HOUSE OF COMMONS LIBRARY

DEBATE PACK

Number CDP 2020/0143, 26 November 2020

Debate on e-petition 255823, relating to deaths in Mental Health care

By Elizabeth Parkin; Aaron Kulakiewicz

Summary

A Westminster Hall debate on petitions relating to deaths in Mental Health care is scheduled for Monday 30 November 2020 from 4:30-6:00pm. The motion for debate is: "That this House has considered e-petition 255823, relating to deaths in Mental Health care". The subject for this debate was determined by the Petitions Committee and Petitions Committee member Mike Hill MP, who will open the debate.

Contents

1. Deaths in mental health care

This debate focuses on e-petition 255823, relating to deaths in mental health care. The petition was created by the mother of Matthew Leahy, a young man who died in 2012 whilst receiving care at the Linden Centre, a mental health unit at what was then the North Essex Partnership University NHS Foundation Trust (the Trust).[1]

The petition also raises concerns about a number of similar deaths at multiple sites within the same Trust and calls for a statutory public inquiry into deaths that occurred in the Trust since the year 2000.

On 16 October 2020, an adjournment debate was held on the subject of Care Quality Commission: Deaths in Mental Health Facilities. The Member in charge, James Cartlidge MP, focused on the case of a constituent, Richard Wade, who took his own life whilst under the care of the Linden Centre in May 2015. During the debate, James Cartlidge raised concerns about the CQC's handling and investigation of Mr Wade's death and several deaths at the Linden Centre.

In response to the debate, the Government announced an independent review into the serious questions raised by a series of deaths of patients at the Linden Centre between 2008 and 2015. The terms of reference of the review have not yet been agreed – the Government have said they wish to engage with the families affected to agree the scope and terms of reference for the review.[2] It has also not yet been announced whether the independent review will have similar terms to a statutory public enquiry, for example providing legal powers to compel witnesses to give evidence. Further information on types of statutory inquiry are available in the Library paper on Statutory commissions of inquiry: the Inquiries Act 2005 (September 2020).

1.1 Reviews and investigations into services at the former North Essex Partnership University NHS Foundation Trust

In June 2019, the Parliamentary and Health Service Ombudsman (PHSO), published its report, Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust. The report found that there were a series of significant failings in the care and treatment of two vulnerable young men, Mr R and Mr Matthew Leahy, who died shortly after being admitted to the Linden Centre. The PHSO also recommended and agreed with NHS Improvement that it would conduct a review of what happened at the Trust.

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1 North Essex Partnership University NHS Foundation Trust merged with South Essex Partnership University NHS Foundation Trust in April 2017, to form the Essex Partnership University NHS Foundation Trust.

2 HC Deb 16 October 2020 c734

In November 2019, the Public Administration and Constitutional Affairs Committee published its scrutiny of the PHSO 'Missed opportunities' report. The Committee's inquiry examined the issues identified in the PHSO report and investigated what actions have since been undertaken in the areas of: safety of acute mental health care provision; leadership; and developing a culture of learning within the NHS. In particular, the Committee noted the significant body of evidence from the Care Quality Commission (CQC), the PHSO report and others that there is a need for significant improvements in the safety and quality of mental health provision throughout the NHS:

> The Committee found that significant improvement in the safety and quality of mental health provision is needed throughout the NHS and it recommends that the Minister and NHS England ensures that this is a top priority. The Committee agrees with the recommendation of the Care Quality Commission that NHS England and NHS Improvement should ensure that patient safety forms part of ongoing mandatory training as part of continuing professional development.
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> On the topic of leadership, the Committee concludes that the PHSO report powerfully demonstrates the need for effective leadership within the NHS. We welcome the Government's proposal to specifically cover plans for leadership in the NHS within the People Plan, to be published later this year. The Government should make clear, however, that ensuring effective leadership within an organisation is not simply a one-off event but rather is an iterative process of continuous improvement.
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> On developing a culture of learning in the NHS, the Committee welcomes the Government's commitment to ensuring the families affected will be involved in the upcoming NHS Improvement and NHS England review. We also welcome the inclusion of Health Service Safety Investigations Bill (HSSIB) in the recent Queen's Speech, a piece of legislation that the Committee has strongly supported for many years. In particular, we believe that the introduction of the 'safe space' principle will facilitate more open investigations and proper learning to reduce repeated incidents and recommend that it be included in the Queen's Speech after the upcoming General Election.[3]

The Health and Safety Executive (HSE) has also investigated how the Trust managed environmental risks from fixed potential ligature points in its inpatient wards between October 2004 and March 2015. Following this investigation, an HSE prosecution is now being brought against the Trust under *Section 3(1) Health and Safety at Work Act 1974*.[4]

As noted above, in response to the adjournment debate on Care Quality Commission: Deaths in Mental Health Facilities (16 October 2020) , the Minister announced that the Government will commission an independent review into the questions raised by a series of deaths of patients at the Linden Centre between 2008 and 2015:

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3 Public Administration and Constitutional Affairs Committee, Follow up on PHSO report: Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust, 31 October 2019, HC31, page 3

4 Health and Safety Executive, HSE to prosecute Essex Partnership University NHS Foundation Trust (EPUFT), 29 September 2020

> I am announcing today that she [the Minister] has set out her intention to commission an independent review into the serious questions raised by a series of tragic deaths of patients at the Linden Centre between 2008 and 2015.
>
> […]
>
> I hope that this announcement today to commission an independent review into issues at the former North Essex partnership trust shows the strength of our commitment and my hon. Friend's commitment in addressing the concerns he and his constituents have raised and in listening to and working with the families involved in these tragedies. We are committed to learning lessons at a national level to improve services across the whole mental health system, so that no other family experiences the same devastating loss as Richard's family and the families of other patients who died at the former North Essex partnership trust.[5]

[5] HC Deb 16 October 2020 c733

2. Patient safety

2.1 Patient safety policies

The NHS Patient Safety Strategy was published in July 2019 and includes national and regional actions to continue to improve patient safety.

The Strategy details the Mental Health Safety Improvement Programme (MHSIP), which focuses on suicide prevention and reduction for mental health inpatients. This Programme provides bespoke support to mental health trusts on their individual safety priorities as well as support around challenges that are common across many or all local systems. The MHSIP works with each of the 54 NHS Trusts providing mental health services to understand their safety concerns and devise an improvement programme accordingly. The Programme launched in May 2018 and was a two-year programme funded until March 2020.[6] Further detail of funding beyond this point is not yet available.

As also outlined in the Strategy, the NHS in England is developing a new Patient Safety Incident Response Framework (PSIRF) to replace the current Serious Incident Framework. The expectation is that all parts of the NHS in England will be using the new framework by Autumn 2021.

High-profile reviews and inquiries such as those at Mid Staffordshire, Gosport and Morecambe Bay have found serious failings in hospital care, and highlighted that patients, families, carers and staff can experience closed and defensive cultures when things go wrong in the NHS. Long-standing failings identified in care provided to people with mental illness and learning disability have also led to a particular focus on these areas.[7]

Further information on patient safety is available in the Library briefing on The structure of the NHS in England – section 7 (June 2020)

2.2 Suicide prevention policy in England

The national suicide prevention strategy, Preventing Suicide in England: A cross-government outcomes strategy to save lives, was first published in 2012. Its key aims were to reduce the suicide rate in the general population in England, and better support those bereaved or affected by suicide. The strategy was updated in 2017 to include addressing self-harm as an issue in itself. The strategy included a commitment to reduce the rate of suicides in England by 10% by 2020/21 (compared to 2015 levels).

The Cross-Government suicide prevention workplan (January 2019) commits every area of Government to taking action on suicide and sets out clear deliverables and timescales to monitor progress against the key commitments set out in the Suicide Prevention Strategy.

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[6] PQ 197068 [on mental health services], 30 November 2018

[7] Further information can be found in the Library briefings on Learning Disability and Mental health policy.

The Five Year Forward View for Mental Health was published in February 2016 by the independent Mental Health Taskforce. The report made recommendations on suicide prevention and reduction, also including an objective to reduce suicides by 10% in England by 2020/21.[8]

The NHS Long-term Plan (January 2019) reaffirmed the NHS's commitment to make suicide prevention a priority over the next decade. The Long-term Plan committed to implementing the Mental Health Safety Improvement Programme. As noted above, this was a dedicated two-year programme focusing on suicide prevention and reduction for mental health inpatients which began in May 2018. Further detail of funding beyond this is not yet available. However, the Government has allocated funding of £57 million for suicide prevention by 2023/24.[9]

In January 2018, the then Health Secretary Jeremy Hunt also announced a zero-suicide ambition for mental health inpatients.[10] This included a new requirement for NHS mental health organisations in England to draw up detailed plans to achieve zero suicides, starting with those in inpatient settings. The plans include:

- Asking that all suicides by mental health patients are reported and published more quickly;
- Requiring Trusts to "strengthen the package of suicide prevention measures" they have in place;
- Ensuring that there are thorough investigations after all suicide attempts, with a focus on learning from errors; and
- Encouraging a "cultural shift within mental health services" so that suicides are not viewed as inevitable.

The then Health Secretary said this would result in England becoming the first country in the world to roll out zero suicides as a national ambition.[11]

Since October 2018, there has been a designated Minister for Suicide Prevention in the Department of Health and Social Care who is responsible for leading "a national effort on suicide prevention".

The National Confidential Inquiry into Suicide and Safety in Mental Health publishes annual reports on suicide in England, Northern Ireland, Scotland and Wales, and provides recommendations to improve patient safety in mental health settings and reduce suicide rates.

Further information is available in the following Library briefings:

- Mental health policy in England (October 2020)
- Suicide prevention: Policy and strategy (October 2019)

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8 NHS England, *Five Year Forward View for Mental Health*, February 2016, p13
9 PQ 54973 [on suicide: males], 4 June 2020
10 Public Health England, Department of Health and Social Care [DHSC], *New Funding for Health and Social Care in England*, 16 May 2018
11 'Zero suicide is our simple but powerful NHS mission', *The Telegraph*, 31 January 2018 (an opinion piece written by Jeremy Hunt MP)

2.3 Learning from deaths

In December 2016, the CQC published its review Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The CQC found that Trusts were not able to demonstrate best practice in identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The then Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement[12] made a range of commitments to improve how Trusts learn from reviewing the care of patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information.

The Secretary of State at the time also asked the NHS National Quality Board to draw up guidance on reviewing and learning from the care provided to people who die. This was published in March 2017: Learning from Deaths in the NHS. The guidance aims to standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process

2.4 Investigation and enforcement powers

The CQC is currently the lead inspection and enforcement body for safety and quality of patient treatment and care, for health and adult social care providers registered with the CQC. These powers were transferred from the Health and Safety Executive (HSE) to the CQC on 1 April 2015. The HSE and local authorities remain the lead inspection and enforcement bodies for providers not registered with the CQC.

The powers were transferred from the HSE to the CQC following concerns about the regulatory gaps in investigation and enforcement which had emerged between the two organisations. The Francis Report into care at Mid-Staffordshire NHS Foundation Trust (February 2013) said:

> Therefore, there is an unsatisfactory gap in the ability of regulators to enforce criminal sanctions in serious cases, in particular those involving death or serious harm to individuals where serious deficiencies in standards are involved. For understandable reasons, given the breadth of its responsibilities, its lack of specialist expertise in healthcare issues, and the existence of regulators apparently better equipped to make judgements on them, the HSE has been reluctant to take a less restrictive approach to healthcare cases. On the other hand, the CQC has relatively limited powers to prosecute. This restriction has, in part, been formed by reservations about the value of criminal enforcement in healthcare.
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> […]

[12] CQC review of deaths of NHS patients, 13 December 2016

> Therefore, there is a strong case for increasing the availability of such sanctions in healthcare and for allowing the CQC the powers to use them.[13]

An ambition to strengthen the CQC's enforcement powers was contained in their new strategy -Raising standards, putting people first: Our strategy for 2013-2016. The changes were intended to enable the CQC to pinpoint more clearly the standards below which care must not fall, and take appropriate enforcement action, in line with the Francis report's recommendations:

> We are working with the Department of Health, Monitor and the NHS Trust Development Authority to develop how this will work and to review our regulatory and enforcement powers to make sure we, or others, have the power to act where necessary. We will work closely with the Health and Safety Executive to make sure that appropriate action is taken against healthcare providers who break health-and-safety law.[14]

In an Impact Assessment for changes to its enforcement policy, the CQC also recognised this regulatory gap:

> Finally, the proposed changes will help to close regulatory gaps associated with confusion over roles and responsibilities for enforcement action. CQC's powers of prosecution will align more closely with those of the Health and Safety Executive, and the two regulators will set out an agreement giving more clarity about how their prosecution roles join up. This will help to ensure events such as Mid-Staffordshire and Winterbourne View are dealt with appropriately and in a timely manner to help protect users and their families from adverse effects of poor quality care.[15]

The CQC, HSE and local authorities published a memorandum of understanding setting out their respective responsibilities.

The CQC's enforcement policy (published in 2015) sets out in full their revised approach to addressing breaches of regulations. These powers are given under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.*

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13 Ibid, para 13.147,

14 CQC, Raising standards, putting people first: Our strategy for 2013 to 2016, 2013, page 11

15 CQC, Impact Assessment: Guidance on CQC's enforcement powers Changes to enforcement policy and enforcement powers, July 2014 para 7

3. Parliamentary Material

3.1 Debates

Care Quality Commission: Deaths in Mental Health Facilities

16 Oct 2020 | House of Commons | 682 c734

3.2 Parliamentary Questions

Autism and Suicide: Mental Health Services

03 Mar 2020 | 20633

Asked by: Ellie Reeves

To ask the Secretary of State for Health and Social Care, what guidance is provided to mental health assessment staff on (a) autism and (b) suicide; and whether that guidance refers to tips on suicide forums on how to pass mental health assessments.

Answering Member: Ms Nadine Dorries |
Department: Department of Health and Social Care

Following the death of Callie Lewis in 2018, Kent and Medway NHS Trust have initiated a series of actions. The Trust has updated its suicide prevention training for staff, including refreshing its suicide prevention strategy to specifically reference autism. This training is now a mandatory annual requirement for all Trust staff within inpatient, liaison psychiatry and crisis settings. The Trust has updated its training to include the risks of suicide forums.

In January 2019, we published the first Cross-Government Suicide Prevention Workplan, which sets out an ambitious programme across national and local government and the National Health Service.

Compulsorily Detained Psychiatric Patients: Death

29 Jan 2020 | 6047

Asked by: Barbara Keeley

To ask the Secretary of State for Health and Social Care, how many people who were detained under the Mental Health Act 1983 died in each year since 2010.

Answering Member: Ms Nadine Dorries |
Department: Department of Health and Social Care

Information on the number of people detained under the Mental Health Act and who died subsequent to detention is not held centrally. Information on the number of deaths in detention is attached.

Compulsorily Detained Psychiatric Patients: Suicide

10 Jul 2019 | 272210

Asked by: Caroline Lucas

To ask the Secretary of State for Health and Social Care, how many people have taken their own lives while being detained under the Mental Health Act 1983 in an (a) NHS and (b) private hospital in each of the last 10 years.

Answering Member: Jackie Doyle-Price | Department: Department of Health and Social Care

All service providers, including the National Health Service and private hospitals, must notify the Care Quality Commission when a person has died while being detained under the Mental Health Act 1983.

The number of deaths of patients detained under the Act and recorded as 'self-inflicted' is shown in the attached table.

Suicide: North West

28 Jun 2019 | 266769

Asked by: Sir Mark Hendrick

To ask the Secretary of State for Health and Social Care, how many deaths of patients in the care of each mental health NHS trust in the North West were attributed to suicide in (a) 2017, (b) 2018 (c) 2019; and what steps his Department is taking to reduce the level of deaths by suicide among patients undergoing treatment for mental health problems.

Answering Member: Seema Kennedy | Department: Department of Health and Social Care

This information is not available in the format requested.

The latest information on suicide registrations for 2017 was published by the Office for National Statistics in September 2018 and can be found at the following link:

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

The latest National Confidential Inquiry into Suicide and Safety in Mental Health report was published in October 2018 and is available at the following link:

https://sites.manchester.ac.uk/ncish/reports/

In January 2018, the former Secretary of State for Health and Social Care (Rt. hon. Jeremy Hunt MP) announced a zero suicide ambition for the National Health Service, starting with mental health inpatients. Every NHS mental health provider was required to put in place a zero suicide policy during 2018/19. There has been significant progress made by trusts in developing zero suicide plans, with regional suicide prevention leads supporting trusts to finalise these.

For those requiring support for a mental health problem, under the NHS Long Term Plan, there will be a comprehensive expansion of mental health services, with an additional £2.3 billion in real terms by 2023/24. This will give 380,000 more adults access to psychological therapies and 345,000 more children and young people greater support in the next five years.

Mental Health Services: Children

03 Apr 2019 | 238637

Asked by: Luciana Berger

To ask the Secretary of State for Health and Social Care, how many children have died in psychiatric in-patient units in each year since 2010.

Answering Member: Jackie Doyle-Price | Department: Department of Health and Social Care

The Department does not hold the information requested prior to 2013. Since January 2013, the National Health Service has reported 22 deaths of patients under the care of inpatient children and young people's mental health services as follows:

- 2013 (four deaths);

- 2014 (three deaths);

- 2015 (two deaths);

- 2016 (two deaths);

- 2017 (three deaths);

- 2018 (four deaths); and

- 2019 (four deaths).

All of these deaths were reported as suspected self-inflicted deaths at the point of notification to the Department. The final determination of cause of death is determined by the Coroner at inquest.

Al deaths of patients under the care of inpatient children and young people's mental health services are reported to Ministers, the Care Quality Commission, and the National Confidential Inquiry into Suicide and Safety in Mental Health which includes the figures in its annual reports.

Mental Health Services

05 Dec 2018 | 197608

Asked by: Barbara Keeley

To ask the Secretary of State for Health and Social Care, what recent progress he has made on the Mental Health Safety Improvement Programme; and if he will make a statement.

Answering Member: Jackie Doyle-Price | Department: Department of Health and Social Care

The Mental Health Safety Improvement Programme (MHSIP) was rolled out in April 2018 and is a two-year programme funded until March 2020.

The overall aim of the programme is for every National Health Service trust providing core mental health services in England to have understood its safety priorities and have made a measurable improvement in at least one key area of mental health safety by 31 March 2020.

From January 2019, MHSIP engagement meetings with trusts will align with the Care Quality Commission inspection cycle to ensure that there is a timely follow-up to the inspection findings.

Given the nature of the programme, it is too early to provide trend analysis at this stage.

Mental Health Services: Children and Young People

15 May 2018 | 141812

Asked by: Mary Robinson

To ask the Secretary of State for Health and Social Care, how many patients have died whilst under the care of inpatient children and adolescent mental health services since January 2013.

Answering member: Jackie Doyle-Price | Department: Department of Health and Social Care

Since January 2013, the National Health Service has reported 17 deaths of patients under the care of inpatient children and young people's mental health services. Following the written statement to Parliament by the then Parliamentary Under-Secretary for Public Health and Innovation (Nicola Blackwood) on 20 January 2017 (HCWS 427), all deaths of patients under the care of inpatient children and young people's mental health services are reported to Ministers and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which will include the figures in its annual reports.

Patient safety is a key priority for this Government and we published Learning from Deaths guidance to the NHS in 2017 to improve the way the NHS investigates and learns from deaths to prevent future tragedies. My Rt. hon. Friend the Secretary of State for Health and Social Care also announced a zero suicide ambition for mental health inpatients in January this year, which is supported by £25 million of investment, so that every mental health provider of NHS services has a zero suicide policy in place.

Suicide: Essex

08 Mar 2018 | 131085

Asked by: Norman Lamb

To ask the Secretary of State for Health and Social Care, what information his Department holds on the number of inpatient suicide deaths recorded at (a) North Essex Partnership NHS Foundation Trust, (b) South Essex Partnership NHS Foundation Trust and (c) Essex Partnership

University NHS Foundation Trust in (i) 2015-16, (ii) 2016-17 and (iii) 2017-18.

Answering Member: Jackie Doyle-Price | Department: Department of Health and Social Care

NHS Digital collects data on restrictive interventions through the Mental Health Services Data Set (MHSDS). The data for 2017/18 is not yet available and the data for 2015/16 is incomplete as it is from a previous data set, the Mental Health and Learning Disabilities Data Set (MHLDDS). The MHLDDS only covers eight months of the year from April 2015. Due to the changes in scope across the two data sets they would not be directly comparable.

NHS Digital has provided the number of recorded instances of physical interventions in 2016/17 only from the MHSDS:

- North Essex Partnership NHS Foundation Trust – 195; and

- South Essex Partnership NHS Foundation Trust – 1,065.

Data for Essex Partnership University NHS Foundation Trust is not yet available as the organisation only opened on April 2017.

Data on deaths by suicide by mental health provider are not routinely collected centrally.

3.3 Committee Reports

Follow up on PHSO report: Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust
Second Report of Session 2019
House of Commons Public Administration and Constitutional Affairs Committee
HC 31
4 November 2019

3.4 Statements

Children's Mental Health Inpatient Services
20 Jan 2017 | HCWS427
Nicola Blackwood | Under-Secretary of State for Health

CQC: NHS Deaths Review
13 Dec 2016 | 618 cc621-635
Jeremy Hunt | Secretary of State for Health

4. Press Releases and Reports

4.1 Press Releases

HSE to prosecute Essex Partnership University NHS Foundation Trust (EPUFT)

Health and Safety Executive

29th September 2020

4.2 Reports

Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust

Parliamentary and Health Service Ombudsman

11 June 2019

Suicide prevention: cross-government plan

Department of Health and Social Care

22 January 2019

Gosport War Memorial Hospital: The Report of the Gosport Independent Panel

Gosport Independent Panel

June 2018

National Guidance on Learning from Deaths

National Quality Board

March 2017

The five year forward view for mental health

The independent Mental Health Taskforce

February 2016

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England

Care Quality Commission

December 2016

Morecambe Bay Investigation: Report

Morecambe Bay Investigation

3 March 2015

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Mid Staffordshire NHS Foundation Trust Public Inquiry 2013

6 February 2013

Raising standards, putting people first Our strategy for 2013 to 2016

Care Quality Commission

2013

Preventing suicide in England: A cross-government outcomes strategy to save lives

Department of Health

September 2012

5. Press Articles

5.1 Press Articles

The following is a selection of news and media articles relevant to this debate.

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Linden Centre: Deaths at Essex mental health unit to be probed

BBC

16 October 2020

The scandal of suicide in mental health hospitals

The Telegraph

13 September 2020

Zero suicide is our simple but powerful NHS mission

The Telegraph

31 January 2018 (an opinion piece written by Jeremy Hunt MP)

Families whose loved ones died in NHS mental health care call for inquiry and reforms as police drop investigation

The Independent

5 November 2018

Deaths at Essex NHS Trust institutions probed by police

BBC

14 September 2017

Police investigate deaths at Essex mental health unit

The Guardian

19 May 2017

NHS MENTAL HEALTH HOSPITAL 'FAILED TO ACT AFTER TWO PATIENT SUICIDES'

The Independent

27 January 2016

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