Preventing Deaths in Detention of Adults with Mental Health Conditions

An Inquiry by the Equality and Human Rights Commission

Executive summary

Equality and Human Rights Commission

Foreword

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Between 2010 and 2013 367 adults with mental health conditions died of 'non-natural' causes while in state detention in police cells and psychiatric wards. Another 295 adults died in prison of 'non-natural' causes, many of these had mental health conditions. Since 2013 that number has risen considerably. Each of them left behind loved ones who have suffered as a result of these deaths.

The Equality and Human Rights Commission's role is to promote and enforce the laws that protect everyone's rights to fairness, dignity and respect. We launched this Inquiry to ensure that the human rights of some of the most vulnerable members of society – those with serious mental health conditions – were being protected as far as possible.

Our Inquiry reveals that despite many reports and recommendations, serious mistakes have gone on for far too long. The same errors are being made time and time again, leading to deaths and near misses.

Yet it also shows that making improvements is not necessarily complicated or costly: openness and transparency and learning from mistakes are just about getting the basics right.

By listening and responding to individuals and their families organisations can improve the care and protection they provide and prevent further unnecessary and avoidable harm.

During the course of our work, we consulted with and were helped greatly by several organisations, including the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Prisons (HMIP), the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO).

We also met with the National Offender Management Service, Welsh Government, Department of Health, NHS England, NHS Wales and the Home Office.

We received evidence from individuals and organisations affected by the topic of our Inquiry. In the course of this Inquiry, the team was able to spend time talking to some of the families of those who died in detention and their experiences are central to our report. We would like to thank all of those involved, in particular the family members, for their help and support. We would also like to thank the Commission's Inquiry team for their hard work.

We hope that this report provides valuable insights and recommendations which can bring about real change in the way that adults with mental health conditions are treated in detention. Our aim is to help prevent further unnecessary tragedies.

Executive summary

Overview of the Inquiry

Our Inquiry was launched in June 2014 to examine how compliance with human rights obligations can reduce 'non-natural' deaths of adults with mental health conditions in state detention. We looked at deaths in three state detention settings – prisons, police cells and hospitals – consulting with inspectorates, regulators and others with responsibilities in this area. The Terms of Reference for the Inquiry are in the Appendix.

The Equality and Human Rights Commission's (the Commission's) Inquiry examined the available evidence in relation to the deaths of 367 adults with mental health conditions who died of 'non-natural' causes while in police cells or as detained patients over the period 2010-13, plus a further 295 who died in prison custody, many of whom also had mental health conditions.

This is a large number in itself, yet for each individual who died there are family members and other loved ones who suffer as a result of these deaths. Previous inquiries, investigations, inquests and court cases have established that, too often, the circumstances surrounding deaths in detention involve breaches of people's most basic human rights – including the right to life. We wanted to establish whether a focus on increased compliance with Article 2 of the European Convention on Human Rights, including the State's positive obligation to protect people's life, would reduce avoidable deaths.

One in four British adults experience at least one mental health condition,[1] and one in six are experiencing a mental health condition at any given time. Some people will experience more than one mental health condition.[2] While many people continue to lead productive and fulfilling lives with very little involvement from the State, the Government recognises its role to provide specific care for people experiencing mental health conditions at a time of vulnerability. A small number of those with mental health conditions will be detained by the State either because of an offence they have committed or because they are judged to be a threat to themselves or others.

We wanted to establish whether a focus on increased compliance with Article 2 would reduce avoidable deaths

1 For the purpose of this Inquiry the Commission will define a mental health condition 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.

2 *The Fundamental Facts 2007*, p. 7. Available at: http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard

In 2012/13 there were over 50,000 detentions in psychiatric hospitals, and this number is increasing. The prison service does not currently record the number of prisoners with mental health conditions. The most recent national data relates to 1997, where 92 per cent of male prisoners were reported to have one of the following five conditions: psychosis, neurosis, personality disorder, alcohol misuse and drug dependence. Seventy per cent had at least two of these.[3] Statistics for England show that police cells were used as a place of safety 6,028 times in 2013/14.[4] That equates to 115 occasions each week when someone was held by the police because of their perceived risk to themselves or to others.

Human rights give essential protection to everyone. Our rights are protected under the Human Rights Act 1998, by the European Convention on Human Rights, and by other key obligations of the State to uphold the Optional Protocol to the UN Convention against Torture. In the UK the National Preventive Mechanism (NPM) is charged with carrying out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment.

In 2012/13 there were over 50,000 detentions in psychiatric hospitals, and this number is increasing

They not only protect individuals from the acts and omissions of the State and public authorities acting on its behalf but also oblige those authorities to take steps to protect them in certain carefully defined circumstances.

Recommendations

We make four major recommendations which, if implemented, we believe would reduce deaths and give families, government and institutions a greater assurance that human rights obligations have been met and all has been done to protect the lives of those the State has detained.

Our recommendations are addressed at government, regulators and inspectorates and the leaders and managers of individual institutions. These are included in more detail in Chapter 3 of the full report.

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

3 Singleton N. et al (1998) *Psychiatric Morbidity Among Prisoners,* 1997. London: ONS.

4 HSCIC, Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England 2013-2014, Annual figures. October 2014.

training and ensuring more joined up working. Where this is not currently the situation 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 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.

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.

Main findings

For **detained patients in hospitals** we were not able to access much of the information that follows a non-natural death, such as individual investigation reports. Detained patients are a particularly vulnerable group in the UK who are being held in order to keep them, and others, safe. The care given to them must reflect their specific needs and it is incumbent on society to monitor this care.

There is no body charged with ensuring that investigations take place or that

Statistics for England show that police cells were used as a place of safety 6,028 times in 2013/14

learning is identified (including at other hospitals), as in the prison and police settings. The inevitable conclusion is that this is an opaque system where families of those who die in psychiatric hospitals are shut out of the care preceding and the investigation following a death.

In healthcare settings, a Coroner's inquest into the death of a detained patient is compliant with Article 2. However, we would like to see a model in place similar to the role of the investigatory bodies in the police and prison settings. The Government should take steps to ensure it can be confident that independent investigations are indeed taking place, that staff are supported to speak candidly about events and there are no deaths in psychiatric hospitals that could have been prevented. The Commission considers this to be such an immediate opportunity to reduce the deaths of detained patients that we intend to take this forward with those responsible for providing and regulating psychiatric care in hospitals.

An important and recent change is the introduction in November 2014 of a statutory duty of candour[5] which applies to NHS bodies in England and will apply to all other care providers registered with the Care Quality

5 Care Quality Commission, Guidance for NHS bodies: Regulation 5: fit and proper persons: directors and Regulation 20: duty of candour, November 2014.

Commission (CQC) from 1 April 2015. The duty means that care providers must ensure they are open and honest with people when something goes wrong with their care and treatment, in particular staff must be candid when taking part in interviews relating to investigations. This has potential for driving significant improvement and should be monitored closely – if effective it should be applied to other settings including prisons and police.

In relation to **prisons** the debate about how people are detained needs to go beyond the minimum standards that keep people alive. Those responsible for detention must ensure that people are not punished for behaviours that are viewed as disruptive but in fact are symptomatic of illness. Prisons need to monitor the numbers of prisoners with mental health conditions and their severity so that they can reflect on them and make appropriate arrangements for treatment and support.

It is impossible to talk about the high levels of people with mental health conditions in prisons without questioning whether imprisonment is the appropriate place. When an individual has committed a crime, they rightfully pay penance for that crime; as many others have previously stated we remind the Government that the aim of the penal system should be about rehabilitation as well as punishment.

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014

For some people the need for tailored rehabilitation that meets their particular needs might be better served within the community or psychiatric hospitals. This would also mitigate the pressures on prison resources.

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014. HM Inspectorate of Prisons (HMIP) have cited their concerns about the increase in people being imprisoned. They and the Prisons Probation Ombudsman (PPO) have also voiced concerns about staff reductions, tougher regimes and less resources and possible links between the deaths and these factors. Any link between these factors and the increase in non-natural deaths since 2013 is complex and needs to be better understood. Therefore those responsible for keeping prisoners safe should work together to understand and address these issues. Any deterioration in conditions of detention and adverse impact on those with mental health conditions should be monitored and remedied.

In the course of our Inquiry we have come across cases from PPO investigation reports where deaths have resulted from the failure to identify a prisoner's mental health condition and where concerns were identified but not shared with colleagues. These deaths could have been prevented if prisons got the basics right.

There are very few deaths within **police custody**, however every year a number of people with mental health conditions die while being detained. The role of the police is not to provide clinical care to people in need of support however they are often the first on the scene so they cannot ignore the need to be able to

respond appropriately while minimising the use of restraint. This should always be done in partnership with local health providers (including ambulances).

There is a considerable amount of work being done nationally and locally, including the Crisis Care Concordat.[6] These should help ensure quicker assessments and access to clinical care and that people are not being held inappropriately within police cells. Due to be reviewed in 2015 this should ensure that the deaths in this setting will continue to decrease.

The police should record and publish the use of restraint in order to allay concerns that there is discriminatory use against people with mental health conditions and people from ethnic minorities.

Context of the Inquiry

The Independent Advisory Panel on Deaths in Custody collects information in relation to all deaths across detention settings. The Panel is clear that there are gaps in the data.

The numbers of deaths in or following police custody have fallen over the past 10 years. Rates of non-natural deaths in prisons similarly fell after 2004 and remained at a lower level between 2008 and 2012; in 2013, however, there was an increase. This suggests there is a need for continued scrutiny to avoid preventable deaths.

Evidence base and gaps

Our Inquiry examined the evidence that is currently available. Much of this is collected by the Independent Advisory Panel on deaths in custody, although we also contacted central government to ensure they recognised the figures we used.

One of our early conclusions was that improvements are needed in the collection and availability of information in order to provide assurance of the State's compliance with its Article 2 responsibilities. This should include all information necessary to provide an overview of the number and features of the deaths. This should include race, gender, age and location of death.

The right to life

Our Inquiry focused on Article 2 of the European Convention on Human Rights which obliges the State to protect by law everyone's right to life. This obligation includes a positive duty on the State to ensure preventative measures are taken to protect life in certain circumstances and to carry out a proper investigation into deaths for which the State might be responsible. It also means that the unintentional taking of life by public authorities is prohibited. Other key aspects of the rights which protect us all include the Optional Protocol to the UN Convention Against Torture and the role of the NPM.

Article 2 case law focuses on minimum standards of protection which the State is obliged to provide to those within its care. Those responsible for detaining individuals should take appropriate steps to foster good mental health across all three settings in order to be comparable with community-based mental healthcare.

6 See http://www.crisiscareconcordat.org.uk/

The right to non-discrimination

Article 14 of the Convention prohibits discrimination in the enjoyment of the Convention rights. This means that the State must ensure that the right to life of people with mental health conditions is given equal protection to that of other people.

Our approach

Our Human Rights Framework

We constructed a Human Rights Framework based on the right to life and the right to non-discrimination. This Framework translated the legal requirements into practical steps organisations in the three settings should take to ensure their obligations under Articles 2 and 14 are discharged so that the lives of adults with mental health conditions are properly protected while in state detention.

The Framework covers four main areas:

Dignity and respect. To comply with their obligations under Article 2, all of those responsible have a duty to ensure the provision of a safe and respectful environment to minimise risk for vulnerable individuals in detention.

Risk and assessment. An effective risk assessment is critical in ensuring that measures are identified and put in place to reduce risk. Information about risk needs to be communicated and shared between staff to enable agencies to fulfil their duty under Article 2 to protect people in detention.

Treatment and support. To comply with their obligations under Article 2, agencies should provide and be equipped and funded to provide appropriate and timely medical and mental health treatment and support for detained people with mental health conditions.

Investigations. Article 2 imposes a procedural obligation to initiate an effective public investigation by an independent official body into any death for which the State may have some degree of responsibility. This will include deaths from non-natural causes of individuals in state detention.

Collecting evidence

We engaged with the key organisations in the three settings to determine their perspectives on the protection of detained adults with mental health conditions. We reviewed existing evidence, including reports and statistics. We also sought additional evidence which was not already in the public domain where we had identified gaps and we invited submissions from individuals and organisations.

We met with families of those who had died in the three settings and were moved by their stories, the honesty they shared with us and their commitment to honouring the loved ones by ensuring lessons are learned.

There were some cases we were unable to include in our analysis because there is ongoing legal action, including in relation to the use of restraint by staff from the settings.

We met with the National Offender Management Service, Welsh Government, Department of Health, NHS England, NHS Wales and the Home Office.

We received evidence from individuals and organisations affected by the topic of our Inquiry, including focus groups of frontline workers organised by Unison and Black Mental Health UK.

All of the above provided us with invaluable understanding into the settings and have helped shape our findings and recommendations.

Additionally, we reviewed a small sample of guidance on protecting detained individuals produced by statutory organisations in the three settings. Most of the guidance covers the obligation to protect. While there is a strong focus on obligations under the Equality Act we found much less reference to human rights obligations, particularly Article 2.

Involving and consulting others

Many organisations work in this area and we acknowledge their expertise and commitment to reducing the deaths of people in detention settings. There are some major initiatives taking place to action these commitments. It was agreed that by consulting with others we could jointly have a greater impact.

In recognition of the independent examination provided by regulators and inspectorates, the Inquiry team had regular meetings with counterparts at the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Prisons (HMIP), the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO).

We are not the only organisation producing reports of relevance in this area. The current Home Secretary ordered a specific thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. This work includes those with mental health conditions, those from ethnic minority backgrounds and children. The Harris Review has examined the deaths of 18-24-year-old prisoners and will be published later in 2015.

INQUEST and Black Mental Health UK provide the support to the families of people who have died and their tireless campaigning keeps the issues in both political debates and the media.

Appendix: 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**

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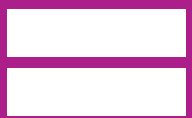

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