Independent
Advisory Panel
on Deaths
in Custody

Investigating deaths under the Mental Health Act: The need for independence and parity

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on Deaths in Custody

September 2025

"Deaths of patients detained under the Mental Health Act 1983 are not subject to any independent investigation in the same way as deaths in police custody (Independent Office Police Complaints) [sic] or in Prison (Prison and Probation Ombudsman). As a result, investigations are not effective, no single body has oversight of previous concerns and how these were going to be rectified by the organisation. Therefore, critical learning and evidence is being lost which may prevent future deaths.

"In addition the Investigations which are currently being undertaken are ineffective either due to a lack of trained, investigators who conduct internal reviews or a lack of understanding of complex health processes and procedures."

Coroner Jeanne Kearsley, Prevention of Future Deaths report into the death of Charlie Millers, 26 May 2024

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The IAPDC is an advisory non-departmental public body that provides independent advice and expertise on deaths in custody to Ministers, senior officials and the Ministerial Board on Deaths in Custody (MBDC). Along with a wide range of senior stakeholders, including Government departments, custody leaders, and charities, it is a member of the MBDC but is independent of Government.[1]

Foreword from IAPDC Chair Lynn Emslie

When the death of a loved one happens while detained by the state, families rightly want answers, transparency, and accountability. While nothing can undo the loss of their loved ones, families want lessons to be learned to prevent deaths in future.

However, as this report explores, too often families bereaved by deaths of individuals whilst detained under MHA feel they are left without answers and that opportunities to learn from deaths are missed.

The IAPDC's latest statistical analysis of deaths in custody found that patients detained under the MHA have the highest rate of death in all detention settings, including three times higher than that of prisons.[2] However, unlike deaths in prisons, immigration detention, and police custody – which are independently investigated by the Prisons and Probation Ombudsman (PPO) and the Independent Office for Police Conduct (IOPC) respectively – the deaths of patients detained under the MHA are not investigated by an independent body prior to an inquest.

Professor Sir Simon Wessely's 2018 independent review of the MHA underlined the importance of ensuring "all investigations are robust, appropriately independent, and involve families". He argued that a case could be made for having an independent body investigate 'unnatural' deaths under the Act and urged the government to return to this issue if progress to improve investigations and learning had not been made after five years.[3]

Our report follows more than seven years on from the 2018 independent review and sets out why independent investigation of all deaths under the MHA is urgently needed. Transparency and accountability are vital to fostering an environment of continuous learning and improvement in our closed institutions. While we broadly welcome changes to National Health Service England's (NHSE) framework for investigating safety incidents within health settings to improve system-wide learning, there remain critical challenges in ensuring deaths in MHA detention are investigated independently and effectively – as this report explores.

Since then, reviews into the safety of care within the healthcare landscape have continued to identify significant challenges, including the recent review conducted by Dr Penny Dash. There will no doubt be significant changes to be made following the Government's implementation of the review's recommendations and the implementation of the 10-year plan for the NHS, which is one reason why this report does not precisely prescribe what kind of mechanism may be needed to remedy the issues it identifies.

But, the consistently high number and rate of deaths in MHA detention highlight why this is so important. Establishing an independent mechanism to investigate these deaths would ensure appropriate scrutiny, parity with other places of custody, and – perhaps most importantly – better answers for bereaved families. Nearly seven years on from Sir Simon Wessely's review, there are strong arguments for revisiting the case for independent investigations now, not just for self-inflicted deaths but for so-called 'natural' deaths as well.

It is particularly important to acknowledge that, while for the purposes of this report we classify these deaths as falling within 'state detention', people detained under the MHA are primarily patients receiving healthcare interventions. Sadly, the stigma associated with being detained for psychiatric care can present a significant barrier to some patients seeking the help they need. It is the IAPDC's hope that improving the investigation and scrutiny of these deaths by an independent mechanism will help to reduce barriers to care and improve public confidence. This underlines also why it is so important to ensure that whatever mechanism is used to independently investigate deaths, it both brings in expertise and learning from across all custody settings while firmly keeping its focus on the unique health settings in which these deaths take place.

We urge the government to heed the findings of our report and ensure all deaths in custody are investigated equally. Finally, I wish to thank my Panel colleague Dr Jake Hard and former Panel member Pauline McCabe OBE for the leadership and dedication they have brought to this work over the last year. I also wish to thank former Panel member Raj Desai for his invaluable input and feedback on the report.

Lynn Emslie

Chair of the Independent Advisory Panel on Deaths in Custody

Executive summary and recommendations

1. Article 2 of the European Convention on Human Rights (ECHR) requires states to safeguard the lives of individuals in detention and conduct effective, independent investigations where deaths occur.[4] These investigations must be independent, prompt, thorough, public, and involve bereaved families. Inquests play a vital role in meeting these requirements.[5]

2. Prior to inquests, however, investigations play an important role, particularly as inquests can take many months, or even years, to conclude. They assist coroners in investigating deaths compatibly with Article 2 and provide an independent source of data and learning. Currently these investigations are conducted independently by the PPO following deaths in prison and immigration detention and by the IOPC after deaths in police custody.

3. Deaths arising whilst a person is detained under the MHA, however, are not automatically investigated by an independent body prior to inquests. This is despite MHA patients having similar health vulnerabilities and co-morbidities as people in prison along with comparable numbers of deaths. While those detained are primarily patients receiving care and treatment for their underlying condition, they share the fundamentally identical position of being detained by the state. The fact that these deaths are not automatically investigated by an independent body creates an inequality when compared with the other places of detention and is particularly strongly felt among families bereaved by deaths in MHA detention.

4. Throughout this report, we set out the key reasons for establishing independent investigations for deaths under the MHA. As well as assisting with Article 2 compliance, the purpose of these independent investigations would be to ensure parity with other detention settings, draw out learning from the specific clinical and physical circumstances often faced by people in detention, allow for thematic learning to be shared across other places of state detention, and ensure appropriate data collection. Meeting these objectives would help to drive improvements in care for both patients under the MHA, and across other forms of state detention.

5. Current arrangements rely on ad hoc investigations commissioned by healthcare providers, resulting in inconsistencies and raising doubts as to whether this approach can be fully effective. Changes have been made to frameworks and guidance governing these investigations which seek to improve health providers' responses and learning after deaths within healthcare settings. However, as valuable as these changes may be in helping drive forward improvements in patient safety outcomes, there remain significant gaps in how deaths in MHA detention are investigated.

6. We have considered the appropriateness of alternative mechanisms for increasing oversight of deaths in detention, short of full investigations undertaken by an independent body. These include the work of the Mental Welfare Commission for Scotland (MWCS) and the Health Services Safety Investigations Body (HSSIB). While these models would provide greater oversight than exists at present, they would not be sufficient to ensure that deaths under the MHA are treated on an equal footing with other detention settings. While valuable means of overseeing and learning from deaths, these alternative mechanisms alone would not meet the objectives we have set out for such investigations.

7. Questions have also been raised as to whether it would be proportionate to investigate all deaths in MHA detention, both 'unnatural' – such as self-inflicted deaths – and 'natural'. There may be questions as to whether more learning is likely to be gained from investigations of self-inflicted versus other kinds of deaths. However, relying on a potentially arbitrary categorisation of 'natural' and 'unnatural' would pose significant risks of missing learning and identifying how deaths may be prevented, whatever their cause. Moreover, the numbers of 'natural' deaths in MHA detention are comparable to those in prison and immigration detention. Those detained in both settings also share similar co-morbidities impacting on their risk of dying in custody. From the experience of the PPO, in prisons and immigration detention, there is the significant potential for independent investigations to draw out valuable learning to improve patient treatment and care and contribute to the prevention of future deaths.

8. The work of existing bodies across the UK that investigate deaths in prisons, immigration detention, and police custody, as well as other existing regulatory and investigative bodies in the healthcare sector, provides a blueprint for the independent investigations of deaths in MHA detention. We draw on this learning in our report. Whilst this could be used to establish a wholly new body, it is our recommendation that Government takes the first step of creating a new mechanism within an existing body or bodies to begin independently investigating these deaths.

Recommended options for reform:

9. Following the recent Review of patient safety across the health and care landscape conducted by Dr Penny Dash (the Dash Review), the IAPDC recognises the value of utilising existing resource and expertise, as well as the benefits of drawing together learning from across detention settings and the different functions that exist within the investigative landscape. Therefore, the IAPDC's recommendation is that:

    I. DHSC sponsors the establishment of a new independent mechanism, utilising existing resources and organisations, to conduct investigations into deaths occurring under MHA detention. This could be set up as part of one distinct body, or through collaborative work across existing investigative bodies within detention and healthcare services.

To ensure the widest range of learning is gathered from these investigations to improve treatment and care, the IAPDC recommends that:

    II. All deaths in MHA detention be investigated – both 'non-natural' and 'natural'.* As part of this, we recommend that a 'panel' approach (as explored more below) be adopted to ensure appropriate clinical resources are allocated to each investigation.

10. Regardless of which body or bodies are tasked with these investigations, the IAPDC recommends that:

    III. Clinical leadership is embedded within the independent investigative mechanism itself. At the very least, this mechanism should have its own clinical leadership to direct, oversee, and quality assure externally commissioned clinical advice. Further scoping may be needed to ensure that the process for obtaining clinical advice is appropriately structured to ensure sufficient independence, quality, and proportionality of investigations.

    IV. The investigative mechanism draws on existing expertise to help shape the clinical review structure and training for clinical reviewers for the investigation of these deaths, collaborating with bodies such as the Parliamentary and Health Services Ombudsman (PHSO) and HSSIB.

11. The body undertaking this role should work together with the relevant health regulatory bodies, including the Care Quality Commission (CQC), to meet common aims of improving patient safety.

* Note: this would not include mental health homicides, as all of these deaths are already subject to automatic independent investigation under a different investigative mechanism.

Chapter 1: Defining the purpose of independent investigations

Article 2 ECHR

12. It is a primary duty of the state to safeguard the lives of those in its care and custody. This is set out in the right to life under Article 2 of the ECHR. Where someone dies in state detention, bereaved family members will rightly ask, 'what more could have been done to save their life? What needs to change now to ensure this never happens again?'

13. Article 2 imposes an obligation on the state to investigate where an individual has died while detained.[6] To satisfy this obligation, the Coroners and Justice Act 2009 requires that an investigation take place into a death where "the deceased died in custody or otherwise in state detention".[7] There are a number of requirements that must be met, as explored below, to ensure the state has properly discharged its duty. Inquests conducted by a coroner are the principal means by which this obligation is fulfilled in England and Wales. As the IAPDC has raised in previous reports, coroners' Prevention of Future Death (PFD) reports can also be important to ensuring lessons are learned for the future.[8]

The definition of a death under the MHA

14. This report focuses on deaths of individuals arising whilst detained under the MHA that automatically trigger investigation by a coroner under Article 2: that is, those detained in the interests of their own health and safety or the protection of others for assessment (section 2) and treatment (section 3), as well as those concerned in criminal proceedings or under sentence under Part III of the MHA. This includes adult psychiatric hospitals as well as the medium- and high-secure hospital estate. This is where, as we explore, there is the strongest case for independent investigations into deaths.

15. At this stage, the report does not focus on cases of individuals who have died while detained voluntarily or while on leave from detention or after being discharged, although a case could be made for investigating these deaths. We have also not considered individuals who may be detained under the Mental Capacity Act 2005 (MCA). The IAPDC notes in particular the comments made on this issue in Sir Simon Wessely's 2018 Independent Review:

> "...following changes to the CJA introduced in 2017, someone who has died whilst subject to DoLS (or, in future, the Liberty Protection Safeguards) is not considered to have been in state detention for purposes of determining that there should be an investigation by a coroner, which means there is no automatic investigation of their death by the coroner. In many cases, this is entirely appropriate, it is simply wrong to consider the natural death of an elderly person in a care home a death in state detention for these purposes simply because they were subject to a DoLS authorisation. But in the case of those in a psychiatric hospital subject to DoLS (or, in future the LPS), it may be far more appropriate to think of them as being in state detention."[9]

16. It may be that deaths of these individuals whose circumstances are analogous to those occurring whilst detained under the MHA should also be considered for investigation by an independent mechanism. Certainly, learning from deaths in MHA detention, identified through investigations conducted along the lines recommended in this report, should be applied to the care of such individuals.

17. Further, this report focuses on both 'natural' and 'unnatural' deaths – those that occur as a result of disease and illness – as well as deaths by suicide or other unnatural causes, such as those resulting from use of force. This will help to ensure there is comparable data between different detention settings. As explored in more detail below, independent investigations would provide valuable insight and learning in both types of deaths.

Death investigations across state detention

18. Where an individual dies while detained by the state in all other settings, such as prisons, immigration detention, and police custody, an independent investigation is undertaken by a separate body prior to the inquest. In the case of deaths in prison custody, immigration detention, and the youth secure estate, the PPO automatically conducts independent investigations to identify what happened and what lessons can be learned to prevent recurrence.

19. As set out in its Terms of Reference, PPO fatal incident investigations support the state's compliance with Article 2.[10] These investigations are sent to the coroner and play an invaluable role in identifying key issues and gathering and preserving evidence which may be considered at the subsequent inquest. The same is the case for deaths in police custody, which are investigated by the IOPC.[11] In recognition of this role, inquests are often adjourned pending the outcome of PPO or IOPC investigations.

20. In 2004, when the PPO's remit was extended to include the investigation of deaths in prisons and immigration detention, the then-Prisons Minister, Paul Goggins, said "All deaths in custody are of grave concern…[HMPPS] deal with some of the most vulnerable people in society. It is essential that in an investigation of this nature, our procedures are beyond reproach…transferring this remit to the ombudsman will increase public confidence through independent scrutiny of the events leading to a death in custody."[12]

21. That same year, the IOPC (then the Independent Police Complaints Commission or IPCC) was given responsibility for investigating deaths in police custody.[13] The report of the inquiry into police custody deaths conducted by Dame Elish Angiolini DBE KC noted, "Before the IPCC it was common for deaths and serious incidents to be investigated by the force where the incident had occurred, with outside forces brought in to investigate the most contentious deaths. This was a system that did nothing to reassure families of the integrity or independence of investigations."[14]

22. Deaths arising under MHA detention, however, was the only setting that did not see this same progress towards the establishment of an independent body to investigate all deaths. In 2004, the Joint Committee on Human Rights (JCHR) undertook an inquiry into deaths in custody in which it raised concerns about the absence of a framework for independently investigating MHA deaths. It stressed the need for consistency across detention settings, stating, "Since the case for such a body has been accepted in relation to police detention…and prison and immigration detention…we can see no reason why deaths amongst this particularly vulnerable group of detained people should not be subject to a similar safeguard".[15]

Treating all custody deaths equally

23. More than twenty years on from the JCHR's report, there is still no single independent body or mechanism that investigates deaths arising whilst a person is detained under the MHA. This is despite repeated calls from across a range of bodies and experts, including the Equality and Human Rights Commission (EHRC),[16] members of Parliament,[17] bereaved families,[18] academics,[19] charities, and more. In its 2015 report, INQUEST noted the "glaring disparity between the manner in which deaths in mental health detention are investigated pre-inquest compared to those in other forms of state custody".[20] In response to these concerns, changes have been made to how deaths in MHA detention are investigated and learned from.

24. As a recent academic review of the subject found, "Each death that occurs in police and prison settings is investigated by independent regulators in addition to inquests. These regulators produce annual reports on how many people die, and in what circumstances, in attempting to learn lessons that prevent future deaths. This provision does not exist for individuals in [mental health related deaths], and this raises very significant concerns about why this particular publicly funded service should be an exception, given the inherent vulnerabilities of people detained, sometimes against their will".[21]

25. 25. The statistics bear out these comparisons. As the IAPDC has found through its research, for a number of years death rates for those in MHA detention have been at least three times higher than for those in prison.[22] According to the last set of data published by CQC, there were 225 deaths between 2023 and 2024.[23] 162 of these were as a result of so-called 'natural causes' – defined as resulting from "old age or a disease, which can be expected or unexpected" – while 71 were due to "unnatural causes" – in other words, "a death as a result of an intentional (that is, harm to self or by another individual) or unintentional (an accident) cause".

26. This is comparable to the 291 deaths reported in prison custody for the year ending in March 2024, 85 of which were deaths by suicide and 171 from natural causes.[24] As set out in the IAPDC's research, which has calculated rates of death across these institutions between the years 2017-2021, people detained under the MHA average 1,314 deaths per 100,000 detained patients, compared to an average of 393 deaths per 100,000 people in prisons. However, the IAPDC's research applies a caution to the data as it is an approximation due to the lack of comprehensive and timely data for deaths in MHA detention, compared to other detention settings, as this report explores further below.[25]

27. There are likely to be many factors underlying the rates of deaths in MHA detention. These may include pre-existing physical health conditions and co-morbidities among those receiving mental healthcare. But other factors may also play a role in many cases, including challenges in providing therapeutic environments, clinical failures, and the impact of restrictions imposed by security measures. As with deaths in prison, such deaths take place in complex circumstances, raising challenging questions around what treatment the individual received, including the management of suicide risk, the quality of care, and what independent role their detention played in the care they received.

28. As this report explores further below, similar concerns have been raised by bereaved families and their representatives for many years. As Deborah Coles, of the charity INQUEST, explained in 2012, "It cannot inspire family or public confidence to have a hospital investigate itself over a death that may have been caused or contributed to by failures of its own staff or systems. This mirrors the discredited practices of the past with police investigating police and internal prison service investigations prior to the establishment of the IPCC [now IOPC] and PPO".[26]

29. It is a strategic principle of the IAPDC to seek and take into account the views of families bereaved by custody deaths.[27] Evidence identified by HSSIB's latest report on Mental Health inpatient settings also confirms the concerns felt by many of those whose family members have died in MHA detention due to the absence of independent investigations.[28] In a recent consultation conducted by INQUEST, bereaved families reported that investigations conducted by healthcare providers are "shrouded in delay, secrecy and in some cases animosity towards families who simply wanted active participation and a truthful account of what caused their relatives' deaths".[29] They continue to have serious concerns around the quality and independence of investigations, feeling that the current lack of independence leaves providers "marking their own homework".[30]

30. The IAPDC has highlighted these issues for more than a decade.[31] As this report explores, it remains the view of the IAPDC that it should be the job of an independent mechanism within an existing body or bodies in the healthcare space – as it is with prisons, police custody, and immigration detention – to investigate deaths occurring whilst detained under the MHA and report on the full circumstances of the death. As a further benefit, this will also help to inform a better understanding of the disparity in the rates of death between the different detention settings. This report explores why and how this might be achieved. Twenty years after the PPO and IOPC were given responsibility for investigating deaths in prison, immigration detention, and police custody, it is in increasingly stark contrast that deaths arising whilst detained under the MHA are still not subject to this safeguard.

The standards and purposes of independent investigations

31. Independent investigations are important for a number of vital purposes, but there are standards with which they should comply in order to be truly independent. In order for the state to comply with its Article 2 obligation to investigate, these investigations must meet the following conditions:

    I. They are initiated by the authorities of their own motion;

    II. There is sufficient independence – institutional, hierarchical and practical – from those involved in the death;

    III. They are effective, which includes taking all reasonable steps to secure relevant evidence and ensures a thorough, objective and impartial analysis of all relevant elements;

    IV. There is a sufficient element of public scrutiny;

    V. There is involvement of next of kin to an appropriate extent to protect their legitimate interests; and

    VI. They are conducted reasonably promptly.[32]

32. These conditions provide a useful set of standards for investigations prior to inquests. It is the view of the IAPDC that any investigations of deaths in MHA detention should aim to meet these standards both as a matter of good practice and to support Article 2 compliance.

33. As highlighted above and explored in further detail below, all deaths in the other places of state detention are automatically investigated by an independent body. Individual deaths under the MHA, however, are not. This report aims to address this anomaly and provide appropriate solutions through its recommendations. Thus, considering the factors set out above, the key reasons for establishing independent investigations for deaths under the MHA are to meet the following objectives:

    I. Ensure parity with other detention settings;

    II. Assist with meeting the Article 2 obligations;

    III. Ensure lessons are learned from these deaths that account for the co-morbidities and specific circumstances often faced by people in detention, as well as evaluating parity of care with the community. As such, learning should be focused on two primary areas: 1) evaluating the clinical care provided to the patient; 2) identifying the impact of restrictions imposed by security measures;

    IV. Allow for thematic learning to be shared and comparisons to be made with other places of state detention; and

    V. Ensure data is collated that is comparable to other detention settings.

34. While this report does not seek to criticise existing processes for investigating these deaths, it recognises that these objectives are currently not being met.

35. This report will address the ways in which automatic investigations of all deaths of people occurring whilst they are detained under the MHA could be integrated into the current investigative and regulatory landscape to ensure these objectives are met. As part of this, we acknowledge the changing nature of the healthcare landscape, following the Dash Review, and the importance of drawing on existing expertise and learning in conducting clinical investigations, while maintaining a patient-centred approach to the investigation of deaths within the unique context of secure healthcare.

Chapter 2: The current system

36. The Serious Incident Framework (SIF) was implemented by NHSE in 2015 to address concerns around its investigative processes following patient safety incidents.[33] However, serious challenges remained, with a report from CQC in 2016 finding that "[m]ost NHS Trusts report that they follow [SIF] when carrying out investigations. Despite this, the quality of investigations is variable, and staff are applying the methods identified in the framework inconsistently".[34]

37. The National Guidance on Learning from Deaths was published in 2017 in response to the recommendations of the CQC's 2016 review.[35] The guidance – which remains in force – seeks to improve and standardise the way in which NHSE providers identify, report, investigate, and learn from deaths. It also sets expectations as to how deaths should be reviewed and investigated. In doing so, it requires individual organisations to have a policy setting out how they will respond to deaths that occur under their care and "ensure that there is an appropriate investigation".[36] Overall, the guidance is an overarching guide on the threshold for deaths investigations and a framework within which other investigation processes sit.

38. In August 2022, SIF was replaced by the Patient Safety Incident Response Framework (PSIRF).[37] The NHS define the PSIRF as outlining the "approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety".[38] One of the methods of learning the PSIRF sets out is the Patient Safety Incident Investigation (PSII), which is designed for systems-based, organisational learning.[39] A locally-led PSII is required in response to all deaths of patients detained under the MHA where the review undertaken under the Learning from Deaths guidance has determined that the death is "thought more likely than not [to be] due to problems in care".[40] The only circumstance which requires a PSII by the NHSE Regional Independent Investigation Team is a mental health-related homicide.[41]

39. In contrast with SIF, the PSIRF does not prescribe what to investigate or how investigations should take place. It does not mandate investigations as the only method for learning from patient safety incidents. Instead, the Learning from Deaths guidance is intended to be used as a triage process for determining which deaths should be investigated under the PSIRF, while the PSIRF offers a range of learning response tools to be used following a patient safety incident. While the previous framework required an appropriate investigation after each individual death, the aim of the PSIRF is to move away from single-case reviews and root-cause analysis approaches, instead focusing on identifying and addressing systemic issues and themes across multiple cases to improve patient safety.

40. Overall, the PSIRF has a fundamentally different purpose from that of independent investigations. Its approach provides valuable focus on identifying and implementing system-wide learning. Nonetheless, questions remain as to how it alone can adequately improve investigations and learning from deaths of patients detained under the MHA. For example, SIF set out specific guidance relating to the investigation of deaths in MHA detention, which is not present in the PSIRF. While the previous framework was referenced by and clearly aligned to the Learning from Deaths guidance, it is not immediately clear how this new framework fits with the Learning from Deaths guidance. This is highlighted in HSSIB's latest report, which "identified a divergence in scope and investigation methodology" between these two frameworks and notes the "tension between these frameworks which reflects the broader challenge of balancing systemic learning with individual case review and accountability" and how this can lead to inconsistent approaches to investigating deaths.[42] As the PSIRF has not been designed specifically for this purpose, it is unclear whether it is sufficient to ensure a consistent approach to the investigation of deaths arising under the MHA and other secure environments.

41. The IAPDC supports all efforts within NHSE to improve learning after MHA deaths and promote better patient safety outcomes. But independent investigations should work in tandem to the PSIRF and other processes to maximise learning and ensure the prevention of deaths. Indeed, while the purposes of these two approaches are different, they are not conflicting: the automatic investigation of all deaths should also highlight areas for systemic improvements. Investigations by an independent mechanism should therefore be seen as complementary to (and not a replacement for) the PSIRF approach, working in tandem to maximise system-wide learning and preventing avoidable deaths. Independent investigations would also ensure parity with the individual investigations undertaken in other detention settings and assist with meeting the appropriate standard for an Article 2 compliant investigation of a death in detention, in a way that the PSIRF is not designed to do.

Continuing challenges for bereaved families

42. While NHS Trusts are seeking to adopt the PSIRF approach for all patient safety incidents, these investigations continue to face challenges limiting their effectiveness and ability to meet families' expectations. INQUEST found in its 2023 report into the experience of those whose relatives died in connection with mental health services that "for many families, the hospitals and trusts control the process from the outset and from that point onwards dictate the tone, direction and scope of what follows."[43] As the report continued:

> "...families felt ill-equipped to make informed decisions or plan their engagement with the investigations, which in turn made managing expectations difficult. For many, this lack of involvement at the outset meant the process was already flawed; it simply didn't involve families enough to elicit their observations, thoughts, concerns and recommendations in order to create a meaningful account of what happened... Families felt they had little or in some cases no role in establishing the terms of reference for the investigatory process. This compounded existing concerns regarding the hospitals' and trusts' failures to recognise the complexity of care."[44]

43. Further evidence from families raises questions as to whether existing investigations are able to fully meet the standards set out in Chapter 1. While some families reported good experiences with individual investigators, others reported serious concerns as to their expertise, effectiveness, and ultimately their independence. One family stated that an investigator told them, "If I rock the boat too much I won't get asked to do reports again",[45] while another recounted, "the investigator said he'd struggled to get statements from people, and "it wasn't his job" to chase them up."[46]

44. Further, as INQUEST report in their evidence to the Lampard Inquiry into the deaths of mental health inpatients in Essex stated: "[They have] not seen any noticeable improvement in the investigation of patients' deaths following the introduction of the PSIRF and in fact have seen examples of worsening practice. There continue to be significant delays in deaths being investigated and lessons being learned. Importantly, thus far, despite requirements set out in the PSIRF, they have not seen an improvement in the engagement of families. Families remain excluded from the process, and it is often only once they have obtained legal representation and request information that this is shared but even then, this does not necessarily lead to any meaningful engagement." [47]

45. As INQUEST continue in their evidence: "In one Essex case in which INQUEST has supported the family, [Essex Partnership University NHS Foundation Trust] refused to share the names of the investigators with the family and provided no update between the family sharing a list of their questions and the provision of the draft report. The introduction of the process of sharing a draft report with families, as introduced by the PSIRF, does not appear to have made any material difference as generally, a final draft is shared by which time it is too late for the family to have any proper engagement or for further investigations to take place."[48]

46. Challenges no doubt remain for families in engaging with existing independent bodies that investigate deaths in custody.[49] But such a new independent mechanism investigating deaths arising whilst detained under the MHA would be better placed to ensure the standards set out in Chapter 1 are followed, assist with the identification of systemic themes and learning, and demonstrate greater consistency, effectiveness, and independence in their investigations.

Chapter 3: Challenges with investigations and data

47. The role of inquests is to determine the answers to the four key questions set out in the 2009 Act: "who the deceased was" and "how, when and where the deceased came by his or her death".[50] In order to give effect to the requirements of Article 2, the Act requires a broader investigation for inquests engaging the right to life, which will include suicides and other categories of suspicious deaths in custody or state detention.[51]

48. In practice, investigations undertaken prior to inquests often greatly assist coroners in their investigations. The Chief Coroner's Annual Report 2023 emphasised the impact of delays and the backlog within the service on the "reliability of the evidence available to coronial investigations".[52] The report also highlighted the continuing under-funding of the service as a "serious and pervasive problem".[48] If issues have not been identified or evidence has been lost during the initial investigation, the effectiveness and adequacy of the subsequent inquest is potentially undermined, as it may not be possible for the inquest to resolve the problems with the earlier investigation. Therefore, while in principle an inquest is able to fulfil the Article 2 requirements, the consistency and practical ability to do so is significantly impacted by the quality of previous investigations.

Coroners' concerns around poor quality investigations

49. Investigations by independent bodies into deaths in immigration detention, prison, or police custody provide assistance to coroners. In many cases, it may be the findings of an independent investigation that identify the most important areas for the coroner to focus on when carrying out their own investigation. They help ensure, among other things, that all possible evidential sources are identified, the evidence is secured, relevant witnesses are identified and interviewed in a timely manner, and relevant failings in care are highlighted. As the PPO's Terms of Reference set out, its investigations support the state in fulfilling its obligations under Article 2 "by working together with coroners to ensure as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are made clear".[54]

50. Coroners themselves continue to raise concerns around the impact of inconsistent and poor-quality investigations of deaths arising whilst detained under the MHA. Most starkly, in the PFD report published in May 2024 relating to the death of Charlie Millers, a coroner found that the lack of any independent body to investigate deaths in MHA raises a risk of future deaths:

> "Deaths of patients detained under the Mental Health Act 1983 are not subject to any independent investigation in the same way as deaths in police custody (Independent Office Police Conduct) [sic] or in Prison (Prisons and Probation Ombudsman). As a result, investigations are not effective, no single body has oversight of previous concerns and how these were going to be rectified by the organisation. Therefore, critical learning and evidence is being lost which may prevent future deaths.
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> "In addition the Investigations which are currently being undertaken are ineffective either due to a lack of trained, investigators who conduct internal reviews or a lack of understanding of complex health processes and procedures."[55]

51. Other PFD reports have raised similar concerns. The report issued following the inquest into the death of Sharon Langley, published in February 2023, noted among its matters of concern "the reliability of the Trust investigation and how the Trust learned lessons" after the death.[56] In another PFD report, the coroner found that the report of a Trust's investigation into a MHA death had "omissions" relating to significant circumstances of the death and that there had been "pressure to sign the report off although it remained incomplete".[57]

52. Cases such as these led the IAPDC to note in its 2023 report the intimate connection between the quality of investigations and the role of the coroner: "The lack of consistent, automatic, and independent post-death investigation for deaths under the MHA suggests that it is particularly important that PFD reports regarding such deaths are comprehensive and effective in driving necessary change."[58]

Questions around data on deaths

54. Separately, the IAPDC have for several years raised concerns about the quality of data on deaths of those detained under the MHA. Data provided annually by the CQC often contains large numbers of deaths that are 'undetermined' at the time of reporting, making it difficult to identify how many deaths by suicide and so-called 'natural' deaths there are each year.[59] This data is gathered by the CQC from notifications by healthcare providers of a death in their care but before reporting their data, the CQC waits for determinations by coroners as to the cause of death. This contrasts with other detention settings that use provisional language when reporting apparent self-inflicted deaths prior to determination by a coroner, which ensures timely and potentially actionable data.

55. At the same time, there appear to be discrepancies between the number of deaths identified by the CQC and those reported by coroners which resulted in inquests. This may be as a result of differences between how bodies report their data, but it could suggest that deaths of individuals detained under the MHA are being underreported to coroners. By law, all deaths in detention should be referred to coroners,[60] but a 2016 article in the Health Services Journal suggested that more than 700 deaths of individuals occurring whilst detained under the MHA may have gone unreported between 2011 and 2014.[61]

56. The article contrasted the 373 deaths of people detained under the MHA reported to coroners during this period with data from the CQC and the Health Inspectorate for Wales (HIW) showing 1,115 deaths over that same period. Reviewing the data, we also found that the number of deaths reported to coroners between 2010 and 2015 seems surprisingly low in comparison to the number of deaths reported to the CQC during a similar period (2010/11-2014/15). (For this data, see the Annex to this report).

57. Limitations in the publicly available data in this area makes it difficult to compare and analyse the overall number and rates of deaths of patients detained under the MHA with the number of inquests held. For example, the CQC is the body responsible for publishing data on deaths of individuals occurring whilst detained under the MHA and it does so by financial year without providing a breakdown by month. In contrast, the MoJ publishes its annual coroners' statistics by calendar year and, similarly, does not provide a breakdown by month. This means it is not possible to strictly compare the two datasets.

58. While the apparent discrepancy seems to diminish from 2015 onwards, there remain some continuing differences.[62] In contrast, the number of deaths in prison and police custody reported to coroners more closely match the annual deaths data published by HMPPS and IOPC. Again, while it is difficult to make direct comparisons due to the different methods used to record data, comparisons can be drawn between HMPPS data and coroners' statistics as both datasets are recorded by calendar year. Between 2011 and 2023, HMPPS data on deaths and the number of deaths reported to coroners are more closely matched, with only minor inconsistencies. This therefore leaves a continuing impression that there is a greater discrepancy in the figures for deaths arising whilst detained under the MHA and inquests into those deaths, compared to other detention settings.

59. The new Medical Examiner system may help to ensure these discrepancies are minimised or avoided, since any MHA deaths that are wrongly not referred to the coroner should then be considered by the Medical Examiner, who should then refer them to the coroner. However, the development of an independent investigative mechanism would help resolve remaining challenges around deaths data. In line with the objectives set out in Chapter 1, a dedicated mechanism would help provide another comparable source of data on deaths occurring under MHA detention. This could ensure, among other things, that the Ministerial Board on Deaths in Custody (MBDC) has the best available information to help fulfil its role in reducing deaths across all areas of state detention.

60. While an independent investigative mechanism would still rely on healthcare providers to notify them of all deaths in MHA detention, as with other detention settings, they could publish data on the number of investigations they are conducting and so provide a further independent source of data, as well as providing greater transparency. This would also provide an additional safeguard to ensure the deaths it is investigating are always reported to coroners. This investigative mechanism could also give a provisional categorisation of the death, enabling them to reduce the number of deaths in their statistics that are categorised as 'Undetermined', much as HMPPS already do quarterly[63] and the PPO do annually.[64]

Chapter 4: Alternative models for improving investigations and care

61. In recent years, alternative ways of improving investigations and learning after deaths have been developed. These include a model for increased oversight of deaths proposed by the Mental Welfare Commission for Scotland (MWCS) for those detained under Scottish mental health legislation.65 At the time of writing, HSSIB investigates patient safety concerns across NHS services in England and in independent healthcare settings where safety learning could also help to improve NHS care, including mental health services and prisons.66

The MWCS model

62. The MWCS states on its website, "Scotland does not currently have a national unified system for investigating deaths of people who are subject to compulsory care and treatment."[67] During a process of legislative change in 2015, "concerns were raised with Ministers that there was not a consistent approach across Scotland to decisions or procedures on whether to review, and how to review, deaths of people who were being detained for care and treatment".[68] This issue was the subject of a review by the MWCS, published in 2022, which recommended a new model to be adopted. (The model recommended by the MWCS review has not yet been allocated funding, so is not being implemented at this time.)[69]

63. The review examined evidence from stakeholders such as Scotland's NHS Boards and Health and Social Care Partnerships, the Scottish Human Rights Commission, medical professional bodies, mental health charities, and individuals with lived experience and bereaved families.[70] It found that "not all deaths [in mental health detention] are investigated, especially in cases where the deaths have not been recorded as 'unavoidable' or 'unexpected', despite the fact that the people who died may have spent long periods of time" in detention. It also found that, "Most deaths of people subject to mental health detention[71] at the time of their death are not currently being reviewed locally or investigated consistently in a way that can be said to be independent".[72]

63. This was particularly concerning in view of the fact that, as a matter of Scottish law, not all deaths in mental health detention are the subject of a Fatal Accident Investigation (FAI) by the Procurator Fiscal (the equivalent of a coroner's inquest in England and Wales).[73] It also found that "there is wide variation in the time taken to carry out investigations – from a few weeks to as much as two years – and that families and carers are often excluded from the process."[74]

65. It recommended a model in which the MWCS is "responsible for initiating, directing, and quality assuring the process of investigating deaths during compulsory treatment in all cases".[75] In other words, rather than automatically investigating deaths themselves, the MWCS would largely oversee the investigation of such deaths by healthcare providers, while conducting its own investigations in some cases. It would also be "responsible for producing and disseminating an annual report on the results of the reviews", "follow[ing] up on recommendations made at a local and national level", and "develop[ing] guidance and standards for use by local services when undertaking reviews into deaths during compulsory treatment".[76]

66. A similar model was also recommended by the 2016 Independent Mental Health Taskforce.[77] It recommended that DHSC should ensure the remit of the then Healthcare Safety Investigation Branch (now HSSIB) "includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement".[78]

The HSSIB model

67. It is important to note that the Dash Review recommends that the functions of HSSIB are transferred to CQC and that it continues to operate as a discrete branch within CQC, retaining its independence.[79] The recommendations of the Review have been accepted by Government, but are yet to be implemented. Since it is unclear how the operation of HSSIB will change going forward, this report considers the role and function of HSSIB in its current form.

68. The remit of HSSIB contrasts with that of MCWS. Rather than reviewing investigations by NHS or private providers, HSSIB conduct their own patient safety investigations. These "do not find blame or liability with individuals or organisations" but rather seek to "understand why patients may have been harmed or be at risk of harm".[80] Their investigations "take a system perspective and aim to reduce the likelihood of patient safety incidents from happening". These investigations also look at the ways in which these bodies respond to and learn from deaths, including by reviewing internal investigation procedures.

69. HSSIB has looked into systemic issues leading to deaths under the MHA – for example its most recent report into the into learning from deaths in mental health inpatient services covers a range of learning drawn from the investigative processes of and responses to concerning cases of deaths arising during detention under the MHA.[81] Rather than investigating individual deaths like other bodies dedicated to investigating deaths in custody, such as the PPO, HSSIB instead take a system-wide, thematic approach by examining a selection of cases to draw out important themes and learning. Its founding statute, the Health and Social Care Act 2022, requires the protection of specific materials held by HSSIB and prohibits the disclosure of such materials to any person, including for legal proceedings, although there are some specific exceptions.[82] This prevents its material and reports from being used to assist inquests, unlike those produced by other independent investigative bodies such as the IOPC or PPO.

Why more is needed

70. These two models for MHA deaths investigations seek to address some of the problems identified in this report by improving the quality and consistency of investigations and learning following a death occurring whilst under MHA detention. As with the PSIRF, both are valuable means of improving system-wide safety issues to prevent deaths. However, the establishment of individual investigations of deaths occurring whilst individuals are detained under the MHA by an independent mechanism would complement these existing systems for patient safety investigations.

71. The IAPDC believes these should work in tandem, approaching patient safety in complementary but distinct ways. Having different purposes from individual investigations, the MWCS and HSSIB models by themselves are unlikely to meet the standards set out in Chapter 1, including those relating to Article 2 ECHR, due to the legal frameworks MCWS and HSSIB operate within. Indeed, within prisons, individual investigations are conducted via the work of the PPO while HSSIB conducts wider investigations of prison healthcare through its systemic and thematic approach, such as its recent investigations of healthcare provision prisons.[83]

72. As noted above, the HSSIB model does not investigate individual cases and is not permitted to share information from its investigations with coroners to aid inquests in meeting the requirements of Article 2, unless an exception to protected disclosure applies. The MWCS's own review into the situation in Scotland raised these same issues, with some respondents expressing "concerns that the current proposal is not Article 2 compliant, as the investigation would not be independent, would not appear to allow for effective participation by families, and would be lacking in public scrutiny".[84] Others suggested that "deaths of those in mental health detention would not receive the same independent scrutiny as those in police or prison custody".[85]

73. The MWCS responded by stating that, although "[t]here will be occasions when the Commission will move directly to its own investigation if it considers it is inappropriate for the local service(s) to carry out the investigation", "other key considerations need to be balanced with the argument that 'independence' in reviews surpasses all other rights and principles".[86]

74. As identified above, bereaved families often have concerns that investigations commissioned by Trusts and private providers into the deaths of their loved ones amount to the authorities "marking their own homework".[87] HSSIB plays a vital role in addressing the concerns regarding the quality and consistency of existing investigations raised in previous chapters and driving improvements to current processes. However, this does not address the questions of independence and effectiveness raised by bereaved families – HSSIB's role is not to produce individual investigation reports which could then be used to inform coronial investigations like those of the PPO – for which a different approach is needed.

75. Overall, while each of these models help drive improvements, the auditing and oversight of investigations commissioned by Trusts and private providers – as in the MWCS model – would not be sufficient to provide the independence and effectiveness that deaths in MHA detention demand. At the same time, overarching, system-wide patient safety investigations – such as those conducted by HSSIB – will help healthcare providers improve their care at the systems level, but they will not be able to satisfy the need for independent investigations of individual deaths arising during detention under the MHA. The benefits of an independent mechanism tasked with investigating these deaths should be seen as complementary, rather than superseding or replacing these models.

Chapter 5: Investigating all deaths in MHA detention

76. The Independent Review of the MHA, led by Sir Simon Wessely in 2018, looked at whether all deaths during detention under the MHA should be investigated by an independent body. It concluded that, with between 200-300 deaths each year, it would be "disproportionate" to recommend "further independent investigations" for all deaths, although a "stronger case" could be made for such investigations of 'unnatural' deaths.[88] He recommended returning to this issue after five years, particularly whether changes to existing frameworks for investigation and learning were having a significant impact.

77. Severe mental ill health and detention both pose risks to physical health. As the IAPDC Chair, Lynn Emslie, identifies in her foreword to this report, there are strong arguments for revisiting the case for independent investigations now, not just for self-inflicted deaths but for so-called 'natural' deaths as well.

The risks and impact of detention

78. The impact of poor mental health on physical health is well understood, with individuals with severe mental ill health at "greater risk of poor physical health and hav[ing] a higher premature mortality than the general population".[89] Those with severe mental ill health have an "increased risk of premature death [...] compared to the general population", which "corresponds to a reduction in life expectancy of 10-20 years".[90]

79. In its latest statistical analysis report, the IAPDC found significantly higher rates of deaths in detention settings, compared to the general population.[91] Further, in its most recent research report, the IAPDC identified that factors related to detention, such as "length of stay, involuntary admission, and a lack of access to appropriate care", were associated with increased risk of death and merited further exploration.[92]

80. These unique factors make it particularly important that individual investigations are conducted to fully understand what happened and the extent to which they played a role in the specific circumstances of the death. Questions may arise in individual cases as to whether the care provided was adequate for a patient's specific needs and whether detention itself had an impact on their physical health.

81. Indeed, 'equivalence' of care is an important guiding principle when considering the care provided to a person in state detention. Care provided within secure and other detained settings (including those detained under the MHA), cannot be precisely the same as that provided to a person in the wider community. Given the practical challenges and the lack of choice a detained individual has over their care compared to those in the community, authorities have an obligation to ensure the specific context and impact of detention on patients' health and healthcare is taken into consideration and fully investigated. The characteristics of those detained may require distinct aspects of care to meet their specific healthcare needs. Additionally, the context of care within a secure environment alters how healthcare services are organised and delivered.

82. Establishing an independent investigative mechanism for both natural and unnatural deaths would not only ensure parity with other detention settings but may also help to ensure parity with the standard and quality of care available in the community. While these investigations will vary in their scope, detail, and depth, they could play a key role in understanding and addressing the unique complexities of care of those in MHA detention. Individuals detained under the MHA are likely to have pre-existing health conditions and co-morbidities that play a significant or even decisive role in their deaths. But the extent to which these factors contribute to the death of an individual can only be identified by a systematic approach to fully effective and independent investigation.

Driving improvements to healthcare

83. HSSIB plays an important role in overseeing and investigating patient safety in healthcare settings. Its approach will help to ensure lessons are learned after 'natural' deaths to drive improvements to healthcare provision. However, while it may be argued that this may render additional individual investigations of 'natural' deaths unnecessary for ensuring learning, as explained in the previous chapter, the IAPDC believe that this should not replace the independent investigation of individual deaths, nor the learning opportunities provided by these investigations.

84. At present, the PPO investigate 'natural' deaths in prisons, immigration detention, and the youth estate. It publishes a review of the recommendations that it issues following each investigation, providing a breakdown of those recommendations by category, with the largest proportion of these relating to healthcare.[93] It also publishes Learning Lessons Bulletins, which draws together learning identified from individual investigations and provides recommendations for system-wide learning, including within healthcare services.[94] These are particularly important for identifying learning from natural deaths from a public health perspective. For example, the PPO produced numerous Learning Lessons Bulletins that identified learning for both prison and healthcare staff from deaths caused by COVID-19. These findings provide valuable feedback for healthcare providers in these settings, helping to drive improvement. It is anticipated that feedback relating to MHA detention would be similarly valuable.

85. HSSIB's own reports continue to identify significant challenges in MHA provision, suggesting further change to existing systems of oversight may be valuable. In its most recent investigation into mental health inpatient settings, HSSIB identified "serious incidents of harm and reports to prevent future deaths where deterioration of patients had not been recognised or responded to."[95] In another case described in the report, HSSIB identified "incidents where physical health monitoring had not supported recognition of changes in a patient's long-term condition or prevented known complications from care", such as those with diabetes developing life-threatening diabetic ketoacidosis, the management of weight gain connected to medication, and where patients developed blood clots contributed to by inactivity and dehydration.

86. While there will always be opportunities to improve care under any system, this suggests that an independent mechanism only investigating self-inflicted deaths would pose a risk of missing relevant care failures, learning opportunities, and preventable deaths that could be taken from investigations of 'natural' deaths. Numbers of natural deaths arising whilst detained under the MHA are comparable to those in prison. The latter are the largest proportion of deaths investigated by the PPO, with a substantial proportion of its recommendations relating to these deaths.[86] Investigating all deaths in MHA detention could be helpful in identifying learning regarding the health inequalities faced by detained individuals. It would also, as explored in previous chapters, help meet the needs of bereaved families.

87. Further, the categories 'natural' and 'unnatural' can be artificial and unhelpful in considering deaths in detention. This has been raised by other reviews into this area, with the independent review into data on mental health inpatient care, led by Dr Geraldine Strathdee, receiving evidence that "the use of natural and unnatural in relation to deaths can be unhelpful in that they relate to the way someone has died rather than the cause of death".[97] All deaths can be multifactorial, the identification of which may be key to prevention. Ensuring a consistent system of categorisation of deaths across the detention landscape is also important for accurate comparison of data and the identification of opportunities for cross-detention learning. Further work should be done to determine the most appropriate system for initial categorisation for deaths of people who are detained under the MHA and ensure alignment with any future changes to such categorisations in other detention settings.

88. These concerns may lead to consideration of different options for investigating deaths in MHA detention. The maximalist option would be for an independent mechanism to investigate all deaths, natural and 'unnatural', while the minimalist approach would be to restrict such a mechanism to investigating only those deaths classed as 'unnatural'. While the IAPDC believes there are strong arguments for the former, the latter would be a significant improvement on the status quo.

Chapter 6: Establishing independent investigations of MHA deaths

89. We have considered two ways in which existing resources and structures could be used to enable such an independent mechanism to investigate deaths arising whilst detained under the MHA. One option would be to establish an entirely new discrete investigative function within an existing body. Another option would be for existing bodies to work together to establish an investigative mechanism, drawing on their various areas of expertise and specialist resources. There are several existing bodies that could provide models for conducting these investigations or could even take on this mechanism themselves, either separately or in collaboration with other bodies.

90. There are currently a range of bodies that investigate incidents involving deaths in custody and healthcare complaints in different ways, as well as performing regulatory functions. Some of these bodies have a dedicated role to investigate individual deaths. The PPO investigates all deaths in prisons and immigration detention across England and Wales. The IOPC similarly investigates deaths during or following police custody and contact in England and Wales. There are also a number of bodies whose purpose is to investigate complaints relating to healthcare, including situations where there has been a death in detention. For example, the PHSO investigates complaints brought by patients or family members relating to healthcare in England, which could include those relating to a death of individuals occurring whilst detained under the MHA. The Public Services Ombudsman Wales (PSOW) undertakes a similar role for healthcare services in Wales.

Existing independent investigative or oversight bodies

PPO

91. The PPO – under its Fatal Incidents Investigations Function – carries out independent investigations into deaths in prisons and immigration detention as well as the deaths of prisoners within 14 days of release. These investigations are conducted in line with their non-statutory ToR, setting out its unfettered access to material, premises, and people to conduct its investigations.[98]

92. Its investigations cover the circumstances of the deaths, examining the decisions and actions relating to the management, supervision, care, and treatment of individuals held in institutions within their remit. Following its investigations, the PPO makes recommendations for change where necessary, and many of these relate to the provision of mental healthcare. In 2023/24, for example, the PPO made 32 recommendations relating to mental health provision following a death.[99] As set out above, alongside its investigations, the PPO also publishes Learning Lessons Bulletins, which draw on learning from its individual investigations using case study examples, and identifies areas for system-wide learning and improvement both in the place of detention and its healthcare providers.

93. In 2023/24, the PPO investigated 360 deaths in prison and immigration detention. This amounted to 104 self-inflicted deaths, 188 from 'natural' causes, and 45 'other non-natural' deaths (including those awaiting classification). (58 of the overall number of deaths were following release). NHSE-commissioned clinical reviewers assist these investigations by determining the equivalence of care to what would have been expected in the community. Importantly, these clinical reviewers are "independent of the establishment's healthcare and, where appropriate, will conduct joint interviews with the PPO investigator", which "allows for comprehensive examination of the actions of both custodial and healthcare staff to take place".[100]

IOPC

94. The IOPC is an independent body established under the Police Reform Act 2002, which independently investigates deaths during or following police custody or contact in England and Wales. It also provides oversight of the police complaints system. Police forces have a statutory duty to refer policing deaths to the IOPC, although it is not required to investigate every death referred to it and can refer a case back to the local police force for investigation. While it has significant experience and expertise in the investigations of deaths in one form of custody, the circumstances of these deaths are often very different from those arising whilst detained under the MHA, involving only a maximum of a few days in custody rather than weeks, months, or years.

PHSO

95. The PHSO investigate complaints by patients and families regarding the care they have received by NHSE, with its powers set out in the Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993. While the PHSO has significant expertise and experience in conducting investigations into health settings, including prison healthcare and MHA detention, its remit is to conduct investigations into complaints, rather than deaths and it does not have the ability to initiate investigations itself. We understand that complaints brought by family members following a death during detention under the MHA are very infrequent, particularly when considering the overall number of deaths arising whilst detained under the MHA.

PSOW

96. The PSOW investigates complaints made or referred to it involving Welsh public services, including both NHS Wales and independent healthcare providers. Its powers were established in the Public Services Ombudsman (Wales) Act 2005 and extended in the Public Services Ombudsman (Wales) Act 2019 to allow the PSOW to initiate investigations itself where there might be systemic service failures, known as 'own initiative' investigations. The 2019 Act gave the PSOW the power to compel organisations and individuals to give evidence and enforce cooperation with the investigation to ensure full and effective investigations. Despite its experience and expertise of investigating health settings, like the PHSO, the PSOW's remit is largely to investigate the complaint, rather than the death and we understand that it has only very rarely investigated deaths occurring whilst an individual is detained under the MHA.

CQC

97. CQC is an executive non-departmental public body, established under the Health and Social Care Act 2008. It regulates health and adult social care services in England, with the aim of ensuring safe, effective and high-quality care, and driving improvements within healthcare services. The role of CQC is to register care service providers; monitor, inspect and rate services to ensure they are meeting CQC's quality standards; take action where poor care is identified; and publish independent reports on major quality issues in health and social care. CQC has a duty under the MHA "to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship".[101]

98. CQC also has a duty under the MHA to review complaints relating to how a services uses its powers or carries out its duties under the MHA.[102] It received 2,241 MHA complaints in 2023/24 and carried out in-depth investigations into 10 of these complaints. Such investigations are undertaken by MHA reviewers if complainants were dissatisfied with the response following initial complaints investigations by the mental health service provider. Complaints can be made by anyone, including staff, patients, or members of the public. If CQC upholds the complaint, it will make recommendations to the provider to ensure learning and improvement. Much like the PHSO and PSOW, its expertise is in health and social care settings, and its remit lies in regulatory and complaints-based investigations. Both these investigations serve an entirely different purpose, and their remit is governed by statute. As such, it does not investigate deaths. The number of investigations they undertake, particularly in the case of complaints investigations, is also much smaller than the number that would be required for MHA deaths investigations.

Independently investigating deaths arising whilst an individual is detained under the MHA using an existing body or bodies

99. As canvassed above, there is currently a significant and anomalous gap in investigations into deaths arising whilst detained under the MHA. Existing bodies that examine healthcare settings do not conduct own-initiative investigations into deaths arising whilst detained under the MHA. Their investigations typically only begin when a family member lodges a complaint, and we understand that PSHO and PSOW have conducted very few investigations into these deaths. By contrast, the PPO has the most relevant expertise as a body automatically conducting individual deaths investigations in other detention settings through its Fatal Incident Investigation Function.

100. MHA detention, however, is an entirely different setting, the investigation of which would require significant healthcare-related expertise. Nevertheless, the IAPDC believes that there is a strong case for relying on the existing experience, expertise, and resource of bodies such as the PPO that already conduct deaths investigations in different settings, potentially enabling this new function to be established more readily. The PPO's Fatal Incident Investigation Team has several key elements which could contribute to establishing this new independent mechanism. For example, its ToR seek to assist with meeting Article 2 obligations, set out in Chapter 1, including its independence and rights of access to evidence. Due to its expertise in this area, learning from the PPO's deaths investigations could also be sought to ensure learning is shared across areas of detention.

101. Regardless of which body or bodies perform this function, it is important to consider from where they derive their powers to investigate these deaths. While some bodies, such as the PPO, conduct their investigations without a statutory basis, the value of statutory status has been highlighted in recent investigations of deaths in MHA detention. The statutory Lampard Inquiry was set up to investigate deaths of patients in inpatient mental health care in Essex between 2000 and 2020. But it originated from a previous non-statutory inquiry granted statutory status so it could compel healthcare services and staff to provide evidence, after very few of the staff involved in the incidents being investigated did so.[103] In the IAPDC's view it is vital that the mechanism investigating deaths under the MHA should have the right of access to compel effective evidence gathering and facilitate full and thorough investigations. This can be achieved in a number of ways, although enshrining these in statute would be best practice.

102. The IAPDC recognises the benefits of drawing on best practice and learning from the existing forms and functions across the investigative landscape to establish an independent mechanism to conduct these investigations. It would be difficult to identify what funding this would require: significant scoping would need to be conducted to identify what resources this mechanism would need, as well as the relevant considerations for obtaining clinical advice.

Clinical advice for investigation of deaths in MHA detention

103. A particularly important consideration for how an independent mechanism would conduct these investigations is their approach to obtaining appropriate clinical advice. Death in detention investigations require clinical advice and input to assist investigators in interpreting medical factors that may be relevant to a person's death. We note that currently each investigative body adopts different approaches and models to commissioning clinical advice and incorporating it within their investigations. In seeking to establish the independent investigations of deaths arising whilst detained under the MHA, it is important to consider best practice in terms of how clinical advice should be incorporated.

104. In keeping with the principle of independence under Article 2, as discussed in Chapter 1, the clinicians supporting investigations with advice should themselves have no actual or perceived conflict of interest in undertaking the report. The ethical principle of professional independence arises not only within their duties in clinical practice but includes their role in conducting death in detention investigations. Therefore, as a key principle, clinical advice should be independent from the organisation providing the care.

105. Additionally, the clinical advice being provided should be based on knowledge of specialist clinical practice relevant within the secure environment as well as up-to-date knowledge relevant to the general healthcare provided to the patient. In this way, the clinical advice for the investigation of deaths under the MHA will require a process which seeks to explore and carefully balance the specialist psychiatric care as well as the general physical healthcare and any other relevant patient needs (e.g. social care provision) in order to evaluate and assess the underlying contributory components.

106. Any existing body or collection of bodies tasked with undertaking the investigation of deaths under the MHA through a new discrete investigative mechanism will require mechanisms by which it can ensure investigators have the necessary training and skillset and that the clinical input is sufficiently qualified and independent to ensure a thorough and robust investigation. It will need to be resourced to do this. Some existing bodies ensure this as part of their primary role in investigating healthcare-related complaints, such as the PHSO in England and the PSOW in Wales.

107. To assist the body or bodies to ensure sufficient clinical expertise is involved, it may be helpful to adopt a similar approach to the PPO's Level 3 'panel' Death in Custody Clinical Review process. A 'panel' review incorporates a chair overseeing other members with the relevant clinical expertise to consider the different aspects that may be relevant to the case. A 'panel' approach and initial 'triage' of a death arising under the MHA could assist in ensuring the correct balance of generalist and specialist knowledge is involved from the outset and a pragmatic approach can then be taken to allocating the necessary resources to the investigation. This approach will also help to prioritise the focus of the clinical aspect of the investigation on the physical health or psychiatric care as well as ensuring there is a sufficient understanding of the factors arising from the security measures of the establishment. Additionally, perceived or actual conflicts of interest can be considered at the earliest stage in order to ensure appropriate independence of the clinicians and practitioners tasked with assisting with the investigation. A 'panel' approach would also be valuable for ensuring a fully joined-up investigation, as well as strengthening the quality assurance aspects of the investigations.

108. As an important additional provision, the IAPDC recommends that clinical expertise and clinical leadership are incorporated within this independent investigative mechanism. This approach would ensure that there is an additional level of quality assurance ensuring consistency between the investigations being carried out and that the gathering of learning could be embedded within their processes in a way that best supports its investigations. At the very least, as an alternative, the mechanism should have its own clinical leadership to direct, oversee, and quality assure externally commissioned clinical advice – making sure, for example, its review process is asking the right questions to conduct effective and independent investigations. The independent mechanism should also ensure appropriate engagement and cooperation with the required regulatory and other investigative bodies.

Chapter 7: The IAPDC's recommended options for reform

109. In this chapter we set out the recommendations for ensuring the independent investigation of deaths arising whilst detained under the MHA. The Dash Review highlighted the large numbers of bodies within healthcare that currently undertake investigations of various kinds. Building on these findings, the IAPDC believes the best way to ensure that these independent investigations are undertaken effectively is to utilise the resources and expertise of an existing body or bodies, rather than adding to this list by establishing an entirely new body. As explored in more detail above, this would help to reduce duplication and improve learning across both healthcare and areas of detention.

110. As Government works to implement the Dash Review, there may be value in using existing resources to build a new, discrete independent investigative mechanism. The important thing, the IAPDC believes, is that independent investigations are properly conducted, however this takes place. Therefore, the IAPDC recommends the following:

To establish an independent fatal incident investigation function

111. To ensure the independence and equality of investigations of deaths arising whilst detained under the MHA, a new mechanism should be established within an existing body or bodies across the health, detention, and investigative landscape to investigate these deaths. Drawing on cross-sector expertise and experience is important to ensure that this mechanism maintains the appropriate patient- and healthcare-centred approach within the specific and unique context of detention under the MHA. This would not only make best use of existing resource, expertise, and experience but it would seek to ensure learning is identified and drawn together from the other areas across both healthcare and detention settings.

112. To achieve this, this mechanism should be appropriately staffed to ensure it has the necessary expertise. This may also require collaborative working from a number of bodies with both investigative and clinical expertise. Many existing bodies that may be appropriate to house this mechanism do not have their own internal clinical leadership or quality assurance. For example, the PPO's clinical advice is provided by NHSE and HIW in England and Wales respectively.

113. To ensure there is sufficient clinical expertise relevant to deaths occurring whilst detained under the MHA, and subject to scoping and agreement, clinical advice could be obtained from another body with this existing resource. This would help ensure an appropriate level of independent clinical expertise and advice is being obtained to assist with the medical aspects of the death investigations. As set out above, this could include a 'panel' approach to ensure that deaths occurring whilst detained under the MHA incorporated a balanced approach to both the general physical and specialist psychiatric healthcare elements. In addition, the mechanism should have its own clinical leadership to direct, oversee, and quality assure externally commissioned clinical advice.

114. Regardless of whether one existing body or multiple bodies supports this independent mechanism, further scoping would be needed to identify what resource may be required to ensure there is the expertise to investigate the unique context of detained healthcare deaths. This should be done in partnership with bodies such as the PPO, HSSIB, CQC, and PHSO, by drawing on learning from the structures of these bodies, to ensure that investigations and processes serve the purposes of independent investigations set out earlier in this report.

Proposal for Next Steps

115. As addressed throughout this report, regardless of which proposed option is taken forward, a further scoping exercise is needed to develop the following areas:

    I. **Necessary expertise:** drawing on existing learning and resources from other investigative bodies, such as the PPO, HSSIB, and PHSO, to assist with setting up this new mechanism. This will also help with other operational aspects, such as understanding what expertise is needed and establishing procedures for training, to avoid duplication.

    II. **Clinical advice:** determining the most appropriate method for ensuring that the clinical advice provided is backed by sufficient expertise and independence, as well as having a process to ensure quality assurance. As set out above, this could be done in partnership with an existing body that already undertakes clinical investigative work, and further work should be done to determine whether this is done on an interim basis while the mechanism gathers its own internal clinical resources, or whether permanent partnership regarding resources or training would be more appropriate.

    III. **Categorisation of deaths:** identifying an appropriate methodology to ensure that the mechanism can provide a provisional categorisation of the death in its investigation that is comparable to other detention settings, while not interfering with the coroner's judgement.

    IV. **Data:** ensuring effective data gathering so that the data on deaths can be better compared across detention settings, to help inform the work of the MBDC.

    V. **Statutory footing:** considering placing in legislation the mechanism, its responsibilities, and the duty of organisations it investigates to comply with such investigations.

116. To conclude, this report has explored the reasons for establishing independent investigations of deaths of people arising whilst they have been detained under the MHA, the possible forms they could take, and the purpose they would fulfil. In the IAPDC's view, it is vital that all deaths that occur in detention, where the state is responsible for an individual's care, are investigated equally, with the same rigour and standard of investigation. Overall, this process should strengthen the state's compliance with its Article 2 obligations and ensure effective learning and improvement from deaths to prevent further deaths occurring in similar circumstances.

ANNEX – DATA ON INQUESTS

Table 1: Deaths under the MHA reported to the CQC and deaths under the MHA reported to coroner between 2010 and 2023.

CQC MHA deaths data[104]		Deaths in MHA detention reported to coroners[105]	
2010/11	N/A	2011	83
2011/12	236	2012	93
2012/13	275	2013	97
2013/14	198	2014	100
2014/15	227	2015	188
2015/16	266	2016	252
2016/17	247	2017	196
2017/18	247	2018	171
2018/19	195	2019	144
2019/20	240	2020	219
2020/21	363	2021	170
2021/22	270	2022	193
2022/23	264	2023	147

Table 2: Recorded prison and police custody deaths and deaths in these two settings reported to coroners.

HMPPS prison deaths data[106]		Prison deaths reported to coroners		IOPC police deaths data[107]		Police deaths reported to coroners	
2011	192	2011	185	2010/11	21	2011	22
2012	192	2012	152	2011/12	15	2012	9
2013	215	2013	155	2012/13	15	2013	12
2014	243	2014	220	2013/14	11	2014	10
2015	257	2015	261	2014/15	18	2015	11
2016	354	2016	298	2015/16	14	2016	10
2017	295	2017	293	2016/17	14	2017	19
2018	325	2018	316	2017/18	23	2018	15
2019	300	2019	299	2018/19	17	2019	14
2020	318	2020	318	2019/20	18	2020	8
2021	371	2021	373	2020/21	19	2021	18
2022	301	2022	300	2021/22	11	2022	12
2023	311	2023	309	2022/23	23	2023	20

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Endnotes