15 million of Department of Health money would be made available for the provision of more health-based places of safety. This is important as it will help to ensure that people experiencing a mental health crisis are taken to a more appropriate place for assessments and treatment under sections 135 and 136 of the Mental Health Act 1983 and, importantly, not a police cell. Alongside this, there has been a reduction in the use of police cells as places of safety for people detained under sections 135 and 136 of the Act. Further change is afoot through legislation that will be introduced in the Policing and Crime Bill, which will prohibit the use of police cells as places of safety for those under 18 years of age and further reduce their use for adults. Additional changes in this setting include measures to improve guidance on the use of restraint, and the collection and collation of data on its use. Analysis of the impact of the Mental Health Crisis Care Concordat shows it has been a significant development in improving crisis care. The Concordat is a national agreement, initiated in February 2014, with the aim of ensuring that mental health services work alongside the police and other services to provide the most effective care for a person experiencing a mental health crisis.

‘It has been estimated that between 20 and 40 per cent of police time is spent on mental health-related matters.’

Conclusion and recommendations

Our review of progress leads us to conclude that there are some key areas where changes need to be made to help prevent further unnecessary deaths of adults with mental health conditions in detention.

These are different for the three settings. The most critical change for the hospital setting is the establishment of oversight of independent investigations of non-natural deaths of detained patients. In the prison setting, the key challenge is to put in place additional measures, urgently, to address the increasing number of non-natural deaths. For the police setting, the most pressing challenge is to sustain the initiatives in place to ensure quicker assessments for people experiencing a mental health crisis. We would like to see a sustained reduction in the number of non-natural deaths in police custody.

We are making a number of recommendations to address our concerns; some of which were made in the inquiry report but others that are new. We sincerely hope these recommendations are implemented to help prevent further unnecessary tragedies.

Chapter 2: Why we have carried out this review

In February 2015, we published the findings of our inquiry into non-natural[1] deaths of adults with mental health conditions[2] in detention in prisons, police custody and psychiatric hospitals, in which we examined how compliance with human rights obligations can reduce non-natural deaths in detention (EHRC, 2015). We wanted to establish whether a focus on increased compliance with Article 2 of the European Convention on Human Rights (ECHR) would reduce avoidable deaths.

We examined available evidence relating to the non-natural deaths of 367 adults with mental health conditions who died while in state detention between 2010–2013 in police cells and psychiatric wards, and 295 adults who died non-natural deaths in prisons, many of whom had mental health conditions. An important part of the evidence was testimonies at a family listening day organised by INQUEST, a charity that offers advice to families bereaved by deaths in detention from families in a similar situation.[3] Our inquiry found that, despite many previous reports and recommendations, serious and basic mistakes were repeatedly being made and, in many cases, lessons were not being learned to prevent future deaths.

[1] For our inquiry, this was defined as the following categories: self-inflicted/suicide; deaths caused by another person including homicide; other non-natural deaths including overdose and accidental deaths; and deaths the cause of which is unknown.

[2] For our inquiry, this was defined as any disorder or disability of the mind. This definition is identical to the definition of a 'mental disorder' in section 1 of the Mental Health Act 2007.

[3] See: http://www.equalityhumanrights.com/publication/inquiry-non-natural-deaths-detention-adults-mental-health-conditions-2010%E2%80%9313 [accessed: 3 March 2016]

We made four major recommendations which we believed would reduce deaths and increase compliance with Article 2 of the ECHR, with a number of specific recommendations under these.

Recommendation 1

Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

Recommendation 2

Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe, including implementing recommendations, improving staff training and ensuring more joined-up working. This should explicitly be part of the inspection regimes.

Recommendation 3

In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour that applies to NHS bodies in England. If it proves to be effective this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

Recommendation 4

The Equality and Human Rights Commission's (2015) Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach, as well as ensuring compliance with each individual element, will reduce non-natural deaths and should help to inform and shape policy decisions.

Although the three settings we looked at are very different, evidence to our inquiry highlighted some common themes and some specific problems for each setting. Following the launch of our inquiry report, we received a cross-Government response to our recommendations. This included responses from the Home Office, Department of Health (DH) and the Ministry of Justice. This response is included in Appendix 2.

We have revisited the three settings to examine developments and progress in the areas where we had concerns and to see whether our recommendations had been implemented. We recognise that some changes will take longer to embed but we wanted to know what action is being taken to address our concerns.

We have structured this report around our four main recommendations to allow us to make comparisons in the areas of progress against each.

Chapter 3: Overview of the three settings

Health

In relation to patients detained under the Mental Health Act 1983, the data published by the Independent Advisory Panel on Deaths in Custody (IAP) (2015) show that there were 209 deaths in 2014. This figure excludes 23 deaths that occurred away from hospital premises and 10 deaths within seven days of the use of restraint. Of the 209 deaths, 168 were from natural causes, 32 were non-natural, and the cause was unknown for nine.

Data for 2014/15 in England show there was an increase in the number of detentions under the Mental Health Act 1983 of 9.8 per cent compared to the previous year (HSCIC, 2015). This continues the trend since 2012 of an increasing number of detentions under the Act and underlines the importance of ensuring that the care for this particularly vulnerable group of people reflects their specific needs.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) has reported an increase in the number of suicides of patients under crisis resolution/home treatment (CR/HT) over the period 2005 to 2007, little change between 2008 and 2012, but with an estimated rise in 2013. The NCISH report suggested that these findings might reflect the reduced availability of local in-patient beds, with increasing reliance on home treatment as an alternative to admission.

Prisons

Numbers of non-natural deaths in prisons increased in 2014 and 2015, for both self-inflicted deaths and homicides, showing a year-on-year increase since 2013.

The rate of self-inflicted deaths (per 1,000 prisoners) has reached levels last seen in 2007. There were 84 non-natural deaths in prisons in England and Wales in 2013 and this increased to 98 non-natural deaths in 2014. In 2015, there were 104 non-natural deaths in prisons.

We do not know how many of these deaths were of people with mental health conditions, as data on this is not currently collated. We urge the collection, collation and publication of this information.

Organisations including Her Majesty's Inspector of Prisons (HMIP) have raised concerns about increasing levels of violence and declining safety in prisons. There were eight homicides in 2015. This is higher than in any year since the current set of records began in 1978. The previous highest number in the past 38 years was in 1978 itself, when there were five homicides.

Since our previous report, some changes have been put in place or are in progress to address problems with assessing risk and offering better support for prisoners with mental health conditions. This includes changes to improve the initial assessments of prisoners' mental health and the Person Escort Record (PER), used across the Criminal Justice System to share information about people transferred between agencies, is being reviewed. Changes are being made to entry-level training for prison officers and to improve peer support for prisoners.

Prison deaths

Since 2013, in England and Wales, there has been an increasing number of non-natural deaths in prisons.

These changes are welcome. Our review of evidence, however, shows that further improvements need to be made. An examination by the PPO of their investigations into deaths in prison custody between 2012 and 2014, where the prisoner had been identified as having mental health needs, found that the identification and treatment of mental health issues remained variable, and that there were many areas for improvement. The new NHS commissioning framework (Health and Justice Commissioning Intentions) has relatively few indicators on mental health. We understand that this is still in development, but agree with those who state the need for mental health to be a priority on the list of indicators. The recent speech by the Prime Minister on prison reform included the announcement that there will be a move towards full co-commissioning of mental health treatment by prison governors and NHS England (Cameron, 2016).

Police

In 2014/15, there were 17 deaths in or following police custody. Eight of these were of people with mental health problems; numbers have fluctuated around this level for the past five years. Figures from over the last seven years suggest that deaths are now consistently at around this level and have fallen from higher levels in the previous decade.

The Mental Health Crisis Care Concordat is a national agreement, initiated in February 2014 with the aim of ensuring that mental health services work alongside the police and other services to provide the most effective care for a person experiencing a mental health crisis.[4] One of the key successes of this agreement has been the reduction in the number of people being held in police cells as a place of safety. It has brought together 22 national bodies and been hailed as an effective catalyst for partnership working. While recognising that there has been significant momentum generated, progress has not been consistent. Her Majesty's Inspectorate of Constabulary (HMIC)'s (2015) thematic report on the welfare of vulnerable people in police custody highlighted the way in which the lack of appropriate mental health provision to prevent crises or support those in need of emergency care is leading to the unnecessary and sometimes unsafe detention of people with mental health problems.

[4] See: http://www.crisiscareconcordat.org.uk/ [accessed: 19 February 2016]

The Care Quality Commission (CQC)'s (2015) report on crisis care highlighted inconsistencies in care and delays in assessments across the country. Such delays can affect access to appropriate treatment. It is essential that successful pilot projects, which have provided the foundation for much of the partnership working, are adequately funded.

The debate on the current direction of commissioning crisis care is an extremely important one with an increased narrative about prioritising early intervention and a whole systems approach. In order to support people staying out of crisis there needs to be resourcing in services such as drug and alcohol. Current funding trends indicate that local authorities are now spending considerably less in this area.

Work is underway to produce new guidance on the use of restraint, including when police officers are called into hospitals. There has also been progress in relation to the collection of data on restraint. While the police appear to be making a concerted effort to improve the way they respond to those in their care with mental health issues, this is not their core role. They have identified bottlenecks elsewhere in the system, with particular frustration caused by delays in assessments and the lack of acute beds.

Table 3.1
Numbers of deaths of in-patients in detention, England and Wales, 2010–14

Deaths of in-patients who were detained under the Mental Health Act 1983		
	Total	Self-inflicted
2010	323	54
2011	283	51
2012	341	52
2013	282	41
2014	242	(25)*

Source: IAP (2015), Deaths in State Custody: An examination of the cases 2000 to 2014. Available at: http://iapdeathsincustody.independent.gov.uk/news/iap-statistical-analysis-fo-recorded-deaths-in-state-custody-between-2000-and-2014 [accessed: 19 February 2016]

Notes: A number of the statistics have been revised since we published our report in February 2015.

The figures provided previously by CQC and Healthcare Inspectorate Wales (HIW) were amended following a data-cleansing exercise. However, the numbers of natural and non-natural deaths have not been published.

* The number of self-inflicted deaths for 2014 does not include deaths off-site or within seven days of restraint.

Table 3.2
Numbers of deaths in prison custody, England and Wales, 2010–2014

All deaths in prison custody			
	Total	Natural	Non-natural
2010	198	126	72
2011	192	122	70
2012	192	123	69
2013	215	131	84
2014	243	145	98
2015	257	146	104

Source: Ministry of Justice (2016), Safety in custody quarterly update to September 2015. Available at: https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2015 [accessed: 19 February 2016]

Notes: Data are not available on the numbers of people with mental health conditions.

Total for 2015 includes seven deaths, for which the cause is as yet undetermined.

The rate of self-inflicted deaths was the same in 2014 and 2015, but the highest since 2007.

Table 3.3
Numbers of deaths of people with mental health conditions in or following police custody

Deaths of people with mental health conditions in or following police custody			
	Total	Natural	Non-natural
2010	7	3	4
2011	8	1	7
2012	5	2	3
2013	6	4	2
2014	7*	3	2

Source: Source: Sarah Morley (IPCC), enquiries@ipcc.gsi.gov.uk, 2016. 'Additional data requested'. [Email communication]. Angus Cleary, Angus.Cleary@equalityhumanrights.com. 22 January 2016: 11:44.

Notes: * Cause of death is awaited for two cases.

IPCC publish data by financial year, therefore this data has been extracted for this report so that it can be compared against other data.

Research on deaths following release from detention

During the course of our inquiry several respondents raised concerns about the number of people dying on release from prison or police custody.

While outside the original terms of reference, we have since contracted researchers from Sheffield Hallam University to review the available evidence. The IPCC provided reports for the research. We were hoping to publish the outcome of this research within this progress review; however, at the time of writing this report, we have been unable to access the necessary information from the National Offender Management Service (NOMS) in time to enable us to do this. We aim to publish a detailed report outlining our research findings in Spring 2016.

Chapter 4: Recommendations 2016

We are able to report that progress has been made in some areas by Government, regulators and inspectorates in implementing our recommendations to reduce non-natural deaths in detention.

In particular, the use of police cells as a place of safety for people experiencing a mental health crisis has fallen and planned legislative changes should help to reduce this further. The Government has recognised that changes need to be made to address the increasing number of non-natural deaths in prisons and some are being made to the assessment of risk and transfer of information. Deaths of detained patients have decreased and steps are being taken to improve the recording of data on the use of restraint.

We make a number of recommendations which we believe will, if implemented, address the remaining problems and reduce non-natural deaths in detention in prisons, police custody and psychiatric hospitals. We have grouped these under recommendations that we are continuing to make from our inquiry report and new recommendations from our review of progress.

‘Deaths of detained patients have decreased and steps are being taken to improve the recording of data on the use of restraint.’

Recommendations from our inquiry that still require implementation

- There should be a statutory obligation on institutions in the three settings to respond to recommendations from investigations and inspections by publishing an action plan, as this will improve transparency and accountability and will help to ensure that recommendations for improvements are implemented. This learning should be a key area of work for the IAP.
- Segregation should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance, which is clearly defined and understood by prison staff.
- Article 2 (the Right to Life) should be central to the development of policies, procedures and investigations into deaths of people in the care of the state. The Equality and Human Rights Commission's (2015) Article 2 Framework should be used to support this.
- Families should be fully involved in the investigations process and given relevant information and support throughout and following the outcome. This will help to ensure that lessons can be learned to prevent future deaths.

New recommendations 2016

All settings

- The impact of the statutory duty of candour that applies to NHS bodies in England should be formally evaluated by the Government in 2016 so that any recommended improvements can be made and shared across other public service functions, including the prison and police settings.

Psychiatric hospitals

- We welcome the announcement by the Secretary of State to establish medical examiners[5] who will review the causes of deaths of patients receiving healthcare services. This is an important first step in understanding why deaths occur and what can be done to avoid further deaths.
- However, we are still very concerned about the process of investigation, particularly in relation to the non-natural deaths of patients in psychiatric hospitals. The medical examiners will only take up post in April 2018. Before then, we recommend a Government review specifically into deaths in these settings. This would highlight the nature of any inadequacies in the current system and how these need to be addressed. This process should therefore take place while arrangements for the medical examiners are being worked out and will help to inform their role.
- The remit of the HSIB should include mental health and incorporate an oversight function of independent investigations into non-natural deaths of detained patients. The Government should also consider whether any other groups with protected characteristics, such as learning disabilities, would benefit from HSIB having specific accountabilities in relation to them.
- The agreed action plans from the seminar on data collection (hosted by the Equality and Human Rights Commission) will be shared with the IAP and the Ministerial Council on Deaths in Custody.

[5] See: https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture [accessed: 14 March 2016]

Prisons

- Urgent changes need to be put in place by the Government to address the root causes leading to the high levels of non-natural deaths in prisons, including greater access to specialist mental healthcare.
- Data on the use of restraint should be routinely published in the prison setting by the Ministry of Justice to aid transparency and accountability.
- Data on the number of prisoners with mental health conditions should be collated and this should be routinely published.
- The changes being made through the review of the Assessment, Care in Custody and Teamwork (ACCT) process used to manage and support prisoners who are at risk of suicide or self-harm, including those to the guidance for staff on risks and triggers, should be the right ones to ensure they are effective. Training should be provided to staff to ensure they know how to use the process.

Police

- Any changes being put in place for the commissioning of healthcare in police custody must incorporate the planned improvements that were due to be made by NHS England.

Chapter 5: Structured approaches for learning lessons in all three settings

Independent body to investigate deaths of detained patients

Progress since our previous report

In the Government response to our inquiry, the DH told us that they are 'open to new ways of improving the system for investigating deaths and learning lessons that are supported by evidence. The DH will consider this recommendation alongside the results from the Public Administration Select Committee (PASC) Inquiry into investigation of clinical failure in the NHS'.

In July 2015 the Secretary of State for Health announced the establishment of an Independent Patient Safety Investigation Service (IPSIS).[6] This is now titled the HSIB, which will operate from April 2016, and will offer support and guidance to NHS organisations on investigations and carry out certain investigations itself.

The number of organisations calling for an independent body to investigate deaths of detained patients has increased over the last year, including the inspectorate CQC (2016) and the Mental Health Taskforce (2016), which has developed a five-year strategy for mental health in England.

[6] See: https://www.gov.uk/government/publications/learning-not-blaming-response-to-3-reports-on-patient-safety [accessed: 19 February 2016]

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‘The number of organisations calling for an independent body to investigate deaths of detained patients has increased over the last year.’

CQC (2016) expressed concerns about the lack of an independent system for investigating the deaths of detained patients in healthcare settings and believe there is much greater opportunity for learning to take place when deaths occur, and for improvements to be put in place. CQC have informed us that there are continuing challenges with the national and local approaches to deaths of people with mental health conditions and learning disabilities in detention and they remain largely unchanged in the months following the inquiry publication. This includes ongoing difficulties with the national datasets and a lack of consistency in the way investigations are carried out or lessons learned when deaths occur.

The findings of the recently published Mazars (2015) report on deaths of people in the care of Southern Health Foundation NHS Trust echo our concern around the lack of national accountability and the need for reassurance that independent and effective investigations are taking place. In response to this report, the Secretary of State for Health (2015) stated that CQC will be undertaking a wider review into how deaths are investigated at a range of NHS trusts across England. Scoping of this review is currently underway. CQC also advocate a requirement to look at all unexpected deaths, including those classified as natural, to determine whether they were avoidable, and is currently working on updating its systems to reflect this change in focus.

Commission recommendations 2016

- There should be a full Government review into whether independent investigations are in fact being carried out into non-natural deaths of detained patients and whether they are of sufficient quality. The work CQC and MONITOR are undertaking following the Mazars report into Southern Health NHS Foundation Trust should identify whether national learning from investigations into unexpected deaths of detained patients is taking place.
- The remit of the HSIB should include mental health and incorporate an oversight function of independent investigations into non-natural deaths of detained patients. The Government should also consider whether any other groups with protected characteristics, such as learning disabilities, would benefit from HSIB having specific accountabilities in relation to them.

The creation of HSIB is a significant opportunity to implement our recommendation for the Government to establish oversight of independent investigations into non-natural deaths of detained patients, if the investigation of these deaths were included within its remit.

This oversight would allow for confirmation that an investigation has taken place, was independent, effective, included family members of the deceased and that any learning has been shared with other relevant organisations. We believe that including this role within the work of HSIB would contribute to increased accountability and transparency in mental health settings and a decrease in the numbers of non-natural deaths in this setting through improved local and national learning.

Our understanding is that the HSIB remit and structure will be agreed in Spring 2016. Our view is that, within the structure and remit of HSIB, there should be specific accountabilities relating to mental health. If this is not the case, we will consider that the Government will have missed an important opportunity to address the concerns expressed by a number of regulators and other key organisations.

Consideration should also be given as to whether HSIB should have specific accountabilities in relation to investigations of deaths, such as around people with learning disabilities, where previous reviews have revealed all trusts and health boards could learn from non-natural deaths.

Mental health services within prisons

Progress since our previous report

Changes are being made by the NOMS to improve the ACCT case management process for managing and supporting prisoners who are at risk of suicide or self-harm. A review of the ACCT process has been completed. This found that the guidance to staff on risks and triggers could be improved. The recommendations from this review will be implemented in 2016. Work to improve support to prisoners includes improvements to peer support, such as a renewed grant agreement with the Samaritans for the Listener Scheme, which encompasses training and awareness raising materials for staff. Improvements are also being made to family engagement. Moreover, NOMS is working with working with NHS England to improve constant supervision arrangements.

A further development is a review of the PER used across the Criminal Justice System to share information about people transferred between agencies. A thematic review of the PER form by HMIP (2012) identified two key issues: maintaining quality in large-scale processes where risks might be infrequent but serious for the individuals concerned; and ensuring communication between the operational staff involved is effective and informed by a good understanding of each other's needs. We have been told that what is effective in reducing risk is good interaction between prisoners and staff, which can help to ensure that wing staff know what might lead a prisoner to take their own life and be able to take steps to prevent this.

The Government needs to be alert to the importance of workable staff-to-prisoner ratios, which can help to reduce risk. The Chief Inspector of Prisons stated in HMIP's Annual Report 2014–15 that: 'It remains my view that staff shortages, overcrowding and the wider policy changes described in this report have had a significant impact on prison safety' (p.10).

NHS England has responsibility for commissioning health care services and facilities for adult prisoners in England. It has entered into partnership agreements with other Government departments, including NOMS and Public Health England, to strengthen their work. NHS England is moving towards an integrated model of commissioning and has introduced Health and Justice Indicators of Performance (HJIPS). These provide a mechanism for monitoring and establishing whether the service has been delivered. NHS England will be reviewing the indicators in 2016, and it is critical that mental health is central to these.

A further change is the development of a new integrated health IT system across the criminal justice estate, planned for implementation in 2016, that will electronically link health and care records wherever they are held. This could make real improvements to access to and the sharing of medical information within prisons.

Of serious concern is that non-natural deaths of prisoners continue to rise year on year, reaching levels last seen in 2007, despite initiatives aimed at reducing these deaths. In its 2014/15 Annual Report, PPO reported that: 'There were 76 self-inflicted deaths. This is a welcome decrease (16%) from 2013–14, but remains high relative to recent years' (p. 13).

The Government's response to our inquiry recommendations stated that new options for improving mental health provision for offenders, including specialist provisions in prisons, were being developed with partners in the DH and NHS England, as well as the Welsh Government. Significantly, the PPO's (2016) recently published learning lessons report on prisoner mental health identifies 'significant room for improvement in the provision of mental health care' (p. 3).

The regulators and inspectorate of prisons have publically expressed concerns about poor assessment of risk and decreasing levels of safety and violence management in prisons. PPO (2015) has stated that there 'remains an urgent need to improve safety in custody and reduce the unacceptable rate of suicides in prison' (p. 3). HMIP has reported gaps in the identification of risks for new prisoners, at a time when they were most vulnerable, and expressed concern about the number of self-inflicted deaths of prisoners on ACCTs.

A review of deaths of young people (the Harris Review, 2015) mirrors many of the findings of our inquiry report and recommends steps that should be followed to avoid future deaths. This review found that 'despite the prevalence of mental health issues in custody, we have seen stark evidence that vulnerable young adults are not getting access to the support and treatment they need' (p.12). In December 2015, the Government published a detailed response to the recommendations in the Harris Review (Ministry of Justice, 2015a).

Future commitments

In February 2016, the Prime Minister announced major reforms to prisons. These reforms include plans for prison governors and NHS England to co-commission mental health treatment in prisons and for healthcare data to be published on a prison-by-prison basis (Cameron, 2016).

Commission recommendations 2016

- Urgent changes need to be put in place by the Government to address the root causes leading to the high levels of non-natural deaths in prisons, including greater access to specialist mental healthcare.
- Data on the number of prisoners with mental health conditions should be collated and this should be routinely published.

Learning lessons and implementing recommendations

Progress since previous report

HMIP has an existing protocol with PPO to follow up on its recommendations on deaths in custody. In its response to our request for updated information regarding the prison setting, HMIP (2015) told us that they 'have found insufficient attention to implementing PPO recommendations in many prisons' (p. 35).

In 2015, HMIP began to publish on its website the action plans it receives from the establishments it inspects[7] as a way of increasing transparency and accountability. HMIP has called for there to be a statutory duty on inspected establishments to provide an action plan, which is considered good practice for the discharge of duties under the Optional Protocol to the Convention Against Torture (OPCAT).

The Chief Coroner continues to raise the issue of inconsistency in data collection and recording.

In November 2015, NHS England delivered two one-day workshops in undertaking clinical reviews following deaths in prison detention to approximately 50 clinical reviewers. A further date of training for those who were unable to attend the previous workshops has been arranged in March 2016.

New powers have been taken on by CQC from April 2015 from the Health and Safety Executive to prosecute health and care providers for failure to provide safe care and treatment. CQC has also undertaken further work in establishing a single point of contact for coroners' reports in relation to deaths in health and social care settings, to ensure that any concerns raised in these reports are effectively logged, analysed, managed and reviewed. A further change is that CQC will receive all coroners' reports in health and social care inquests to help reduce risk more effectively and promptly. The system is currently focused on managing risk at the healthcare provider level. For national learning, CQC would still look to the Chief Coroner's Office publications.

In July 2015, the Home Secretary announced a major independent review of deaths and serious incidents in police custody (May, 2015). This is being led by Dame Elish Angiolini DBE QC. The review will examine the procedures and processes surrounding deaths and serious incidents in police custody, identify areas for improvement and develop recommendations to ensure appropriate, humane institutional treatment when such incidents occur. We are pleased that INQUEST will be representing families and providing policy input to the review. We hope this review leads to real improvements, which are implemented quickly and effectively. We are feeding the conclusions and recommendations from our inquiry into this review.

[7] Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/ [accessed: 11 February 2016]

Commission recommendations 2016

There should be a statutory obligation on institutions in the three settings to respond to recommendations from investigations and inspections by publishing an action plan. This change will improve transparency and accountability and will help to ensure that recommendations for improvements are implemented. This learning should be a key area of work for the IAP.

Access to medical information in police custody

Previous report recommendation/s

- In our inquiry report, we welcomed planned changes expected to take place from April 2016 for the transfer of the commissioning responsibility for all police custodial healthcare to NHS England.

Progress since previous report

It was recently announced that this change will no longer be happening and responsibility for commissioning healthcare in police custody will remain with Police and Crime Commissioners. This lack of change could mean that the necessary improvements to improving access to medical information in police custody and treatment are not made. The British Medical Association recently wrote to the Home Secretary in relation to their concerns about the planned changes.

Commission recommendations 2016

Any changes being put in place for the commissioning of healthcare in police custody must incorporate the planned improvements that were due to be made by NHS England.[8]

[8] Available at: http://web.bma.org.uk/pressrel.nsf/wall/7F292609A7880F3580257F2C003B72E3?OpenDocument [accessed: 11 February 2016]

Chapter 6: Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities

The use of restraint

Progress since our previous report

There are very few deaths resulting from the use of restraint in the three settings, however the fact that there are some means it continues to be an area of concern for those working in the field.

Progress is being made in the police setting where measures are being introduced to improve guidance on the use of restraint and the collection and collation of data. Changes are being made to improve the recording of data where restraint has been used by police officers, including in psychiatric hospitals.

A Mental Health and Restraint Reference Group has been established, led by the College of Policing and independently chaired by Lord Carlile, to examine the role of police in restraint and the use of force specifically during psychiatric emergencies. The Equality and Human Rights Commission is a member of this group. New guidance is due to be published in 2016.

In 2015, HMIC and HMIP reviewed the assessment criteria (the 'Expectations for Police Custody') for their joint inspections of police custody, drawing on learning from HMIC's thematic inspection on the welfare of vulnerable people in police custody (HMIC, 2015). The revised 'Expectations' will be published in Spring 2016 and will strengthen the inspectorates' focus on vulnerability and the use of force in custody.

A further change is the proposal to introduce an Annual Data Requirement (ADR) on the use of force, due to be in place from 2017/18. This is a welcome development as it will enable the analysis of data on the use of aid transparency and accountability and help to enable the identification of any disproportionality in the use of force, including restraint, to allay public concerns.

Data on the use of restraint in prisons are still only collected in the youth secure estate and not in adult prisons. The Government's response to our inquiry recommendations stated: 'While there are no plans to publish use of force data relating to the wider prison estate, it is released in response to Parliamentary Questions and Freedom of Information Act 2000 requests.' (see Appendix 2).

The recording of data on restraint incidents in hospitals in England is incomplete, with only 46 out of 67 mental health organisations submitting returns in 2013/14 (Health and Social Care Information Centre, 2014). Without this data, it is difficult to monitor practice, either locally or nationally (CQCa, 2015). However, from 2016, data on the use of restraint and other restrictive interventions will be included in the Health and Social Care Information Centre (HSCIC)'s Mental Health and Learning Disability Minimum Dataset. Additional work has focused on increasing the number of complete returns and improving definitions to strengthen robustness and comparability between organisations (DH, 2014). We hope that these changes will lead to improvements in the collection of data on the use of restraint in hospitals.

Commission recommendations 2016

Data on the use of restraint should be routinely published in the prison setting by the Ministry of Justice, to aid transparency and accountability.

Violence and safety in prisons

Progress since our previous report

According to data from the Ministry of Justice (2015), there were eight homicides in prisons in 2015; the highest number since 1978. Inspections by HMIP have identified concerns about levels of safety within prisons and rising levels of violence. In its 2014-15 Annual Report, HMIP highlighted concerns about increasing levels of violence in prisons, stating: 'You were more likely to die in prison than five years ago. More prisoners were murdered, killed themselves, self-harmed and were victims of assaults than five years ago' (p. 8). PPO (2015) has stated that there 'remains an urgent need to improve safety in custody' (p. 3).

The use of New Psychoactive Substances (NPS) has been linked to violence and may be connected to some of the non-natural deaths in prisons, according to PPO. PPO has reported emerging evidence from its investigations suggesting that the use of NPS poses dangers to both physical and mental health, and there may in some cases be links to suicide or self-harm. HMIP's 2014-15 Annual Report confirms that their use has grown, leading to problems such as bullying, debt and medical emergencies requiring hospitalisation.

The Government acknowledges that violence in prisons has increased in recent years. In a debate in Parliament in January 2016,[9] the Secretary of State for Justice acknowledged this, stating: 'There is no single, simple solution to the problems we face, but we are determined to make progress.' Changes being introduced by the Government include trialling the use of body-worn cameras and training sniffer dogs to detect NPS.

Legislation is being introduced through the Psychoactive Substances Bill to make it an offence to produce, supply, offer to supply, possess with intent to supply, import or export psychoactive substances. In September 2015, HMIP made a submission to the Home Affairs Committee Inquiry on NPS, which outlined some concerns about the proposed legislation.[10]

[9] Available at: http://www.theyworkforyou.com/debates/?id=2016-01-11b.573.0&s=speaker%3A11858%22+l+%22g573.2pq%3DLj0oHg [accessed: 11 February 2016]

[10] http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/HMIP-submission-to-HASC-inquiry-on-NPS.pdf [accessed: 11 February 2016]

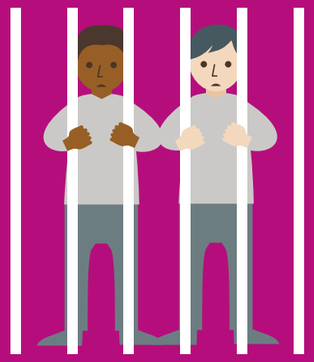
Risk assessments in prisons

Progress since our previous report

In prisons, formal risk assessments are carried out by both prison and healthcare staff on reception, and all staff are responsible for identifying prisoners at risk of self-harm or suicide throughout their time in custody. The review of the ACCT case management process for prisoners at risk found that the guidance to staff on risks and triggers could be improved and there are plans to revise it during 2016.

PPO continues to raise concerns about risk assessments in prisons. Its 2014–15 Annual Report says that: 'Throughout the year, we continued to investigate a number of deaths where we found that the staff had not assessed the level of a prisoner's risk appropriately and had not opened ACCT procedures when it appeared appropriate. On occasions, prison reception staff, in particular, put too much emphasis on the prisoner's presentation, rather than fully taking into account known risk factors' (p. 23).

NOMS has completed a review of the effectiveness of the ACCT process in the adult prison estate. The review has explored a range of issues that have been identified by PPO investigations, HMIP reports, coroners' inquests, and NOMS internal audits. Additionally, NOMS has undertaken internal research to obtain the views of both prisoners and staff on the ACCT process at a number of prisons. The review has been completed and NOMS will be implementing the recommendations in 2016. Getting the ACCT process right will be crucial to improving lives of vulnerable people in prison.



'You were more likely to die in prison than five years ago. More prisoners were murdered, killed themselves, self-harmed and were victims of assaults than five years ago'.

(HMIP Annual Report 2014-15, p. 8)

Commission recommendations 2016

The changes being made through the review of the ACCT process used to manage and support prisoners who are at risk of suicide or self-harm, including changes to the guidance for staff on risks and triggers, should be the right ones to ensure they are effective. Training should be provided to staff to ensure they know how to use the process.

The use of segregation in prisons

Progress since our previous report

We continue to be concerned about the use of segregation for prisoners with mental health conditions.

In 2013/14, there were eight self-inflicted deaths of prisoners in prison segregation units, four of whom had been assessed as at risk of suicide and self-harm, according to PPO (2015a).

The Prison Service's own instructions recognise the potentially damaging effect of segregation on those who may be at risk of suicide and self-harm but the PPO (2015a) says that too often staff do not give enough consideration to other options. The UK National Preventative Mechanism (HMIP, 2015) has undertaken work on segregation (isolation and solitary confinement) across all detention settings, including commitments for next steps.

NOMS has recently made amendments to its segregation policy, which arose as a result of a Supreme Court judgment (*R (on the application of Bourgass and another) v Secretary of State for Justice* [2015]). NOMS is undertaking a wider review of segregation policy and in early 2016 will be consulting on further changes to the segregation system. Both HMIP (2015a) and PPO (2015b) submitted detailed comments to the consultation by NOMS on the changes to its segregation policy.

Commission recommendations 2016

Segregation should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance, which is clearly defined and understood by prison staff.

People being held in police cells under sections 135/136 of the Mental Health Act 1983

Progress since our previous report

There has been a welcome reduction in the use of police cells as places of safety for people detained under sections 135/136 of the Mental Health Act 1983. During 2014/15, the HSCIC (2015) report that: 'Over the same period the number of instances where section 136 was used to make a short-term detention to a police cell fell by 33.7 per cent in England, according to data published by the National Police Chiefs' Council'.

We welcome Home Secretary Theresa May's announcement in May 2015 that an extra £15 million of DH money would be made available for the provision of more health-based places of safety.

Legislation is being introduced through the Policing and Crime Bill to take forward the policing powers elements of the review of the use of sections 135 and 136 of the Mental Health Act 1983. This will prohibit the use of police cells as places of safety for those under 18 years of age and further reduce their use for adults.

The National Police Chiefs' Council has begun to publish some data on people detained under the Mental Health Act 1983 and more extensive data will be collected in 2015/16. This will aid transparency and enable an assessment of disproportionality in the use of detentions on age or ethnicity grounds. The data collected will include the number of detentions under sections 135 and 136, the age and ethnicity of detainees, type of place of safety used, including where police custody is used and the reason for this, and the mode of transportation (including where a police vehicle is used, the reason for this). Forces will provide the data for 2015/16 – which the Home Office will subsequently publish – on a voluntary basis with a view to it becoming a mandatory part of the Home Office's ADR for section 135 and 136 of the Act for all forces in England and Wales from 2016/17.

Case study: Dorset street triage and Liaison and Diversion scheme – update

A short case study for the Dorset Liaison and Diversion scheme was in the original inquiry report.

This has continued to evolve alongside street triage over the last 12 months. The aim of street triage is that the police and NHS work together, with mental health specialists typically embedded into the front line police response. To underpin this development, they have sought to gain a better understanding of the characteristics of those they detain under section 136. Bournemouth University was commissioned to carry out this research, which examined the use of section 136 in Dorset during the six-month period April to September 2015.

The resulting (unpublished) report set out factors which contributed to the need to use section 136. Suicidal thoughts were recorded in 79% of the 203 cases recorded during this period. Other factors were: drug and alcohol misuse (56%); interpersonal relationship problems (45%); and accommodation issues (16%). (Most cases involved more than one factor.) The study has given valuable insights into complex needs. Given the range of factors involved, the report indicated that a holistic approach to service provision was needed. A multi-agency commissioning group has recently been established in Dorset that includes a range of health and care services. One of the key challenges they face is that thresholds for referral are high. Their response has been to plan and commission more preventative services, often in close collaboration with the third sector, such as providing a support worker to those who appear regularly in custody.

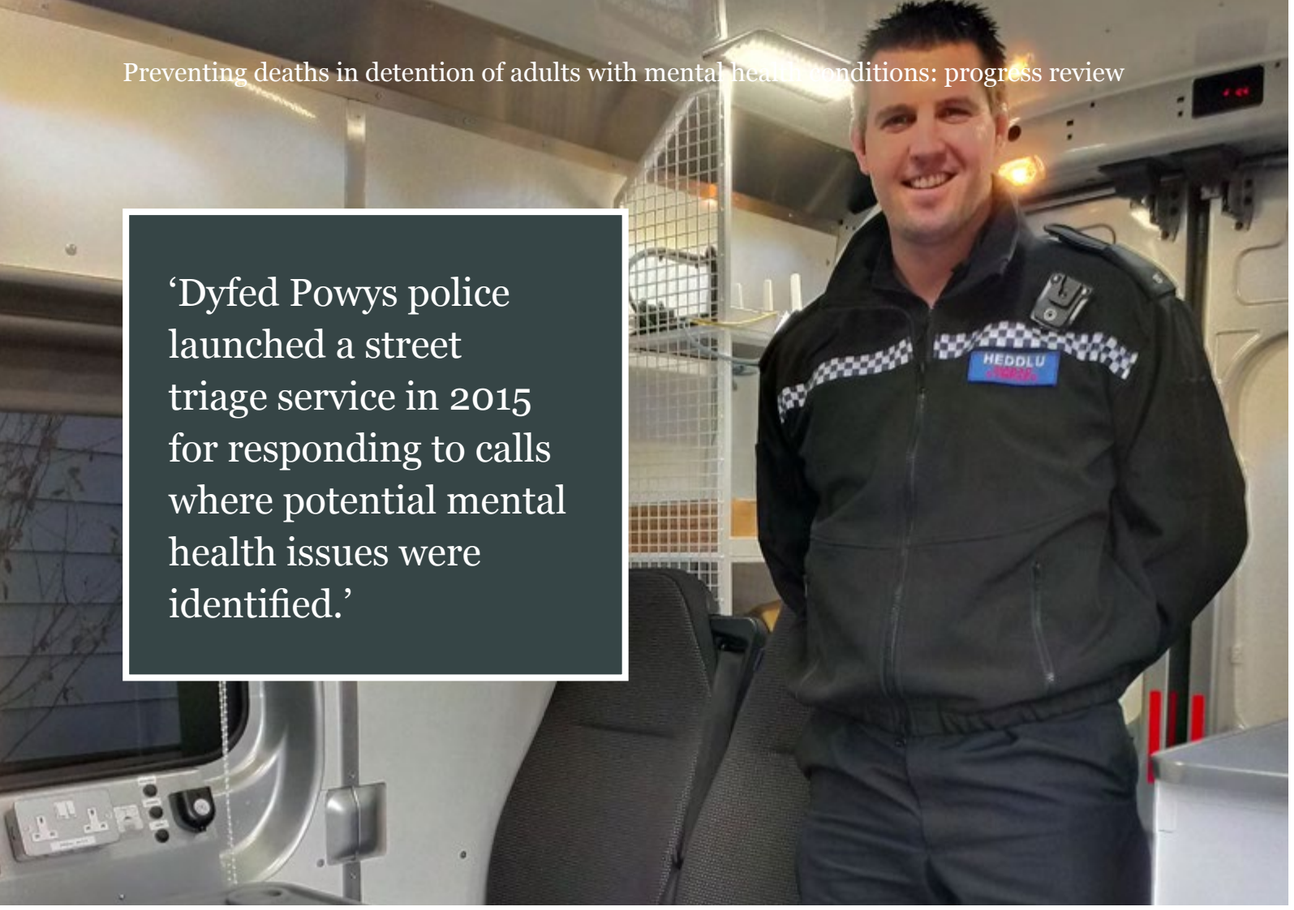
Section 136 detention: factors contributing to a mental health crisis

Case study: Dyfed Powys street triage

Dyfed Powys police launched a street triage service in 2015 for responding to calls where potential mental health issues were identified.

The aim was to ensure that the least intrusive options were used whenever possible. Section 136 detentions typically take up a considerable amount of police time. Use of police custody for these detainees has dropped by nearly 50 per cent in the first 12 months, which represents a considerable efficiency saving. Initially, significant effort and persuasion were needed to embed effective partnerships across police, health and social services. The size and rural nature of the area have influenced the type of triage service developed. A hybrid model was adopted that combined an unmarked police vehicle with telephone support to front line officers.

Those delivering the service have been given the autonomy to continually reshape and develop it, as their understanding and analysis has developed. Regular reviews and re-evaluation, supported by the University of South Wales, have helped inform their thinking. In future this will include an 8–12 week follow-up with detainees to identify best practice. An unexpected finding has been the client group is much older than anticipated, with considerable demand coming from single males aged over 65. Strong support and buy-in at a senior level has helped the team embed a more sophisticated view of mental health across the force and develop the confidence to deal with most mental health situations.



‘Dyfed Powys police launched a street triage service in 2015 for responding to calls where potential mental health issues were identified.’

Progress in implementing the Crisis Care Concordat in England and Wales

Progress since our previous report

Analysis of the impact of the Mental Health Crisis Care Concordat shows it has been a significant development in improving crisis care. The Concordat has received widespread support and been hailed as an effective catalyst for partnership working between the police, health services and other agencies.

While recognising that it is only one measure, sustained progress has been achieved in the reduction in the use of police cells for section 135 and section 136 detentions. All areas now have action plans and most have updated these and produced progress reports. The major success has been in partnership working between all services involved in crisis care support and much better integration and understanding of what each organisation can do. It is also making the difficult transition from pilot status to a sustainable and embedded programme.

A development in Wales is the introduction in December 2015 of a Mental Health Crisis Care Concordat by the Welsh Government in partnership with key health and police bodies. The Concordat commits organisations that have signed up to it to work together to intervene early and, if possible, to reduce the likelihood of people posing a risk to themselves or others as a result of a mental health condition. A key part of the approach is to substantially decrease the use of police custody for the purpose of detaining people with mental health conditions.

We welcome the introduction of a Concordat in Wales and hope that it will ensure that people experiencing a mental health crisis are able to get the support and treatment they require.

Staff training on mental health

Progress since our previous report

We are pleased to see that some improvements have been made to the training available.

For police officers and staff, a comprehensive new Approved Professional Practice (APP) on mental health has been developed by the College of Policing and will be available from April 2016. The APP will be for staff members who have contact with the public and those who have a strategic oversight role. This APP should help to address substantial concerns about the very limited training police officers receive as part of their initial training.

In the prison setting, NOMS has reviewed the entry-level training that all new prison officers receive and from January 2016 a new 10-week Prison Officer Entry Level Training course and supporting qualification will be introduced. As part of this, all new recruits will receive training in basic life support. This revised course will have expanded content in relation to safer custody and mental health issues, and there will be more emphasis on building stronger staff-prisoner relationships.

Chapter 7: In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families

Statutory duty of candor

Previous report recommendation/s

We recommended that:

- If the statutory duty of candour introduced in April 2015 proves to be effective, it should be applied to the other settings too, particularly in investigations and inquiries into non-natural deaths.

Progress since our previous report

There has been no formal analysis of the impact of the duty of candour.

The Government's response to the Harris Review of self-inflicted deaths of 18–24 year olds in NOMS custody rejected the recommendation for a statutory duty of candour to be placed upon staff working in prisons (Ministry of Justice, 2015a). The reason stated for this was that 'NOMS staff are required to behave in accordance with the Professional Standards statement (see PSI 06/2010 Conduct and Discipline)', which states that they 'must carry out their duties loyally, conscientiously, honestly and with integrity. They must take responsibility and be accountable for their actions' (p. 57).

Commission recommendations 2016

The impact of the statutory duty of candour which applies to NHS bodies in England should be formally evaluated by the Government in 2016 so that any recommended improvements can be made and shared across other public service functions, including the prison and police settings.

Numbers of beds in psychiatric hospitals

Evidence to the Equality and Human Rights Commission's (2015a) comprehensive review of progress towards greater equality and human rights protection in Britain is that a lack of sufficient community-based provision, together with reductions in numbers of beds in mental health units in England, leads to delays in accessing services and placements a long distance away from home, family and friends. In 2015, CQC reported continued problems with access to beds in adult mental health inpatient settings (CQC, 2015b). Regular contact with families is important and they can provide critical support to their relatives who have been detained in psychiatric hospitals. It is therefore important that there is sufficient provision of beds in psychiatric hospitals and community-based provision to ensure that families do not have to travel long distances to see their family member.

Involvement of families in investigations

Progress since our previous report

We are pleased that steps have been taken in the right direction in all three settings to improve the involvement of families.

For healthcare settings, NHS England published a revised Serious Incident Framework in March 2015, which builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. This includes guidance on the involvement of families. DH (2015) recently updated their guidance on investigations and the application of Article 2 of the ECHR, which should be read in conjunction with the Serious Incident Framework.

In the prison setting, responses to a survey by the PPO (2015c) of the bereaved families of people who died in the prisons and immigration removal estates between 2013 and 2015 indicated that most families found the service provided by the PPO useful and felt they were dealt with sensitively and professionally.

The forthcoming independent review into deaths and serious incidents in police custody includes a particular focus on family involvement and the support they experience at all stages (Home Office, 2015).

Commission recommendations

Families should be fully involved in the investigations process and given relevant information and support throughout and following the outcome. This will help to ensure that lessons can be learned to prevent future deaths.

Quality of data about the deaths of detained patients

Previous report recommendation/s

We recommended that:

- The Secretary of State for Health should establish responsibility for ensuring oversight of investigations in psychiatric hospitals and national collation of data.

Progress since our previous report

To address this problem, we organised a seminar with the key organisations with responsibility in this area to agree an action plan. This took place in February 2016 and was chaired by Professor Louis Appleby of the NCISH and non-executive director of CQC. Organisations in attendance at the seminar included NHS England, DH, CQC, Office for National Statistics, Public Health Wales, IAP and HSCIC.

Commission recommendations 2016

The agreed action plans from the seminar on data collection (hosted by the Equality and Human Rights Commission) will be shared with the IAP and the Ministerial Council on Deaths in Custody.

Chapter 8: The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings

Progress since our previous report

A number of organisations have used our Article 2 Human Rights Framework in their work (see Appendix 3). We have highlighted below some examples of how our Framework has been used.

Care Quality Commission

CQC has shared the Framework with its inspections and policy teams for use when reviewing or investigating issues relating to the deaths of detained patients. CQC is planning further development work with the products and tools for inspection teams in 2016/17 and continues to be informed by the Framework.

South Staffordshire and Shropshire Foundation Trust

Norbury Psychiatric Intensive Care unit launched a pilot in December 2015. This six-month project aims to implement a human rights approach around the use of physical interventions. Human rights training covering both legal aspects and practice was delivered to staff and patients. This focused on understanding Article 2, obligations on right to life, the Equality and Human Rights Commission Article 2 Framework and linking that to National Institute for Health and Care Excellence (NICE) guidelines requiring the least restrictive approach. Surveys and exit tools will be used with patients as well as monitoring serious incidents, complaints and suggestions. These will assessed at the end of the pilot in July 2016.

In addition to the above examples demonstrating the use of our Framework, HMIP has informed us that it will consider using our Framework in any future reviews of its Expectations, which are independent criteria based on relevant international human rights standards and are used in its inspections.

Individualised care

The Equality and Human Rights Commission's Human Rights Framework includes the rights to proportionate individualised protection where the detainer knows or should know there is a real and immediate risk to life. We have seen initiatives that demonstrate the benefits of this approach. One example is HM Prison Cardiff where a new process has been introduced during the first night screening process. HM Prison Cardiff has developed guidance to assist staff in assessing risk. It identifies particular factors that can increase risk, including particular offences such as domestic violence against an intimate partner or a close family member.

Further detail about this initiative can be found at:
www.equalityhumanrights.com

Commission recommendations 2016

Article 2 (the Right to Life) should be central to the development of policies, procedures and investigations into deaths of people in the care of the state. The Equality and Human Rights Commission's Article 2 Framework should be used to support this.

Setting up new institutions

Previous report recommendation/s

We recommended that:

- The setting up of new institutions (such as Secure Training Centres and the North Wales Prison in Wrexham) must incorporate policies that explicitly address human rights obligations and incorporate the Equality and Human Rights Commission's Human Rights Framework.

Progress since our previous report

A new prison is currently being developed in North Wales. We met with the Head of Safer Custody for the prison, where we reiterated the need for the development of the prison to address human rights obligations and our Article 2 Framework. In the Government response to our inquiry, the Ministry of Justice stated that: 'All new prison establishments are required to comply with existing NOMS policy which recognises human rights obligations.' (see Appendix 2).

In a speech in November 2015 the Secretary of State for Justice announced plans to close old Victorian prison buildings and replace them with new more modern prisons to significantly improve their security and safety (HM Treasury *et al.*, 2015). The Equality and Human Rights Commission expects the development of any new prisons to ensure compliance with Article 2 of the ECHR and our Human Rights Framework.

Commission recommendations 2016

The setting up of new institutions that detain individuals must incorporate policies that explicitly address human rights obligations and incorporate our Human Rights Framework.

'All new prison establishments are required to comply with existing NOMS policy which recognises human rights obligations.'

Chapter 9: Progress review in Scotland

Following the publication of the Equality and Human Rights Commission's inquiry report (2015b), key stakeholders across the sectors (police, prisons, hospitals) submitted action plans to the Commission in Scotland, based on the five Scottish recommendations made in the report. The Commission will review progress against these action plans in October 2016. The update below reflects work that has been undertaken at this mid-point, and planned future activity which was highlighted in the action plans for 2016.

Legal update

In December 2015, the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill was passed by the Scottish Parliament. Currently, Fatal Accident Inquiries (FAIs) are not mandatory for people who die while detained under mental health legislation. An amendment to the Bill was tabled to change this but was not taken forward. However, section 37 of the Mental Health (Scotland) Act 2015[11] requires the Scottish Government to carry out a review of the arrangements for investigating the deaths of patients who, at the time of death, were detained in or admitted voluntarily to hospital for the purpose of receiving treatment for a mental disorder.

This review must be carried out within three years of that section coming into force, which means by 24 December 2018. The Scottish Government has however given an undertaking in Parliament that the review should commence as soon as possible.

[11] Available at: http://www.legislation.gov.uk/asp/2015/9/contents/enacted [accessed: 11 February 2016]

A new provision in the Inquires into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill requires all participants at FAIs to whom a sheriff has directed a recommendation to respond in writing. They must set out how they propose to implement the recommendation or an explanation of why they are not complying. Scottish Ministers will be required to produce an annual report on responses to recommendations.

Update across settings

Police

There were five deaths in police custody in 2014 and no deaths in 2015. The Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) Custody Inspection Framework is under review. As part of this work, HMICS have completed an exercise to map the Equality and Human Rights Commission's Human Rights Framework against their own Custody Inspection Framework. HMICS will continue to develop their Framework further in 2016 following completion of the review.

Across Scotland, Police Scotland and NHS Boards are working collaboratively to develop a model of mental health community triage. This follows successful work undertaken between January and June 2015 involving Police Scotland and NHS Greater Glasgow and Clyde Crisis Out of Hours CPN Service.

Police Scotland have developed e-learning training on mental health awareness for all staff and a four-hour blended learning package on dealing with people in mental health crisis/suicide prevention. This training was delivered to all probationers throughout 2015 and will be rolled out to all operational officers. Police Scotland are developing a suicide prevention document focused on people coming in to police custody and also includes the pre-release risk assessment process.

The Police Investigations and Review Commissioner (PIRC) are reviewing the feasibility of widening the protected characteristics[12] currently collated in relation to non-natural deaths.

[12] This refers to the nine characteristics protected under the Equality Act 2010, and the grounds upon which discrimination is unlawful. The characteristics are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

The total number of deaths in prison in Scotland in 2014 was

24 natural and non-natural,

the same as in 2013

Prisons

As most of the deaths in prison are not yet determined by an FAI, it is not possible to comment on the number of non-natural prison deaths in 2014. The total number of deaths in prison in Scotland in 2014 – both natural and non-natural – was 24, the same as in 2013.

HMIPS introduced new standards for inspecting and monitoring prisons in March 2015. These standards are based on a large body of legislation, guidance and case law. HMIPS are introducing a new 'post-inspection' process that aims to facilitate continuous improvement within Scottish prisons.

Hospitals

Updated figures for the number of non-natural deaths of detained patients in hospitals are not available.

In November 2015, the Chief Medical Officer for Scotland issued a formal letter to practitioners on instruction from the Lord Advocate to highlight updated guidance on reporting deaths to the Procurator Fiscal. The death of any patient who was subject to compulsory treatment under mental health legislation at the time of their death should now be reported to the Procurator Fiscal, even where deaths appeared to be from natural causes. The Chief Medical Officer stated: 'The change has been introduced to ensure that these deaths are given the appropriate level of scrutiny in accordance with Article 2 of the European Convention on Human Rights' (p.1).

Cross-cutting

Since December 2015, the Mental Welfare Commission for Scotland (MWC) has been publishing reports of all visits to services. In 2016, the MWC will provide training on the Equality and Human Rights Commission's Human Rights Framework for staff, and will review their investigations work. This will consider whether human rights considerations, particularly our Framework, is appropriately embedded in the processes for considering the deaths of patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.[13] This work is due to be completed by September 2016. The MWC will publish three national reports during 2016, based on a programme of visits to people in a range of settings, many of whom will be detained. Relevant human rights issues will be highlighted in these reports.

'Across Scotland, Police Scotland and NHS Boards are working collaboratively to develop a model of mental health community triage.'

(c) Graham Barclay/Bloomberg via Getty Images

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Appendix 1: Previous inquiry recommendations

Recommendation 1

Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

All settings

Responsible agencies in all three settings should ensure that recommendations from investigations are followed up and lessons are learned.

Investigatory bodies need to continue to improve (or monitor and review) the quality of their investigations and their involvement with the bereaved families.

We recommend that the review of the role of the Independent Advisory Panel on Deaths in Custody (IAP) in 2015 should reflect the impact of their work to date and consider how they could ensure their initiatives are integrated into the working practice of detention settings. The Equality and Human Rights Commission ('the Commission') will feed into this review.

Prisons

The setting up of new institutions (such as Secure Training Centres[14] and the North Wales Prison in Wrexham) must incorporate policies which explicitly address human rights obligations and incorporate the Commission's Human Rights Framework.

The Government should consult on their proposed improvements to mental health services within prisons. These improvements should be matched with sufficient resources.

A thorough review should be conducted to understand the increase in non-natural deaths from 2013 in order to implement recommendations in 2015, either by a thematic review by Her Majesty's Inspector of Prisons (HMIP) or other urgent means.

Recommendation 2

Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined-up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.

All settings

Organisations which do not deliver to the standards outlined in the Commission's Human Rights Framework risk being in breach of human rights obligations.

Risk assessments need to be carried out, be effective, be reviewed regularly and shared with all relevant agencies and staff.

Training in mental health awareness should be mandatory and ongoing for all frontline staff so they are better able to identify and appropriately support people with mental health conditions.

[14] See: http://www.equalityhumanrights.com/legal-and-policy/our-legal-work/parliamentary-briefings/criminal-justice-and-courts-bill-2014-use-physical-restraint-secure-colleges [accessed: 19 February 2016]

There needs to be a clear process which sets out how the implementation of recommendations from investigations into a death (including the inquest) will be followed up. This is the joint responsibility of those who run individual institutions and the regulatory and inspectorate bodies which make those recommendations.

We recommend increased statutory obligations on institutions to publically respond to recommendations (for example, through action plans) from inspectors and regulators in relation to deaths in detention.

We recommend that the IAP principles for safer restraint are fully implemented in the three settings. Restraint should only be used when all other options to keep detainees and others (including staff) safe have been exhausted.

Prisons

Prisons should set up a system that alerts staff of possible events or dates which may trigger increased vulnerability for a prisoner (for example, anniversary of imprisonment, bereavement or trial date).

Segregation[15] should not be used for prisoners with mental health conditions, unless there is an exceptional circumstance. An 'exceptional circumstance' should be clearly defined and understood by prison staff. Where prisoners with mental health conditions are segregated, their level of risk and the requirement to be segregated should be regularly reviewed.

Police

Each police force needs a dedicated senior lead and resources on mental health (as in South Wales) to ensure appropriate support (including diversion routes) to people in custody.

The Government to continue the financial commitment to ensuring the provision of sufficient mental health crisis care so that people receive appropriate treatment when it is needed and police cells are not used as a place of safety.

[15] For the purpose of our report, 'segregation' is when a prisoner is kept apart from other prisoners and they may be kept in another part of prison called the segregation unit.

Recommendation 3

In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour that applies to NHS bodies in England. If it proves to be effective, this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

All settings

Families should be fully involved in the investigations process and given appropriate information and support.

The Chief Coroner to continue to produce summary reports (as outlined in the Coroners and Justice Act 2009)[16] from Preventing Future Deaths Reports, particularly to ensure there is the opportunity for learning from non-natural deaths in psychiatric hospitals.

The use of force/restraint should be recorded, monitored and the data made publically available in all detention settings, including where the police use force on detained patients in a hospital setting (IAP, 2013).

Psychiatric hospitals

The Secretary of State for Health should establish responsibility for ensuring oversight of investigations in psychiatric hospitals and national collation of data. The Government should reconsider appointing an independent body to investigate deaths of detained patients in psychiatric care.

NHS Wales and Healthcare Inspectorate Wales data should be systematically collected, analysed and made publically available with full breakdowns by protected characteristics as defined in the Equality Act 2010.[17]

[16] Available at: http://www.legislation.gov.uk/ukpga/2009/25/contents [accessed: 11 February 2016]

[17] Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents [accessed: 11 February 2016]

Prisons

Each prison establishment to ensure it has a staff member responsible for identifying and implementing learning from investigations and work to prevent deaths being undertaken in other prisons. They should ensure there is accurate data relating to the numbers of prisoners with a mental health condition to enable appropriate resource planning.

Recommendation 4

The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

The following points explain how the Framework can support those responsible for the detention of people.

All 12 steps in section A must be taken to prevent otherwise avoidable deaths.

It should be used to inform and shape policy decisions in all three settings at national and local level.

It should be used as a practical checklist by individual institutions to measure Article 2 compliance.

It should be used as a practical checklist for those tasked with investigating deaths in detention.

It should be used as a flexible measurement tool which can be adapted by individual institutions to tailor the steps required to be taken to secure Article 2 compliance.

Appendix 2: Cross-Government response to previous inquiry recommendations

Recommendations from EHRC report: 'Preventing deaths in detention of adults with mental health conditions'

February 2015

Government Response: Department of Health, Ministry of Justice and Home Office

Recommendation 1

Structured approaches for learning lessons in all three settings [prisons, police cells and hospitals] should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

All settings

Responsible agencies in all three settings should ensure that recommendations from investigations are followed up and lessons are learned.

Investigatory bodies need to continue to improve (or monitor and review) the quality of their investigations and their involvement with the bereaved families.

We recommend that the review of the role of the Independent Advisory Panel on Deaths in Custody (IAP) in 2015 should reflect the impact of their work to date and consider how they could ensure their initiatives are integrated into the working practice of detention settings. The Equality and Human Rights Commission (the Commission) will feed into this review.

Department of Health Response:

- NHS England is responsible for coordinating and delivering national guidance, information and support for investigations. It will publish a new Serious Incident Framework shortly. The Framework seeks to support the NHS to ensure that robust systems are in place for reporting, investigating and responding to serious incidents so that lessons are learned and appropriate action is taken to prevent further harm.
- Openness and transparency are key to prevention and the Framework includes the publication of both investigation reports and action plans to prevent recurrence as good practice.
- In developing the Framework, NHS England have engaged with a group of families and family representatives of those bereaved by serious incidents to try and improve family involvement in investigations by understanding 'what good involvement looks like'. This has informed the revised Framework, which puts patient and family involvement at the centre of the process.
- The Government has placed a new duty of candour on all health and care organisations to ensure that when something goes wrong, patients and their relatives are told about it promptly. The duty of candour came into force for NHS bodies in November 2014 and will be extended to all providers registered with the Care Quality Commission (CQC) in April 2015.
- In order to lay the foundation for the continuing improvement of healthcare quality and safety in England, CQC have introduced a new inspection regime: new fundamental standards which come into force for all providers of health and social care in April 2015; a new intelligence-led model of inspection using expert inspectors, clinical specialists and including public representation; and new enforcement powers for CQC including co-ordination of powers with other bodies.
- DH welcomes the review of the role of the Independent Advisory Panel on Deaths in Custody (IAP) as part of the ALB triennial review and will contribute fully.

Ministry of Justice Response:

- NOMS makes strenuous efforts to learn from every death in custody. Our processes for learning from deaths are described in detail in Prison Service Instruction 64/2011: Safer Custody.
- We respond to all recommendations from the Prison and Probation Ombudsman (PPO) and these responses are published with the final version of the PPO report.
- We respond to concerns raised by Coroners in prevention of future deaths reports in accordance with our statutory duty to do so, and our responses are published on the Chief Coroner's website.
- NOMS welcomes, supports and will contribute to the triennial review of the IAP.

Home Office Response:

- There is a legal duty on recipients to respond to recommendations from IPCC investigations. They do not have to carry out the recommendation, but they do have to say what action they have taken, or plan to take; or why they have not taken, or do not plan to take, any action. They must provide responses within 56 days.
- Forces have a legal duty to publish a response to HMIC inspections under section 55 of the Police Act 1996. This duty does not require forces to respond specifically to recommendations made.

- The Home Office has no immediate plans to change these legislative arrangements, but is examining how collectively we can better take advantage of lessons learned from various agencies.
- Following the March 2014 publication, Review of the IPCC's work in investigating deaths, the IPCC is working to implement measures to improve the quality of investigations, and the family liaison experience, following a death in custody.
- The Home Office will consider this recommendation together with co-sponsors of the Ministerial Council on Deaths in Custody.

Prisons

The setting up of new institutions (such as Secure Training Centres and the North Wales Prison in Wrexham) must incorporate policies which explicitly address human rights obligations and incorporate the Commission's Human Rights Framework.

The Government should consult on their proposed improvements to mental health services within prisons. These improvements should be matched with sufficient resources.

A thorough review should be conducted to understand the increase in non-natural deaths from 2013 in order to implement recommendations in 2015, either by a thematic review by HMIP or other urgent means.

Ministry of Justice Response:

- All new prison establishments are required to comply with existing NOMS policy which recognises human rights obligations.
- The Justice Secretary recently announced his intention to develop new options for improving mental health provision for offenders, including specialist provisions in prisons. These options are being developed with partners in the Department of Health and NHS England, as well as the Welsh Government.

- We continue to review recent self-inflicted deaths to try to understand the reasons for the increase. We have increased safer custody resource to support best practice in prisons, and held two national learning days for staff during 2014 at which lessons learned were shared.
- In March 2015 the PPO published 'Learning from Self-inflicted Deaths in 2013-14', a learning lessons bulletin that pulls together his analysis of deaths in 2013-14. We welcomed this and have ensured that it is disseminated widely across the prison estate with instructions to safer custody teams in all prison establishments to use learning points identified within it to review their local procedures.

Recommendation 2

Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined-up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.

All settings

Organisations which do not deliver to the standards outlined in the Equality and Human Rights Commission's Human Rights Framework risk being in breach of human rights obligations.

Risk assessments need to be carried out, be effective, be reviewed regularly and shared with all relevant agencies and staff.

Training in mental health awareness should be mandatory and ongoing for all frontline staff so they are better able to identify and appropriately support people with mental health conditions.

There needs to be a clear process which sets out how the implementation of recommendations from investigations into a death (including the inquest) will be followed up. This is the joint responsibility of those who run individual institutions and the regulatory and inspectorate bodies which make those recommendations.

We recommend increased statutory obligations on institutions to publically respond to recommendations (for example through action plans) from inspectors and regulators in relation to deaths in detention.

We recommend that the IAP principles for safer restraint are fully implemented in the three settings. Restraint should only be used when all other options to keep detainees and others, including staff, safe, have been exhausted.

Department of Health Response:

- DH and NHS England take compliance with human rights obligations very seriously. The Commission's Framework is a welcome additional resource to support organisations deliver safe and compassionate care.
- The revised Mental Health Act 1983 Code of Practice sets out detailed guidance on the importance of comprehensive risk assessments of those detained under the Act to ensure that their clinical needs are met whilst maintaining their safety and the wider public safety.
- NHS England currently commissions healthcare in prisons. Commissioned health services carry out risk assessments at reception and these are reviewed when health interventions are delivered.
- Providers of health services in prison settings are expected to support their staff in accessing mental health training as part of their professional development and health care staff should meet the professional requirements of their role.
- NHS England will be publishing a revised Serious Incident Framework shortly, which clearly sets out how NHS organisations should work with other organisations (such as the Coroner, CQC and PPO) in relation to investigations and their recommendations.
- The Framework also requires investigation reports to be published in the spirit of openness and transparency.
- 'Positive and Proactive Care' (DH, April 2014) aims to develop a culture across health and social care where physical interventions (restraint) are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time.

- As regulator of the Mental Health Act 1983, the CQC monitors how services exercise their powers and discharge their duties in relation to patients who are detained in hospital or subject to community treatment orders or guardianship. This is to provide a safeguard for individual patients whose rights are restricted. Deaths of detained patients are notified to CQC and this information is reported as part of the CQC annual report.
- The CQC is undertaking analysis of the information available from coroners' investigations and inquests, along with other information it already receives on expected and unexpected deaths.
- The CQC is also working with the Coroners' Society of England and Wales and the Office of the Chief Coroner to establish a memorandum of understanding with the aim of achieving better working relationships and the sharing of information.

Ministry of Justice Response:

- All prisons are required to have procedures in place to identify, manage and support people who are at risk of harm to themselves. Building on this, the National Offender Management Service (NOMS) has put in place additional resources for safer custody work in prisons and at regional level. These staff support safer custody work in prisons and share good practice across establishments.
- PSI 64/2011 Safer Custody explains that it is the responsibility of the safer custody team at the establishment to ensure that action is taken to address recommendations in PPO reports and that concerns raised in regulation 28 reports are addressed. NOMS Equality, Rights and Decency Group takes receipt of the draft version of each PPO report and works with staff at the establishment to check factual accuracy and to formulate an action plan to address the recommendations that is published by the PPO alongside the final report. Most establishments have consolidated safer custody action plans that bring together actions to address PPO recommendations with those derived from other sources, such as audits and inspections.
- In the course of their inspections, HM Inspectorate of Prisons checks the extent to which action has been taken to address the recommendations of PPO investigations into recent deaths and includes information about this in their inspection reports.

- NOMS recognises that prison staff should be provided with an insight into common mental health issues and the need to refer prisoners to qualified specialists in line with their local provision. Over 17,000 prison staff received mental health awareness training between 2006-2009, and this has since been incorporated into the initial training of all new prison officers.
- The Safer Custody suite of training for staff includes a module offering an Introduction to Mental Health, which is available for Governors and Directors to use if they wish to do so. Additionally, there is an enhanced mental health training package aimed at Assessment, Care in Custody and Teamwork (ACCT) assessors and case managers that they are required to complete before taking up their role. ACCT is a system designed to reduce the risk of suicide and self-harm.
- NOMS works closely with health and other partners who have an important role to play in supporting vulnerable prisoners.
- NOMS policy (PSI 64/2011 Safer Custody, PSI 75/2011 Residential Services and PSI 07/2015 Early Days in Custody) is clear about the assessments that should take place – by both custodial staff and healthcare providers – and the requirement to share information with all relevant staff.
- NOMS policy (PSO 1600 Use of Force) complies with the IAP principles on safer restraint.

Home Office Response:

- All police officers receive training in recognising and dealing with mental ill health as part of their initial training. They go on to receive regular refresher training in specialist aspects such as restraint. The College of Policing is currently conducting a major review of its training on mental ill health and related issues with a view to further strengthening it. This will include consultation with expert bodies and interest groups including in the voluntary sector. The review will run through 2015 with a view to new training products being available to the police from the autumn.

- There is already a legal duty on recipients to respond to recommendations from IPCC investigations and outline what action they have taken, or plan to take; or why they have not taken, or do not plan to take, any action. Forces have a legal duty to publish a response to HMIC inspections under section 55 of the Police Act 1996. This duty does not, however, require forces to respond specifically to recommendations made.
- The Home Office is working with the National Policing Lead on Conflict Management on the use of restraint to examine how its use can be made more transparent through a review of data collection.

Police

Each police force needs a dedicated senior lead and resources on mental health (as in South Wales) to ensure appropriate support (including diversion routes) to people in custody.

The Government to continue the financial commitment to ensuring the provision of sufficient mental health crisis care so that people receive appropriate treatment when it is needed and police cells are not used as a place of safety.

Home Office Response:

- All police forces already have a nominated mental health lead. The specific rank of such posts is a local operational matter. Many forces have also (in addition to day to day policing resources) established specific schemes such as street triage in conjunction with health personnel, to enable them to respond more effectively to those experiencing a mental health crisis. The second wave of Liaison and Diversion schemes in police stations and courts will roll out from April 2015 extending liaison and diversion services to cover 50% of the population of England.

- The Home Secretary and police forces have made clear their views that the most appropriate place for a person experiencing a mental health crisis is a health based place of safety. To that end they are determined to reduce the reliance on police cells as an alternative to suitable health facilities. Street triage schemes are having an impact on reducing both the number of section 136 detentions as well as reliance on police cells as a place of safety in areas where they are running. The Home Office has also funded a pilot of an alternative place of safety using a care home in Sussex to increase local capacity and trial the concept. The Home Office continues to work with the Department of Health to ensure that there are adequate local health and care services to assist those experiencing mental ill health.

Recommendation 3

In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour which applies to NHS bodies in England. If it proves to be effective this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

All settings

Families should be fully involved in the investigations process and given appropriate information and support.

The Chief Coroner to continue to produce summary reports (as outlined in the Coroners Act 2009) from preventing Future Deaths Reports, particularly to ensure there is the opportunity for learning from non-natural deaths in psychiatric hospitals.

The use of force/restraint should be recorded, monitored and the data made publically available in all detention settings, including where the police use force on detained patients in a hospital setting.

Department of Health Response:

- DH is committed to transparency and openness. The NHS England Serious Incident Framework will strengthen this commitment to involve and support families in investigations. The guidance requires organisations to provide evidence of the efforts made to support and facilitate engagement with those affected by an incident and this should be clearly documented within the concluding investigation report. This should be considered by the commissioner as part of the sign-off and closure of the serious incident investigation.

- The Government has placed a new duty of candour on all organisations to ensure that when something goes wrong, patients and their relatives are told about it promptly. The duty of candour came into force for NHS bodies in November 2014 and will be extended to all providers registered with the CQC in April 2015.

- ‘Positive and Proactive Care’ (DH, April 2014) aims to develop a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time. The revised Mental Health Act 1983 Code of Practice puts in place local policies and monitoring in line with Positive and Proactive Care.

Ministry of Justice Response:

- NOMS is committed to transparency, including full involvement of families through the Family Liaison Officer role described in Prison Service Instruction 64/2011.

- Prison Service Order 1600 mandates that following all use of force a record is made of the circumstances that lead up to the use of force and the type of force that was used and why. Local procedures are in place to review and monitor including the preparing of quarterly reports.

- The Ministry of Justice and Youth Justice Board publish Minimising and Managing Physical Restraint data which relates to use of force in the secure Young People’s estate. While there are no plans to publish use of force data relating to the wider prison estate, it is released in response to Parliamentary Questions and Freedom of Information Act requests.

Home Office Response:

- HO is actively exploring ways to improve the family liaison experience through discussions with MoJ, IPCC and other relevant agencies.
- The Home Office is working with the National Police Lead on Conflict Management to scope out a data collection series on the use of restraint, which will include both equipment (batons, cuffs, Taser, etc.) and non-use of weapons.

Psychiatric hospitals

The Secretary of State for Health should establish responsibility for ensuring oversight of investigations in psychiatric hospitals and national collation of data. The Government should reconsider appointing an independent body to investigate deaths of detained patients in psychiatric care.

Department of Health Response:

- It is important that local organisations remain responsible for ensuring safety standards, if they are to be accountable for preventing future deaths. However, DH is open to new ways of improving the system for investigating deaths and learning lessons that are supported by evidence. DH will consider this recommendation alongside the results from the Public Administration Select Committee (PASC) Inquiry into investigation of clinical failure in the NHS.

Prisons

Each prison establishment to ensure it has a staff member responsible for identifying and implementing learning from investigations and work to prevent deaths being undertaken in other prisons. They should ensure there is accurate data relating to the numbers of prisoners with a mental health condition to enable appropriate resource planning.

Ministry of Justice Response:

- NOMS makes strenuous efforts to learn from every death in custody. Our processes for learning from deaths in custody are described in detail in Prison Service Instruction 64/2011 Safer Custody and include a local learning strategy in each prison.
- NOMS and individual prisons work closely with our partners in the NHS and Public Health to support health needs assessments for prisoners, including the sharing of aggregate information on health needs.
- Prisons work closely with healthcare services to identify prisoners with mental health conditions and ensure that they are referred to the right services. The NOMS/NHS England Offender Personality Disorder Programme is improving targeting and the application of resources to screening and identification of sentenced prisoners with personality disorders.

Recommendation 4

The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

The following points explain how the Framework can support those responsible for the detention of people.

- All 12 steps in section A must be taken to prevent otherwise avoidable deaths.
- It should be used to inform and shape policy decisions in all three settings at national and local level.
- It should be used as a practical checklist by individual institutions to measure Article 2 compliance.
- It should be used as a practical checklist for those tasked with investigating deaths in detention.
- It should be used as a flexible measurement tool which can be adapted by individual institutions to tailor the steps required to be taken to secure Article 2 compliance.

Department of Health Response:

- DH welcomes this Framework and has drawn it to the attention of NHS England to consider in the revised Serious Incident Framework.

Ministry of Justice Response:

- NOMS welcomes the publication of the Human Rights Framework for Improvement and will ensure that it is disseminated widely to support implementation of our policies which are in accordance with the Human Rights Act 1998.

Home Office Response:

- The Home Office will consider the recommendation to adopt the Human Rights Framework in the context of the police.

Chapter 8: Investigations and preventing future deaths

Recommendations: To address concerns about the quality and transparency of internal investigations into non-natural deaths of detained patients we recommend in England:

The Secretary of State for Health should establish responsibility for ensuring there is full oversight of the investigation process as well as proper collation of information. This would enable national quality assurance and learning.

Department of Health Response:

- DH will consider this recommendation alongside the results from the PASC Inquiry into investigation of clinical failure in the NHS.

Appendix 3: Human Rights Framework for Adults in Detention

Section A of this framework can be used as a checklist by those holding adults in detention in a range of settings.

A failure to ensure that the following rights are in place may indicate a breach of Article 2 of the European Convention on Human Rights, incorporated into domestic law by the Human Rights Act 1998. This list is based on case law.

Overarching both sections of the framework is the obligation under Article 14 of the Convention to ensure that there is no discrimination in the enjoyment of Article 2 rights.

A. Obligation to protect

An obligation to protect life by ensuring the provision of a safe and respectful environment. In particular, by ensuring:

1. Freedom from physical abuse by staff or other detainees
2. Freedom from bullying, threats and disrespectful treatment by staff and other detainees
3. Freedom from neglect by staff or external professionals
4. Freedom from unlawful use of physical restraint
5. An effective risk assessment by a qualified practitioner either before or as soon as reasonably practicable after initial detention
6. An effective review of that risk assessment at regular intervals thereafter
7. Dissemination of those assessments to relevant agencies within and outside of the setting
8. Access to timely and appropriate medical and mental health treatment and support
9. Access to appropriate social support, such as listeners, insiders and regular family contact
10. Information and advice in an appropriate format on how to access this treatment and support
11. Treatment for drug and alcohol abuse and protection from access to them
12. Proportionate individualised protection where the detainer knows or should know there is a real and immediate risk to life.

B. Obligation to investigate

Section B of this framework can be used as a checklist by those investigating non-natural deaths of adults in detention in a range of settings. This list is based on case law.

To conduct an effective investigation that:

1. The state initiates itself
2. Appoints an investigator independent of those implicated in the death
3. Begins promptly and concludes as quickly as is reasonable
4. Takes all reasonable steps to secure relevant evidence relating to the death
5. Takes all reasonable steps to uncover any discriminatory motive behind the death
6. Makes the investigation and its results open to public scrutiny
7. Involves the next of kin and ensures that their interests are protected
8. Holds to account anyone found to be at fault as a result of the investigation, and
9. Shares and puts into practice lessons learned from the investigation to ensure, so far as is possible, that steps are then taken to minimise the risk of similar deaths in the future.

Appendix 4: Inquiry terms of reference

Equality and Human Rights Commission Inquiry into non-natural deaths in detention of adults with mental health conditions

The Equality and Human Rights Commission will examine the available evidence about non-natural deaths in detention of adults with mental health conditions in prisons, police custody and hospitals between 2010 and 2013. The Commission will focus on existing evidence and may contact relevant organisations to increase its understanding.

The Commission will analyse the evidence to establish the extent to which there has been compliance with Article 2, and Article 2 together with Article 14, of the European Convention on Human Rights.

The Commission will develop understanding about how organisations have implemented recommendations from previous inquiries and reports into non-natural deaths in detention.

The Commission will engage with individuals from the key organisations in the three settings to determine their perspectives on the protection of detained adults with mental health conditions.

The Commission's aim is to understand how compliance with the Human Rights Act can reduce or eliminate the risk of further non-natural deaths and make appropriate recommendations.

The Inquiry will focus its evidence gathering in England and Wales. A separate evidence gathering exercise in Scotland, aligned to the Scottish National Action Plan for Human Rights, will allow us to gather comparable data across Great Britain.

Contacts

This publication and related equality and human rights resources are available from the Commission's website: **www.equalityhumanrights.com**.

For advice, information or guidance on equality, discrimination or human rights issues, please contact the **Equality Advisory and Support Service**, a free and independent service.

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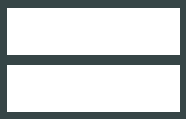

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