

# Preventing deaths in detention of adults with mental health conditions:

progress review

executive summary

# 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.’**

# 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 Prison 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.’

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.

# Contacts

This publication and related equality and human rights resources are available from the Commission's website: [www.equalityhumanrights.com](http://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.

**Website** [www.equalityadvisoryservice.com](http://www.equalityadvisoryservice.com)

**Telephone** 0808 800 0082

**Textphone** 0808 800 0084

**Hours** 09:00 to 20:00 (Monday to Friday)  
10:00 to 14:00 (Saturday)

**Post** FREEPOST Equality Advisory Support Service FPN4431

Questions and comments regarding this publication may be addressed to: [correspondence@equalityhumanrights.com](mailto:correspondence@equalityhumanrights.com). The Commission welcomes your feedback.

## Alternative formats

This guide is available as a PDF file and as a Microsoft Word file from [www.equalityhumanrights.com](http://www.equalityhumanrights.com). For information on accessing a Commission publication in an alternative format, please contact: [correspondence@equalityhumanrights.com](mailto:correspondence@equalityhumanrights.com).

You can download this publication from

[www.equalityhumanrights.com](http://www.equalityhumanrights.com)

© 2016 Equality and Human Rights Commission  
Published March 2016

 **Equality and  
Human Rights  
Commission**