H. M. Coroner
for South London Area

Coroner's Service
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28 June 2017

The Rt Hon David Lidington
Secretary of State for Justice
[redacted]

Dear Secretary of State

On 9th May 2017 I completed an investigation into the death of Olaseni Lewis who died following restraint by police officers at the Bethlem Royal Hospital in Beckenham, where he had been detained under the *Mental Health Act 1983* (MHA)

I am enclosing a copy of my report to prevent future deaths written pursuant to *Regulation 28 of the Coroners Investigations Regulations (2013)* (PFD report).

I am writing separately to you because of a concern that arose during the investigation that does not relate to the risk of future deaths, but relates to the State's obligation to investigate the death of a person detained under the MHA.

Deaths in police or prison/immigration detention are investigated by the Independent Police Complaints Commission (IPCC) or Prisons and Probation Ombudsman (PPO) respectively. There is no similar body or agency to investigate deaths of patients detained under the MHA.

Mr Lewis' death was the subject of a lengthy investigation and re-investigation by the IPCC, who examined the role of the police. Until 2015 there was no investigation of the healthcare providers. Although the Health and Safety Executive (HSE) conducted an investigation into the activities of the Trust they were unable to secure police support, because the Metropolitan Police Service would not have been sufficiently independent to carry out that investigation.

The coroner's inquest is normally the way in which the State discharges the duty to investigate the death of an individual detained by the State. In practice, they are not equipped or resourced to investigate deaths in the way that the police IPCC or PPO can, and so coroners rely heavily on the product of those investigations. In the case of Olaseni Lewis, the Metropolitan Police could not examine the conduct of the healthcare providers because they were themselves subject to investigation.

Following representations by myself and the HSE Devon and Cornwall Police were eventually brought in to carry out an investigation. I have no doubt that their work was adversely affected by the passage of time, and although they worked extremely quickly it delayed matters by a further 12 months or so. The family had to endure a wait of almost seven years before the inquest could take place.

I know that the investigation of deaths in mental health detention is a matter on which representations and recommendations have been made, including a report by the Joint Committee on Human Rights. It is not for me to comment on that debate. The purpose of my letter is to inform you of the difficulty I encountered in my investigation into the death of Olaseni Lewis, and to invite you to consider whether action can be taken to improve matters.

It has been suggested that in the absence of a dedicated independent body to investigate the death of patients detained under the MHA, it might be helpful if the IPCC became signatories to the Work Related Death protocol. It could ensure a more holistic approach to any investigation and that any gaps in the investigative process are quickly recognised.

I am sending copies of this letter to the recipients of the PFD report and to the Secretary of State for Health for their information. If I can provide any further information or assistance please do not hesitate to contact me.

Yours faithfully

[redacted]

Senior Coroner

Lewis.

Ministry of Justice

Dr Phillip Lee MP
Parliamentary Under-Secretary of State for Justice

[redacted]
Senior Coroner, South London Area
Floor 2, Davis House
Robert Street
Croydon, CR0 1QQ

MoJ ref: ADR52806

24 January 2018

Dear [redacted]

INVESTIGATING DEATHS OF PERSONS HELD UNDER THE MENTAL HEALTH ACT

Thank you for your letter of 28 June 2017 addressed to the previous Secretary of State for Justice regarding your concerns about the investigation into deaths of patients held under the Mental Health Act 1983 in light of your experience of conducting the inquest into the death of Olesani Lewis. I am responding as the Minister responsible for coroner law and policy.

We appear not to have received your original letter and I understand that a copy only came to light very recently.

I am grateful to you for highlighting your concerns about the way deaths of patients detained under the Mental Health Act are investigated. I am copying your letter and my reply to my ministerial colleagues at the Department of Health and Social Care as that Department is leading on Steve Reed MP's Mental Health Units (Use of Force) Bill which aims to address the issues.

Yours sincerely

[redacted]

DR PHILLIP LEE MP

[redacted]

Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

39 Victoria Street
London
SW1H 0EU

[redacted]

Your Ref: ADR52806

PO-1117154

[redacted]
Senior Coroner, South London Area
HM Coroner's Service
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23 FEB 2018

Dear [redacted],

Thank you for your letter of 28 June 2017 to David Lidington, which you also copied to Jeremy Hunt, about the death of Mr Olesani Lewis, and the Mental Health Units (Use of Force) Bill. As you are aware, your correspondence to David was forwarded to the Department of Health and Social Care.

As Dr Lee noted in his response to you, the Department for Health and Social Care is working with Steve Reed MP on his Mental Health Units (Use of Force) Private Members Bill. The Bill seeks to address the oversight and management of the use of force in mental health units, and makes provision for investigation into deaths that occur during, or result from, use of force.

I was very saddened to hear about the circumstances surrounding Mr Lewis's death, which is why I was keen to support the Bill. It will address many of the problems which occurred in the lead up to and following Mr Lewis's death. I understand there were many complications in the investigation process across different parts of the system.

We have made progress since the publication of the updated *Serious Incidents Framework* in March 2015. The Framework sets out how NHS providers should respond when things go wrong, to ensure they continually improve the safety of the services they provide. In March 2017, the National Quality Board published *National Guidance on Learning from Deaths,* which is intended to help standardise and improve the way the NHS reports, reviews, investigates and learns from deaths, and engages with bereaved families and carers.

We have also introduced the Healthcare Safety Investigation Branch (HSIB) which became operational in April 2017. The HSIB is an independent branch of NHS Improvement that investigates serious incidents in the NHS, with a strong focus on learning from such incidents.

Whilst we have made progress, we accept that more can be done. This is why we are supporting the Bill and taking further action. The Department published the Health Service Safety Investigations Bill in draft on 14 September 2017 for pre-legislative scrutiny. This will establish the Health Service Safety Investigations Body as an independent statutory body, with powers to conduct investigations into incidents or accidents that appear to evidence risks affecting patient safety, and where lessons can be learned across the system.

You may be aware that, last year, the Prime Minister commissioned the review of Deaths in Police Custody. The Review was led by Dame Elish Angiolini. The Government published its response to the Review, which also made recommendations on the use of restraint and ensuring adequate police training. The recommendations of this review are being taken forward by the Ministerial Council on Deaths in Custody, which is funded by the Home Office, Ministry of Justice, and Department of Health and Social Care.

I hope the information in this letter is useful and provides some assurance of the continued work and improvements we are making within the NHS to ensure that should these terrible events occur they are investigated properly, those involved are held to account for their actions and lessons are learned.

JACKIE DOYLE-PRICE