

INQUEST's submission to the CQC review of investigations into deaths in NHS Trusts

October 2016

POLICY • ADVICE • CAMPAIGNS

INQUEST background



INQUEST's overall aim is to secure an investigative process which prevents future deaths in custody/detention...

INQUEST is an independent, charitable organisation founded in 1981. The organisation provides a free specialist casework service to bereaved families following deaths in all forms of state custody or detention in England and Wales. Its evidence based casework and the collective experience of bereaved people informs INQUEST's strategic policy, research and legal work - giving it a unique overview of the emerging issues, trends and systemic failings arising from custody/detention deaths.

INQUEST's overall aim is to secure an investigative process which prevents future deaths in custody/detention through the dissemination of lessons following post-death investigations, and to uphold the rights of bereaved families as victims to be treated with dignity and respect.

For further information about our work please consult our [website](#) and see our publications [here](#).

Introduction

INQUEST holds longstanding expertise concerning mental health deaths, with increasing focus on those with learning disabilities dying in care settings. These areas remain a priority for INQUEST's casework and campaigning policy work.

Important recent work has included:

- In 2015, the publication of INQUEST's report: *[Deaths in Mental Health Detention: An investigation framework fit for purpose?](#)*
- INQUEST Director Deborah Coles was on the expert advisory group on the establishment of a national *Healthcare Safety Investigation branch (HSIB)*.
- [Equalities and Human Rights Commission, Family Listening Day](#).
- [Independent Advisory Panel on deaths in custody, Family Listening Day](#).

Significant work is also being done by INQUEST concerning the death of children receiving in-patient mental health services, including in the role of private providers who now account for 47% of all CAMHS provision.

Evidence to the review

INQUEST's report '*Deaths in Mental Health Detention: An investigation framework fit for purpose?*' is our primary evidence to the CQC's review. The report sets out key findings and recommendations concerning the current systems in place for the investigation and learning from deaths in mental health settings.

We also submit the following relevant evidence:

- Additional comments from members of the INQUEST Lawyers Group.
- INQUEST's expert witness statements in the cases of Jane Antoniou and Christopher Brennan, setting out gaps in the current systems for



investigation and learning and the need for an independent framework for investigations.

- Collated Regulation 28 'Prevention of Further Death' reports and Records of Inquest from the period 2013 to 2016. These are a sample of reports intended to illustrate the critical importance of these inquest documents as oversight tools for monitoring and learning.

Additional evidence

The details below are intended as a brief update to INQUEST's 2015 report. The bullet points reflect an internal staff discussion providing a current snapshot of issues relevant to the CQC's review. Our experience since publication of the 2015 report is that little of significance has changed. Although these submissions focus on learning and processes that follow a death, many of the points made apply equally to the importance of learning arising out of near deaths. Many of INQUEST's cases have involved a history of near death incidents, often presenting facts and concerns repeated in the circumstances surrounding a death.

1. IDENTIFICATION AND REPORTING OF DEATHS



There remains a lack of any reliable public information about mental health or learning disability deaths.

'What are the barriers and challenges to effective identification and reporting of deaths?'

- 1.1 Problems and gaps in the current system of notification remains a primary barrier to effective identification and reporting of deaths.
 - Limited notification duties mean that providers remain only obliged to inform the CQC of deaths involving patients formally detained.
 - Significant gaps continue including with the omission of contentious natural causes and non sectioned patients.
 - The lack of any notification system concerning community based deaths is preventing monitoring of important patterns across Trusts eg around difficulties/delays in accessing crisis intervention services (a common feature of many INQUEST 'community' deaths). Problems of access to frontline services remain hidden across the system.
 - Deaths occurring shortly after discharge (despite questions around appropriateness of discharge decisions) are largely treated as 'community' deaths without any notification or appropriate investigation or inquest.
 - INQUEST cases also indicate a failure to comply with other CQC notification duties eg absconding sectioned patients.
 - INQUEST FOI exercises and Parliamentary Questions has exposed a lack of accurate information of formally sectioned patients showing that even the current limited notification system is not working.

- There remains too much subjectivity in the system and too much room for error, for example, highlighted by recent revelations that large numbers of mental health deaths are not being reported to coroners. We simply don't know how many deaths are going below the radar.

Failures to inform the CQC, to investigate, to conduct proper inquests and for the CQC to be properly informed in terms of its inspection/monitoring role all flow from a failing notification system.

There remains a lack of any reliable public information about mental health or learning disability deaths. For example, it remains impossible for us to know how many patients have died while receiving in-patient mental health services or where those deaths have occurred. This is unlike any other custody or detention setting where all deaths are notified and made public.

1.2 Suggested recommendations:

- 1.2.1 A simplified, mandatory system of notification is needed, requiring notification to the CQC of all deaths: community, mental health (in and out patients) and learning disability deaths. This should apply to both self inflicted and so called 'natural causes' deaths.
- 1.2.2 A 'triage' type system could be introduced (possibly similar to the PPO) to filter/organise priority cases and help identify type/level of investigation, to include: all in-patient mental health deaths, all learning disability deaths, potentially contentious natural causes deaths, deaths occurring within a week of discharge (given possible illegality around discharge), sustained and serious lack of access to crisis services, all children's deaths (in-patient and community), deaths involving restraint or use of force, deaths that form a pattern of concern.
- 1.2.3 These enhanced notification duties should extend to all private providers of publicly funded care.
- 1.2.4 Increased visibility is needed with the annual publication of figures. Clear annual reporting should include a relevant monitoring breakdown: age, gender, ethnicity, date of death, place of death, and Trust.
- 1.2.5 Parliamentary reporting responsibilities should be introduced for example to the Parliamentary Health Select Committee, also to aid the monitoring of patterns, numbers, institutions, repeat issues etc. These notification duties should be extended to all providers of publicly funded care.

2. IDENTIFICATION AND REPORTING OF DEATHS

'What are the barriers and challenges to completing robust and effective investigations?'

- 2.1 Poor and inconsistent decision making around the type and level of investigation and the lack of independence in the conduct of investigations remains a primary obstacle to effective and robust investigations.

2.2 Independent investigations remain a rarity. Investigations remain primarily 'internal' procedures with limited family involvement and little or no public aspect to the process.

- Independent investigations are largely limited to homicides or cases where a family is legally represented (often with the threat of Judicial Review).
- There is no consistency across Trusts. Some Trusts attempt to introduce some level of independence, for example, drawing upon resources outside the hospital or using a separate unit within the Trust to conduct investigations. Other Trusts will allow investigations to be lead by staff from the same unit.
- Even in the very worst cases where you would expect to see independent investigations commissioned (for examples the deaths of children and where high numbers of other similar deaths have occurred) this is not happening.

2.3 The approach to investigations and investigation reports are inconsistent across Trusts and mainly very poor in quality. It is hard to bring to mind good practice examples from our casework.



The approach to investigations and investigation reports are inconsistent across Trusts and mainly very poor in general.

- Investigations are overly defensive and not strong enough in their findings or recommendations, often failing to address family's key concerns.
- There is no context setting with reference to other deaths/other investigation reports and recommendations/issues/patterns.
- To the extent that concessions are made, these tend to be around more minor aspects of the case. It is common to identify failures but not as root causes.
- Reports are not robust enough for example around disciplinary action. There are few instances of suspensions or other misconduct action.
- Families commonly express their impression from early on in the process that things are being covered up. This view is reinforced by the lack of any significant or serious consequences arising out of investigations.
- There is often significant disparity between investigation reports and inquest findings, highlighting the inadequacy and shortcomings of the investigation. See INQUEST's *Deaths in Mental Health Detention* report for case examples.
- It is common for investigations to be treated as an 'internal' process with an inward focus without sufficient sense or priority being given to the outward facing responsibilities of the Trust in terms of the family, the need for public accountability and the preventative role of the investigation in the context of national learning.
- Families describe their sense that the overriding priority for Trusts in the investigation is one of damage limitation.
- Investigations largely fail to set cases within the national context or recognise the bigger picture.
- Despite a 'Duty of Candour' intended to introduce and strengthen the need for openness, this sits at odds with the continued experience of a closed investigation and a perceived lack of transparency.
- There remains a poor approach to evidence gathering and analysis and significant gaps and errors are common.

- There is a common failure in reports to reference relevant policies in assessing care and conduct and to consider either the extent to which policies have not been followed or any shortcomings in those policies.

In one good report, a thorough investigation was conducted and key failures properly identified. The family was given meaningful input and involvement and felt there had not been an attempt to cover up mistakes. An apology was given from the outset and the family was kept up to date. The report produced strong findings and good recommendations. The HSE were also involved. The inquest also benefited from the better investigation report.



The overriding need for independent investigations sits at the heart of improving the structure and quality of the investigation system.

2.4 Recommendations:

- 2.4.1 The overriding need for independent investigations sits at the heart of improving the structure and quality of the investigation system. Without this families will continue to report overriding concerns of bias and a conflict of interest that drives the process.
- 2.4.2 See INQUEST's *Deaths in Mental Health Detention* report detailing the need for an **independent investigation body**.
- 2.4.3 Independent investigations should apply to all self inflicted in-patient mental health deaths, deaths involving the use of force/restraint, the deaths of children and those with learning disabilities in possibly contentious circumstances. Also in cases where a number of deaths have occurred or a pattern has been identified.
- 2.4.4 Investigations should be set within the context of previous deaths and learning (including other investigation findings/inquest findings/PFD reports)
- 2.4.5 Trusts should be required to identify other similar deaths as part of an investigation report.
- 2.4.6 The separate and expert skills needed to conduct a quality investigation need to be recognised. Too often the task of conducting investigations is treated as an add-on to the jobs of clinicians. A separate resource is needed to develop the specialist skills and approach needed to fulfil this responsibility.
- 2.4.7 More is needed around written guidance, templates etc setting out how a good investigation should be conducted and what a report should contain. Too much is left to the discretion of the Trust who appears to approach the process without any clear structure or consistency around what a good investigation report should look like.
- 2.4.8 Clear protective processes should be in place to enable staff to engage with investigations as openly and honestly as they can, without fear of consequence.

A 28 year old woman with a severe personality disorder and bipolar was arrested for criminal damage and taken to HMP Bronzefield where her mental health seriously deteriorated. She was placed in a segregation unit and was eventually transferred to a psychiatric unit on 28 November 2012. About a month later she was found hanging in her room, having used a bathroom door to tie a ligature. A root cause analysis report was prepared by a senior consultant from Verita commissioned by the Trust. Their investigation was thorough and critical in its findings. The report concluded that her death could not have been predicted but if procedures were followed properly it could possibly have been prevented. The inquest also focused on the findings in the report. Evidence was heard that bathroom doors in the ward were removed following her death. The Coroner issued a Prevention of Further Death report asking NHS England to consider removing doors from bathrooms in all PICU (psychiatric intensive care units) in England.

Christopher Higgins: Christopher was a 36 year old man who in the weeks before his death suffered from his first but acute mental breakdown. His family desperately tried to get him help from the GP and the early intervention team but to no avail. Only after the police were called to the family home on 23 June 2013 was Christopher assessed and admitted to the Fermoy Unit (Norfolk and Suffolk NHS Foundation Trust-NSFT). Following his admission things went from bad to worse with failures in his risk assessment and serious omissions to his risk management plan, for example, a failure to include details of 3-4 self harm and suicide attempts in Christopher's first 24 hours in the unit. On the evening of 24 June 2013, after Christopher returned from an A & E admission following a serious self harm incident, he was allowed outside the unit for a cigarette and dived over the handrail onto a disabled access ramp, fatally injuring himself. In January 2016, only after tireless campaigning by the family and media involvement, an independent inquiry was announced into the rise of unexpected deaths in the care of the NSFT.

Emma Carpenter: Emma was 17 years old when she died of organ failure in an eating disorders unit on 22 December 2006. Throughout her time in the unit, her mother warned the staff that she was carrying weights in her clothing to disguise her true weight but no action was taken to ensure that they recorded her true weight. When she died she was weighing around 4 stone. Her father made a formal complaint to the Trust a year after her death. The Board decided to hold an independent inquiry and agreed the family could have their own independent expert on the panel. When he informed them that his expert was the leading authority on eating disorders they withdrew the invitation. The family found out that Emma was the fifth person to die of the same illness at the same Trust within a seven month period. Although the final report was critical, the inquiry failed to address these other deaths or other key concerns including the removal of documents from Emma's medical records and other matters amounting to possible criminal negligence. There was eventually an inquest held into Emma's death resulting in a critical narrative verdict. The Coroner made a series of prevention of future death recommendations including one to NHS England in relation to national lack of provision of in-patient beds for mentally ill children and adolescents including those suffering from eating disorders.

3. TREATMENT OF FAMILIES THROUGH THE PROCESS

‘What are the barriers and challenges that prevent people from being meaningfully involved and making sure organisations are learning from their experiences?’

- 3.1 Family involvement is not just about questions of openness but about treating families and carers as important sources of information and evidence.
- 3.2 A lack of clear or consistent systems and processes concerning the early stages following a death remain a significant source of stress and difficulty for families.
- Notification of deaths remains poor, with some experience of delays. Inconsistent practices exist across Trusts.
 - There can be a lack of information about where the body has been taken and the processes that will follow.
 - We have seen a lack of sensitive care for example around the return of personal belongings.
 - No information is given about possible sources of independent information and advice, including in relation to bereavement support and counselling.
 - Families are not properly informed of the investigation processes that will follow: what the investigation means, its purpose, who will be responsible, family involvement. No clear written material is provided.
 - Often no named person is given for family to have contact and no indication is given of how/when a family will be able to have input into the process.



A lack of clear or consistent systems and processes concerning the early stages following a death remain a significant source of stress and difficulty for families.

A 29 year old man was sectioned and despite evidence that he used drugs and alcohol whilst out of the hospital, he was allowed unescorted leave and died from a drug overdose. Following his death, the hospital gave his mother her son’s belonging in a paper bag including his half used toilet roll and other toiletries. She wished some sensitivity had prompted a phone call to ask what she would have preferred. She would have been happy to bring a suitcase or collect her son’s belongings herself. She said little things like that make a huge difference. 3 months after her son’s death, his mother received a letter of condolence from the Trust saying that they would be looking at the circumstances to prevent others taking their own lives. There was no evidence to suggest Jack had taken his own life. The Trust later apologised for this.

- 3.3 Similar problems of information sharing and communication with the family continue through the investigation process. Families are often ‘managed’ rather than treated as central to the process, often holding key evidence and information about their relative and circumstances surrounding their death.
- It is a lottery about how well the family is involved and a Trust’s practises around this.
 - Families say they are not treated with dignity or respect and often feel like the processes are about excluding them and limiting their role. This

is particularly so where a family has many questions where a death has occurred in unexpected or contentious circumstances.

- Family members are often primary carers with greater overview/knowledge of the case than anyone else involved. However it remains rare to see detailed statements/evidence taken from family members directly or their involvement with setting terms of reference.
- Families have said that during life they do not feel properly included in care and treatment and that this pattern of exclusion continues following the death.
- Families are often reluctant to attend NHS meetings following a death because they are concerned about “being played” and that the process is first and foremost about damage limitation.
- ‘Confidentiality’ is a common obstacle for engagement, with patient confidentiality continuing to be used inappropriately to obstruct access to medical records and disclosure.
- Investigations are often delayed and protracted processes without adequate updates to families including to explain delays or alterations in timetable.
- Families complain of having to be the primary drivers of the investigation process: seeking updates, calling for meetings, trying to keep the investigation on track in terms of relevant issues and evidence. They are forced to become experts, considering records and evidence in acute detail, due to lack of trust and confidence in the Trust to do the job properly. The poor quality of final reports and complaints of basic errors serves only to entrench fears and suspicions.
- There is inconsistency across Trusts concerning the provision of reports to families. There has been some improvement with this but examples continue of families being allowed to read a report but not being given a copy due to the ‘internal’ nature of the report. In a recent case, the final report was not disclosed until during the inquest hearing.
- It remains common for reports to be shared with families without provision of the underlying evidence to the report (interviews, statements, records, relevant policies etc).
- Reports are generally written primarily for the Trust as audience and not the families, often containing jargon and inaccessible language.



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3.4 Many families describe a difficult experience through the inquest process and in the conduct of NHS legal representatives:

- Attempts to narrow and restrict the scope of the inquest, including arguments against ‘Article 2’ inquests.
- Arguments against a jury.
- Opposition/delay with disclosure of key evidence.
- NHS representatives can be aggressive in pushing for last minute settlements just before long awaited inquests. Families can feel stressed and pressured by this tactic and angry that acceptance/admission is delayed until just before public scrutiny of the death.
- It is common to see strong opposition by NHS lawyers to coroners exercising their Regulation 28 ‘Prevention of Further Death’ powers.

3.5 Recommendations:



Deaths should be placed in the context of other cases to ensure the identification of patterns/themes/concerns.

- 3.5.1 Development of clear post death protocols and procedures is needed, setting minimum standards for all providers concerning communication and information sharing with families at all stages from point of death through to post inquest.
- 3.5.2 These standards should be developed in conjunction with a working group of families and incorporating best practice including the Independent Advisory Panel's guidance on family liaison (to which the Department of Health has signed up). The need for transparency and openness and respect and sensitivity should run through the developed approach. They should cover key areas/stages including:
- Notification of death.
 - Sources of independent advice and information, including bereavement support and counselling.
 - Return of personal belongings.
 - Seeking guidance from families whether and how they would like involvement (for this to be revisited through the investigation given families can change their mind about this).
 - The provision of key uncontested facts concerning the death from the earliest possible stage.
 - Investigation:
 - 'Duty of Candour' and what this should mean in the post death processes.
 - A named contact.
 - Family input into decision making around the investigation level and setting terms of reference.
 - Timeframes including for information sharing and updates.
 - Family involvement and input including identifying questions and concerns.
 - Families as a source of information and evidence (relevant to history, the deceased and the circumstances of death).
 - Opportunities to meet the Trust/provider, including the conduct of meetings and the use of agendas (to be agreed with families).
 - Timing/delays.
 - Disclosure: the need for full and frank disclosure throughout the process.

4. GOVERNANCE AND LEARNING

'What are the barriers and challenges for effective Board reporting and learning from the deaths of people in receipt of care?' Are effective systems/governance in place for driving learning?'

4.1 Setting deaths within the context of other cases

Deaths should be placed in the context of other cases to ensure the identification of patterns/ themes/concerns. This should be done by Trusts in their conduct of investigations and by other relevant watchdog bodies including the CQC.

Multiple cases and repeat patterns should be informing the type of investigation with greater weight given to the need for an independent investigation.

4.2 Inquests as a tool of oversight and learning

Inquests should be treated by Trusts and others as a critically important source of evidence and learning around shortfalls in practices/procedures/systems/operations that have led to a death. It is common for inquest evidence and jury findings to go well beyond the findings and recommendations of investigation reports.

Hannah Evans: Hannah was 22 years old when she died. She was a high achiever but struggled with complex mental health problems and self harming for several years and had been sectioned 3 months before her death. During this time she continued to prepare sophisticated ligatures and constantly planned how she was going to end her own life. The day before she died she was transferred to another ward. She had an intense fear of change and yet was given only 2½ hours notice before her transfer. She was not searched on her way into the unit and her 4 hourly observations were not carried out. She was found hanging in a disabled toilet in January 2015 where she used one of the handles as a ligature point. It remains a mystery how she managed to access the toilet which should have been locked off at all times. Immediately after Hannah's death, the Trust met the family, giving assurance they would be involved with the investigation and able to provide a list of their concerns. The family says they had to push for involvement at every stage and found the final report was extremely poor. They had to return repeatedly with more questions and to identify gaps and errors in the report. In the end the report had to be re-done three times. It was only through the Coroner's inquest that the family was able to secure full disclosure of relevant evidence and that the family's further key questions were addressed. The family says they would never have found out what really happened to their daughter through the SUI alone. Trust lawyers admitted liability a week before the start of the inquest, angering the family who had spent more than a year fighting to get to the truth about what happened to their daughter. The inquest jury reached critical findings, far exceeding the SUI findings, and strong PFD recommendations were made particularly concerning ligature points.

The Coroner's Regulation 28 reports are all about identifying and addressing system failures to prevent further deaths.

Inquest evidence and reports should form a central part in a Trusts post death learning and action and as a critically important oversight tool for other bodies including the CQC, to feed into inspections and other regulatory functions.

4.3 Post inquest action by Trusts

It should be mandatory for Boards to have sight of inquest documentation (expert evidence, jury findings, PFD reports etc) and to be conducting post inquest reviews of cases to inform management, operation and training decisions and learning. Investigation findings and recommendations (including around misconduct action) should be reviewed in light of any new evidence and findings arising from the inquest.

Trusts/Boards should be required to have systems in place for tracking cases, including in relation to recommendations and implementation.

Families should be offered post inquest meetings to be informed/have input into a Trust's post inquest action on changes to policy and practice, also to consider any role for families around training issues. This would also be an opportunity for families to provide feedback on the Trust's investigation process to ensure continuing improvement and good practice development of those processes.



It is common in inquests to see a disconnect between policy and practice, with gaps between management understanding and the experience and understanding of front line staff.

4.4 NHS structure

The NHS is a large and complex system and it can be difficult to identify where responsibility for learning and oversight sits.

A mapping out of structures, roles and areas of responsibility is needed to enable greater visibility and more effective lines of accountability, information sharing and learning. It should be clear where a Coroner can most effectively direct PFD recommendations around unsafe practices, policies and training needs. This should also include where lines of responsibility sit in ensuring the implementation of change.

4.5 Governance v Operations

It is common in inquests to see a disconnect between policy and practice, with gaps between management understanding and the experience and understanding of front line staff. Learning can appear on paper, in the form of amended policies, but not make its way to staff on the ground. It is important that governance structures ensure the proper filtering down of practical learning and change following every death.

4.6 Consistent policies and procedures

Lack of consistency in policies and procedures across Trusts is a significant obstacle to learning and change around patient care and safety. Learning and best practice developments following a death can be isolated to that particular provider. The paper we attach showing the collation of Records of Inquests and 'Prevention of Further Death reports' graphically illustrate this problem. Time and again, the same issues arise in cases around different parts of the country. For example, action arising out an inquest requiring staff to have access to ligature cutters may only give rise to change within that hospital and not to regional or national change.

A system geared to the development of nationally adopted policies and procedures irrespective of the provider is needed.

4.7 Role of CQC

A clearer and more organised system is needed with the post death role and involvement of the CQC. Current problems include:

- A lack of accurate information about the deaths occurring.
- No clear system of how death notifications are feeding through the organisation, including to inform inspection functions or to identify patterns.
- No clear or consistent involvement in inquest processes.
- No clear system for information gathering from deaths/inquest processes as a source of intelligence for inspections and regulatory functions. In cases where attempts are made to try to share important evidence relating to unsafe practices it is not easy to identify who or where that information should pass.
- It is not clear what part a death will play with inspections and the extent to which this may or should prompt an unannounced inspection.
- Deaths that have occurred in intervening periods since a previous inspection are not generally referred to in inspection reports.
- Families express a lot of anger about the inadequate role of the CQC following a death and the difficulties in finding out what is known by the CQC and what if any action is to follow in response to a death.



A clearer and more organized system is needed with the post death role and involvement of the CQC.

It would be helpful for families to be contacted by the CQC following a death and to be kept informed of any post death action. Also to have a named contact within the CQC, with clear published information about what role the CQC will have in the post death processes.

Systems should be in place for the CQC to be made aware of relevant inquests and for the receipt of Records of Inquests and PFD reports to enable proper feeding into its inspection and regulatory functions. Also relevant to the CQC's recently extended role in the consideration of HSE offences.

Publication of an annual report would be helpful identifying key information, patterns and trends.

4.8 Greater accountability

The diffused nature of accountability through the current system renders it ineffectual, with insufficient public focus and pressure on whether and where change is happening.

Clearer structures and publicly available named lines of responsibility are needed to ensure proper accountability through the system. Too often blame is focused on junior level staff with insufficient focus or action on corporate level responsibility for the continuation of unsafe systems and practices, including the failure to implement changes and recommendations following inspections and previous deaths. Much more is needed with the consideration of HSE offences, including the publication of charging decisions. More transparency and action is needed with the referral of individuals to professional bodies such as the GMC and GNC.

5. STRUCTURES FOR LEARNING AND OVERSIGHT

“A lack of any national system for monitoring and oversight is allowing dangerous systems and institutions to go unnoticed and unchecked.”

It should not be the continuing responsibility of families and organisations like INQUEST to piece together and identify concerning patterns.

- 5.1 An independent national learning mechanism is needed to oversee and monitor, including for visibility and tracking around learning and recommendations arising out of deaths, both regionally and nationally. Also to help inform national training programmes.
- 5.2 There is a strong case for Parliamentary scrutiny, for example, for the Health Select Committee to review and publish relevant numbers/breakdowns and trends.
- 5.3 Investigations reports should be published and made publicly available.
- 5.4 There should be greater use of learning bulletins and thematic reviews.
- 5.5 There should be a national framework for the commissioning of urgent independent reviews where concerning patterns are identified.

Since 2004 six in-patients died by hanging at the Linden Centre, run by North Essex Partnership University NHS Foundation Trust. Recommendations were made over and over again focusing on the issue of ligature points. Trust management was first warned about the ligature risk of doors in 2004 following the death of Denise Gregory, who hanged herself with a ligature she tied to the hinges of the door. Following her death, written advice was issued by the Trust to the management recommending that wardrobe handles should be integrated into the door and doors should be fitted so that they open both ways with safety hinges. The handles, however, remained unchanged and in December 2008, 20 year old Ben Morris was able to use them as a ligature point to hang himself. The Trust investigation identified multiple failures in his care and called for a review of ligature points in acute wards. In 2012, two other patients hanged themselves, one using the handles on his window whilst 20 year old Matthew Leahy used the hinges on his bedroom door to tie a ligature. His door did not open outward and had no safety hinges. Yet again recommendations were made that the type of door hinges used needed to be reviewed. In June 2013, the CQC inspected the Linden Centre and highlighted the ligature points as a concern. 11 months later, a 57 year old man was found hanging in the shower rooms in the Linden Centre. 3 days after his death CQC went into Linden Centre again and found 'high risk' potential ligature points. Most importantly they highlighted the fact that door hinges remained unchanged. In May 2015, the day after the CQC report was published, 30 year old Richard Wade was found hanging in Linden Centre. It is suggested that he also used the door in his bathroom to tie a ligature. Melanie Leahy, Matthew Leahy's mum who has been tirelessly campaigning since 2012, said, "The trust has failed in its duty to others as well as my son. These deaths might have been prevented. I believe my son would still be alive if recommendations made after Ben Morris's death in 2008 had been followed appropriately."

6. OTHER

INQUEST has made clear its concern that private providers have been excluded from this review. This is particularly so given the increasingly central role of private providers in the provision of health services, particularly in the provision of mental health care and services to those with learning disabilities. For example, private providers now account for 47% of all CAMHS services. The majority of these places are funded by mental health Trusts whose continuing responsibility and role as commissioning bodies should sit central to investigations and learning arising out of deaths in these private settings.

INQUEST, October 2016

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