Recommendations from the EHRC Inquiry Report on Preventing Deaths in Detention of Adults with Mental Health Conditions

Equality and Human Rights Commission

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Recommendations

We have grouped our recommendations under four broad headings.

Recommendation One

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 Rights Commission (the Commission) will feed into this review.

Prisons:

- The setting up of new institutions (such as Secure Training Centres[1] and the North Wales prison in Wrexham) must incorporate policies which explicitly address human rights obligations and incorporate the Commission's Human Rights Framework.

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

- 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.

Recommendation Two

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.

Prisons:

- Prisons should set up a system which 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[2] 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 places of safety.

Recommendation Three

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.

[2] 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.

- The use of force/restraint[3] 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.

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.

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 Four

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.

[3] Independent Advisory Panel on Deaths in Custody (2013) *IAP Common Principles for Safer Restraint*.

- 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.