

Seni's Law – The Mental Health (Use of Force) Act Statutory Guidance:

INQUEST response and brief for families

Background for families

Seni Lewis, 23, was a young black IT graduate from South Norwood. He died face-down on the floor in a mental health hospital after police officers handcuffed his hands behind his head, put his legs in shackles, and subjected him to prolonged restraint whilst medical staff stood by. Seni's Law, formally titled the **Mental Health Units (Use of Force) Act**, was introduced into parliament by Steve Reed, the family's local MP, to ban the use of violence against mental health patients like Seni. His family have worked tirelessly since his death to see the systemic change so needed.

During the passage of the Bill INQUEST and others highlighted the high levels of restraint routinely used behind the closed walls of secure settings inflicting physical and psychological harms and the ever-present risk of death. Disproportionately, restraint is used against people from black and minority ethnic groups, women and children, young people, and people with learning disabilities and autism. We also drew attention to the lack of independence of the investigation process that follow deaths in mental health settings.

The Mental Health (Use of Force) Act was passed by the UK Parliament in November 2018. After considerable delay, the government has opened a consultation on statutory guidance to implement the Act in May 2021. See here: <https://www.gov.uk/government/consultations/mental-health-units-use-of-force-act-2018-statutory-guidance>. This guidance aims to provide further information on how all hospitals providing NHS-funded care can meet the obligations placed on them by the Act. It is open for public consultation until **17 August 2021**.

INQUEST and bereaved families worked hard throughout the drafting and parliamentary debates on the Act to make sure this essential legislation addressed the crucial need for stronger safeguards and reporting around use of force in mental health settings and the need for independent investigations following any restraint related death. There are aspects of the Act that we had hoped would be stronger, but generally we think it has the potential to play a significantly positive role and so are keen for it to be implemented as soon as possible. We hope the protections of this Bill and greater scrutiny and oversight will be part of a drive towards the change in culture and practice needed to end the use of force and ensure those in crisis are treated with dignity and respect.

Statutory guidance

The statutory guidance is important because it provides detail and practical guidance for trusts. It is essential that the guidance captures the important principles behind the Act. The guidance should also honour the crucial need for stronger safeguards and help move towards radical reductions in the use of force. At its core, the aim is to ensure that people in mental health units can feel safe, and are treated with dignity and humanity, ensuring any use of restraint is kept to an absolute minimum.

INQUEST was consulted on a preliminary draft of the statutory guidance, which we thought had positive elements but needed to be much stronger on the following:

- Actively tackling racism and disproportionality in the use of force
- Ensuring more meaningful and transparent monitoring of use of force leads to concrete actions to change and improve

- Bringing Article 2 (right to life) requirements into the investigations of deaths/serious injuries where use of force has played a role

We provided feedback on specific points we thought were unclear or needed strengthening. We also discussed the guidance with a small group of bereaved families and fed back comments on the draft.

Where are we now?

We are pleased to see that the Department of Health and Social Care have strengthened the statutory guidance in many ways, taking up a large number of our specific and broader suggestions on the preliminary draft. This is good news. However, we think there are still ways in which the guidance can be stronger.

The government consultation focusses on questions that ask whether the document is clear or not. We think it is still important to provide input on whether we think the guidance covers all of the right issues and in the right way, and so we will be submitting suggestions on the substance of the document.

We want to share our response with you and are doing this before we finalise it in case you have any suggestions to make.

You may also want to respond directly to the consultation, if so you can do this here: <https://consultations.dhsc.gov.uk/60828943bc7a8a37af6d3305>. The easy read version of the guidance is also available here: <https://www.gov.uk/government/consultations/the-law-about-use-of-force-in-mental-health-units-easy-read>.

INQUEST response

Below we outline the key issues we hope to highlight to the government through the public consultation. We would be grateful for your views on additional areas you think important to raise with government.

Key issues

Section 2: mental health units to have a Responsible Person

This section focusses on the role of the Responsible Person (RP), whose duty it is to ensure an organisation complies with the requirements of the Act.

We are pleased that the guidance now clarifies that, where a RP delegates some of their functions, they retain overall accountability for the key duties. We believe this is important in ensuring transparency on who is accountable for use of force policy and practice in a specific unit.

However, the guidance still does not state that delegated staff's names should be published on the unit's website, which may weaken the transparency and accountability of this role. Further, the guidance allows for an RP to be responsible for multiple mental health units that may be operated by the same trust. We are concerned by this, as it is unclear how a single RP working across multiple units would be able to provide the same detailed scrutiny on an organisation's compliance with the Act. We suggest the relevant hospital publish an organisational chart with delegated responsibilities on their website.

Section 3: policy on use of force

This section of the guidance outlines what an organisations' use of force policy should include.

INQUEST welcomes the fact that the policy must now include information about monitoring the use of force on people with protected characteristics: organisations should analyse data on use of force to identify themes that can reduce its disproportionate use on people with shared protected characteristics, such as race, age, gender and disability. The policy should also be reviewed and updated if the organisation is not achieving the policy principles as set out.

However, our response to this consultation will note the lack of a general commitment to tackling disproportionality, discrimination and racism. This is extremely important given what we know about how disproportionately restraint is used against people from black and minority ethnic groups, women and children, young people, and people with learning disabilities and autism.

We are particularly concerned that the guidance states that an RP need only 'consult with whoever they consider it appropriate to consult'. We are worried this wording allows for an RP to decline to consult with patients' families on the policy. We suggest a list on who to consult should be included in the guidance.

Finally, our response will highlight that the policy does not require post-incident review data, investigation and inquest findings and prevention of future deaths reports to be analysed as a preventive tool. The guidance states that this is only good practice, when we believe it must be a requirement if fatal incidents are to be prevented.

Section 4: information about use of force

This section looks at the information that should be provided to patients and their families on the use of force and their rights. It is positive the guidance now ensures information on the use of force should include what action the organisation will take if the inappropriate use of force is identified.

However, it is not clear whether it will be a requirement to publish information on the use of force, in what format this information will be provided, and how it will be communicated to patients and their families and how they can exercise their rights.

The guidance is not strong enough on making sure patients receive this information, for instance through advocates. It must ensure patients' legal rights to advocacy are communicated to them in relation to use of force.

Section 5: training in appropriate use of force

Positively, training on how to avoid and reduce use of force should recognise the high levels of trauma for people from Black and racialized backgrounds who may also have previous experience of coercive practice from the police. This is also the case for women and girls who may have experiences of abuse and violence. Training should also cover what inappropriate use of force is and what action will be taken against it.

However, we are concerned the guidance on training does not clarify the reality that the use of force has resulted in the death of patients and that any form of restraint can be fatal. We believe this needs to be covered to emphasise the importance of appropriately understanding the risks associated with using force.

We are also concerned that the training of staff only needs to be provided ‘as soon as reasonably practicable’. We think there should be interim measures in place for staff working while awaiting adequate training. This could include ensuring staff are briefed on a use of force protocol. We believe there should also be a requirement in the guidance for staff to take refresher courses in training.

Finally, we are concerned the RP is responsible for deciding whether the training given is of an adequate standard. We do not think this an appropriately robust or independent way of monitoring training performance. Further, we believe more detail should be provided in the statutory guidance as to what the ‘adequate standard’ of training is.

Section 6: recording of use of force

We are concerned that this section of the guidance, which outlines how staff should collect data on the use of force, provides no information on how to sanction staff who are not fulfilling this duty. Further, there is no duty in the guidance for staff to record the reasons for calling the police during an incident nor the importance of mental health staff still maintaining control of the situation, and not deferring to police. Given the death of Olaseni Lewis after police were called to a mental health setting and saw medical staff stand by as he was subject to dangerous restraint, and in whose legacy this Bill was passed, we believe it is crucial this information is provided.

A new section has been added to the guidance on ‘negligible use of force’. We are concerned about writing off this low level of force from the reporting/wider safeguards in the guidance, and though there is a list of types of force that can’t be considered negligible, it obviously leaves quite a discretionary area in the middle. If there is frequent ‘negligible use of force’, there would be no way of picking this up and it could be quite controlling/coercive in nature even if not as physically forceful. We note that in the context of the work INQUEST did on the use of restraint in secure training centres, there was a whole raft of use of force/coercion that was in staff’s eyes insignificant but when reviewed systematically revealed systemic and dangerous practice and culture. In order to ensure consistency in the recording of all uses of force, we propose eliminating the ‘negligible’ loophole.

The guidance also states that NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. However, it does not include the reporting of voluntary or informal patient deaths, and suggests that deaths, including deaths following the use of force would not be reported to the CQC (although it states that these deaths should be reported to the local Coroner). This is a serious omission that needs addressing. In reporting deaths to the local Coroner, they must be made aware of the use of force as part of the reporting process.

Section 9: investigation of deaths or serious injuries.

Key to INQUEST’s concerns raised during the passage of the Bill was the issue that deaths relating to the use of force in mental health settings do not give rise to a pre-inquest investigation by a person or body separate from that setting. Instead, there exists a situation where the NHS Trust or private provider is investigating itself and its staff. We feel this does not inspire family and public trust and confidence. These internal investigations in mental health settings do not allow for meaningful learning, or national oversight on issues which may be widespread.

As currently drafted, the guidance says that investigations should be independent of those involved in the incident, timely and of good quality. The guidance does not go nearly far enough in establishing the important principle of hierarchical independence from the institution and NHS Trust or private provider. This is a missed opportunity.

In our view this guidance needs to be much stronger and must require that an investigation of a death or serious injury be treated as stage 3 of the Serious Incident Framework 2015 (which is currently the most up to date guidance). This may help to add at least an element of independent investigation when someone dies or is seriously injured and that there is an investigation commissioned that is completely independent of the NHS Trust or private provider. In our view this will help family/public confidence, the quality of the investigation and subsequent inquest and the opportunity for learning.

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