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Deaths in Psychiatric Detention

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Carly Speed- 'Deaths in Psychiatric Detention'

Entry for A Companion to State Power, Rights and Liberties

In 2007 it was found that 23% of individuals in England had at least one psychiatric disorder (McManus et al 2009). Therefore, it was unsurprising that between the 1st April 2013 and the 31st March 2014 the Mental Health Act was used 53,176 times to detain patients for longer than 72 hours. This was 5% more than 2012/2013 and 30% more than 2003/2004 (Health and Social Care Information Centre, 2014).

Between 2000 and 2013 there were 4,573 deaths of detained patients in England and Wales and this accounted for 60% of all deaths in state custody during this time (Independent Advisory Panel on Deaths in Custody, 2013). A particularly contentious area surrounding the deaths of individuals in psychiatric detention is the inquest and investigation processes. In 2015 the charity INQUEST launched a report which examined deaths in mental health detention and three key themes were highlighted. First, the number of deaths and issues related to reporting and monitoring. Second, the lack of provisions in place to ensure post-death accountability and future learning from these deaths. Third, the lack of an independent investigation system compared to deaths in police and prison custody (INQUEST, 2015). Regarding this latter point, INQUEST highlighted that when an individual dies in police or prison custody, these deaths are subject to an independent investigation by either the Independent Police Complaints Commission (IPCC) or the Prisons and Probation Ombudsman (PPO). Therefore, when a coroner's inquest occurs, information is drawn upon from the independent investigation. In contrast, when an individual dies in psychiatric detention, the hospital trust responsible for an individuals' care at the time of their death usually carries out an internal investigation regarding the circumstances surrounding the

death. As a result, when a coroner's inquest takes place regarding a death in psychiatric detention, it has to rely on information gathered from this internal investigation. INQUEST argued that because of this the coroner may be unable to fully investigate systemic failings or provide guidance regarding the prevention of future deaths. Furthermore, INQUEST highlighted that hospital trusts investigating themselves does nothing to improve family or public confidence in the system. It was also noted within the report that bereaved families are often not involved in internal investigations conducted by hospital trusts and also experience difficulties in accessing information and documents related to the investigation.

Similar concerns were also highlighted in a 2015 inquiry by the Equality and Human Rights Commission (EHRC) which examined the deaths of individuals in psychiatric detention in addition to deaths in police and prison custody of those with mental health problems. Of particular interest to the EHRC was compliance with Article 2 of the European Convention on Human Rights. Article 2 is the right to life and compels the state to safeguard the lives of those in its custody. If, however, an individual dies in custody, the Article 2 obligation of the state extends to carrying out an investigation which should be prompt, independent, involve the bereaved family and be open to public scrutiny. The inquiry found that repeated basic errors had been made, lessons were failing to be learnt and there was a lack of appropriate systems and procedures in place and this had contributed to the non-natural deaths of hundreds of people in these different forms of detention (EHRC, 2015). Finally, reiterating the views expressed by INQUEST, the inquiry found that the current system was opaque with bereaved families not being included in their relatives care or an investigation following a death.

Reference List

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