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TRANSCRIPT OF "FILE ON 4" – "A PLACE OF SAFETY?"

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REPORTER:	*Gerry Northam*
PRODUCER:	*Gail Champion*
EDITOR:	*David Ross*

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NORTHAM: As public concern continues over the safety of NHS hospitals, one group of patients has received little attention, yet they are among those in greatest need of protection.

COLES: Every week, between two and three patients in psychiatric hospitals are dying from a self-inflicted death, which is an extremely disturbing figure when one considers their vulnerability.

ACTUALITY IN BRADGATE UNIT

NORTHAM: Here's one place raising particular concern. It's a group of modern, low-rise, yellow brick buildings in hospital grounds in Leicester, housing a unit which has failed to protect patient after patient in the past three and a half years. This week we'll investigate how a succession of mentally ill people treated here have died by their own hands. The local coroner has called it 'a catalogue of failures stemming from an institutional complacency'.

CANEY: I had a phone call from the hospital telling me that Michael had died. They told me that he had hung himself, and I just kept thinking he went into hospital to be safe and I couldn't understand how something like that could have happened when he should have been in safe hands.

NORTHAM: Last week, the High Court in London began considering the case for fully independent investigations of self-inflicted deaths in psychiatric hospitals. While we wait to hear the judgment, File on 4 examines what happens when supposed places of safety prove tragically unsafe.

SIGNATURE TUNE

BROOKES: She was a happy, vivacious girl, she did very well at dancing. She also did swimming in the past and she did very well at that. Basically she applied herself to everything she did. She had got many, many friends – all in all, thoroughly well loved.

NORTHAM: In her teens, Kirsty Brookes suffered from eating disorders and had a history of self-harm and overdoses of paracetamol. She was admitted to an inpatient psychiatric centre called the Bradgate Unit, within the grounds of Glenfield Hospital in Leicester. Her family, of course, worried about her greatly. But her father, Glyn Brookes, says they welcomed the decision to admit Kirsty for specialist care.

BROOKES: When she took an overdose and then was referred to Bradgate Mental Health Unit, of course all we would do was believe she was in the right place, that the system would treat her correctly. And you hope for the best, you believe it is going to be short term, but obviously as life goes on you learn more and you realise it may not be a short thing, it may take a little bit of time to get sorted. But at the end of the day, we thought she is in the right place.

NORTHAM: Did you have any doubts about her safety there?

BROOKES: No, no reason to have doubts at all. She was in a mental health unit, which also offered security if that patient or client needed it.

ACTUALITY ON BENNION ROAD

NORTHAM: This quiet wooded area is set back from the houses on Bennion Road, in an area of Leicester called Beaumont Leys. It's about a mile from the Bradgate Unit. Three years ago, in June 2010, when Kirsty Brookes was nineteen, she was able to make her way here alone, despite the fact that she wasn't supposed to be allowed out unaccompanied. There were staff shortages that day and Kirsty got into the hospital garden, then over the perimeter fence - something she had done before - and onto the public roads. When she arrived here, she made her way among the trees and hanged herself. Her body was found the next morning.

BROOKES: There'd been other absconsions and the fact is that they had identified the issue, identified the fact that she were able to get over this fence via a gate, and they didn't do anything about it. They didn't repair the gate or make the gate more escape-proof until after the death of Kirsty.

NORTHAM: No-one could say the hospital had no warning of the risk Kirsty might do this. She was detained in a secure ward and she had a history of absconding, including by using a gate to jump over the perimeter fence. In addition, she'd only recently twice attempted suicide by hanging and been saved by nursing staff.
Some of the staff said to the inquest that they weren't aware that she wasn't allowed to go out into the garden on her own. What did you think when you heard that?

BROOKES: Well, this contradicts every bit of information that we've had. During the time we used to visit Kirsty, we knew that she had a wristband on which accessed certain areas, you know, you couldn't go out in the garden area if your wristband wasn't coded to allow you into the garden area. The staff should have known. They did know. We knew. But the fact is their care was not up to any standard that you would expect from an institution which was supposed to be looking after people who are unable to look after themselves. It was criminal.

NORTHAM: The Coroner drew attention to failings by Bradgate Unit staff and recorded that these failings contributed to Kirsty's death.

READER IN STUDIO: Despite the known existence of a real and immediate risk to Kirsty's life from self-harm, she had been able to abscond due to not being observed and detained in accordance with her needs and care plan. The conclusion as to the death is that Kirsty Brookes took her own life, in part, due to neglect.

NORTHAM: Kirsty's was the second suicide of what was to become a continuing series at the Bradgate Unit. Two months earlier, 44 year-old Helen Clinton had hanged herself in one of the wards. In her case, the hospital's investigation uncovered a range of failures in nursing and risk management and poor documentation. So how does the Chief Operating Officer responsible for the Bradgate Unit, Paul Miller, explain how similar errors enabled Kirsty Brookes to hang herself only weeks later?

MILLER: The staff obviously assumed that she was allowed to be in the garden and because they could observe her and see her, felt that that was in keeping with their responsibilities.

NORTHAM: How could the staff have assumed that, when it wasn't the case?

MILLER: I'm afraid sometimes staff make mistakes.

NORTHAM: Only two months earlier, another patient, Helen Clinton, had hanged herself, and there too it was said that the level of risk had not been adequately assessed and reported to all staff. Same mistake twice.

MILLER: Well, I think from the outside it could be seen like that, but I think ...

NORTHAM: How would you see it?

MILLER: Well, we have a number of patients in our wards and they are managed in keeping with our risk policy, where our risk assessments are reviewed and reconsidered on a regular basis.

NORTHAM: But here you have two cases in three months, where it's not seemed from the outside, this is what NHS staff have told the inquest or told your internal investigation, the risk was not adequately assessed and reported. That is absolutely critical information.

MILLER: Yes, of course it is critical information and that's why, as a result of both these incidents and indeed other incidents that have occurred, that we have reviewed our risk assessment process and policy, that we have taken staff through further training to make that the risk assessments are as accurate as they possibly can be.

NORTHAM: Each year on average in the UK there are 160 cases like Helen and Kirsty's, where a psychiatric inpatient takes their own life. That's more than three a week. And, as with Kirsty, the normal procedure is that in each case the initial investigation is carried out by the NHS Trust concerned. Mr Miller wouldn't tell us what, if any, disciplinary action had followed, nor whether the member – or members – of staff involved are still employed by the Trust. If, as Mr Miller said, staff training and policy were reviewed after Kirsty's death, the purpose was to prevent the same thing happening again. But then, the following year, once more staff errors allowed a patient to abscond and hang himself.

GUNN-HAMILTON: I am holding a photograph of the whole family taken soon after we came from India in 1963. There is myself, aged ten.

NORTHAM: Standing on the left there?

GUNN-HAMILTON: Yeah, and my brother in the middle.

NORTHAM: He looks a bit suspicious about what's going on?

GUNN-HAMILTON: [LAUGH] Yes, probably because we weren't used to having our photograph taken.

NORTHAM: Parminder Gunn-Hamilton remembers her brother, Gagan Sandhu, with affection. His successful career as a financial adviser was all the more remarkable for the periodic mental illnesses he suffered as a result of his bipolar disorder. After

NORTHAM cont: a particularly distressing episode of mania, he was detained in the Bradgate Unit in July 2011. In his periods of depression, he presented a suicide risk. While he was there, he wrote frequently to his sister, Parminder.

GUNN-HAMILTON: This is a poem Gagan wrote in the last year or so. Now Knighton Park is a beautiful, beautiful park and we used to go and meditate there a lot, it's just a beautiful spot by the stream. 'Oh Knighton Park, oh Knighton Park, how I missed you night and day.' And Knighton Park is where he hung himself in a secluded area, where he used to meditate under a tree, a willow tree by the stream, so you had the water going by. And where he found the rope, we don't know. I think there was a bundle of branches tied up. They think that's where he got it from – nylon blue rope.

NORTHAM: The question for NHS investigators and the inquest was how Gagan Sandhu, who was sectioned under the Mental Health Act, was able to leave the supposed security of his ward and make his way across Leicester to the park. The family's solicitor, Nicola Kitchener, put the story together from official accounts.

KITCHENER: Mr Sandhu was supposed to be escorted at all times.

NORTHAM: And he was supposed to be escorted, even when he was in the hospital grounds, was he?

KITCHENER: He was, inside and outside, yes.

NORTHAM: How, then, was he able to get out?

KITCHENER: It really was as a result of lack of communication. There was a bank nurse that was asked to take Mr Sandhu down to a breakfast club, and unfortunately the staff nurse had not communicated to the bank nurse that he was to be escorted. What happened is she then left him with the occupational therapists down there, one who was engaged with her back to the door with another patient, another one who was in the kitchen, so there was no formal handover of Mr Sandhu to the breakfast club. And due to the fact the bank nurse had not highlighted that he was to be escorted to the occupational therapists, he asked to go to the toilet and was left to go to the toilet unescorted, which is when he absconded from hospital.

NORTHAM: So exactly the risk which had been identified, the hospital didn't protect him against?

KITCHENER: That's absolutely right, yes.

NORTHAM: In words which were an almost exact echo of the finding on Kirsty Brookes' suicide, the Coroner said that the risk to Mr Sandhu was known, but that he was "able to abscond due to not being cared for in accordance with his needs and care plan". She called this 'a gross failure' and said it had 'a clear and direct causal connection' with his death. How then does the Chief Operating Officer responsible for Bradgate, Paul Miller, account for this repeated set of mistakes by staff? Yet again, the problem seems to have been communication.

MILLER: It was indeed a failure of communication, I'm not going to be defensive for one moment at all in relation to this case, and it was a failure to communicate by the staff concerned.

NORTHAM: But it must worry you that you thought you'd put this right three years ago. Mr Sandhu's case then showed that in fact you hadn't put it right.

MILLER: In that particular instance we hadn't put it right, no.

NORTHAM: Let's come onto another worrying thing in Mr Sandhu's case. Evidence from the staff was found to be not reliable. The Coroner said, 'It is clear to me that one nurse – she names - gives ever changing accounts of the events.' Worrying surely?

MILLER: Yes it is very worrying, very worrying indeed. I have to accept that. This is a long term piece of work and obviously we have some members of staff who haven't internalised that message as quickly as we'd like them to have done.

NORTHAM: So when you think you have put things right, it turns out that with some staff you haven't?

MILLER: We have isolated cases where staff have actually made mistakes and staff haven't told the truth to both ourselves and indeed the Coroner's court and this is another example.

NORTHAM: At the most recent inquest, heard last year, the Coroner issued her strongest criticisms so far of the Bradgate Unit. The case involved the death of a 48 year old man, Michael Coltman.

CANEY : As a youngster he was a lovely, bubbly person, full of life, but unfortunately he was diagnosed as schizophrenic. He had lots of voices. He needed the voices to stop and he felt that he wasn't getting the medication to do that, it wasn't happening quick enough.

NORTHAM: Michael's sister, Pauline, was horrified in January last year when Michael drove his car into the wall of a house, trying to silence his voices. He survived the crash and was admitted to the so-called Place Of Safety unit at Bradgate and put on a regime of observations every fifteen minutes. A week later, Pauline learned that the place of safety wasn't safe enough for Michael.

CANEY: I had a phone call from the hospital, telling me that Michael had died. And I just kept saying, 'I don't know what to say, I don't know what to say,' - it was just like I was dreaming and it wasn't really happening.

NORTHAM: Did they tell you how he'd died?

CANEY: They told me that he'd hung himself. We found out about six months later that he'd tried to take his own life in the same way the day before. He had actually taken a sheet off the bed and tried to hang himself, but then obviously shouted out for help.

NORTHAM: And what happened when he cried out for help?

CANEY: They came to him and obviously took the sheet off him, spoke to him and, according to them, they were reassured that he was then fine and he wouldn't attempt it again.

NORTHAM: And what happened to the sheet?

CANEY: Somewhere along the line, some sheets were given back to him, and then the following day he also asked another nurse for further sheets and they were given to him, and it's those sheets that he obviously then took his own life with.

NORTHAM: They were given back?

CANEY: Yes, I was absolutely devastated to think that the same thing could have happened the day before and nobody seemed aware that that had happened, or that the nurse in particular wasn't aware of the circumstances of the day before, which is why she just gave him the sheets. I just kept thinking he went into hospital to be safe and I couldn't understand how something like that could have happened when he should have been in safe hands.

NORTHAM: The sequence of events which emerged at the inquest was even more startling. The day after his bed sheets were returned to him, Michael had a visit from his sister-in-law. At 4pm she told a nurse that he was saying he wanted to end it all. The only change staff made was to take his cigarette lighter off him. At 5pm he asked staff for another bed sheet and was given one. And at 6.45pm he was found dead, hanging from a sheet in his room. When the Coroner heard the full details of miscommunication, muddle and staff ineptitude, she halted the inquest and referred the case to the police for investigation of suspected corporate manslaughter. She was concerned that her previous recommendations after Kirsty Brookes' inquest had not been fully implemented. Michael's sister, Pauline, was astonished.

CANEY: At that point, I just broke down; I just found it so hard to comprehend. And obviously that made us realise, I suppose, at that point just how bad things were and that it had happened to somebody previously, and you keep hearing that, you know, this won't happen again, things are going to get better, but unfortunately it seems to keep happening.

NORTHAM: The Crown Prosecution Service decided the evidence was insufficient for a corporate manslaughter prosecution against the NHS. When the inquest then resumed, the Coroner remarked tartly that the evidence might not be criminal but it was 'abysmal'. Again she raised doubts about the reliability of staff testimony, saying she suspected that some of it had been 'fabricated'. And she did not hold back when expressing her view of the role the Bradgate Unit had played in Michael Coltman's death.

READER IN STUDIO: It is clear to me that there has been a catalogue of failures stemming from an institutional complacency.

NORTHAM: The Leicestershire Partnership NHS Trust, which is responsible for the Bradgate Unit, rejects this suggestion of complacency and insists that systems have been improved. But the succession of self-inflicted deaths among patients has continued. Last year alone there were five more deaths, which brought the total to nine since the start of 2010. Then in January this year there was a further death, making ten in all.

COLES: I would say that it's disproportionately high and is a very shocking figure that warrants proper scrutiny and some very serious questions about what is going on within that unit.

NORTHAM: Deborah Coles of the national charity, Inquest, which represents bereaved families, sees the record of the Bradgate Unit as troubling.

COLES: I would be very concerned that there would be independent investigations carried out into all of those deaths in order to fully establish whether there are particular systemic and individual issues arising from those deaths, because where there are a pattern of deaths, it does suggest that there are some very serious thematic issues of concern that warrant action on behalf of the hospital as a matter of urgency.

NORTHAM: What we found with the Bradgate Unit is that in case after case the same problems are identified – staff shortages, failure of communication, staff not telling the truth to their own investigators. These have come up again and again. Would that again give you cause for concern?

COLES: Absolutely. I would ask the question about why it is that the investigations into these deaths have not resulted in proper learning to ensure that the same thing doesn't happen again. And there is an absolute duty on behalf of the state, when somebody dies in those circumstances, for there to be a proper investigation and action taken to prevent similar deaths occurring, so it's very worrying that that clearly isn't happening.

NORTHAM: Inquest says that in thirty years of the charity's caseload, it has never come across an example of an independent investigation of a suicide in a mental health hospital. How does the recent history of the Bradgate Unit compare with other psychiatric hospitals? The NHS Trust commissioned a review of inpatient suicides by a leading national expert, Professor Louis Appleby, who found that between 2000 and 2009, the Bradgate's record was at the higher end of the national average range. But he gave no comparison for the three and a half years so far of this decade. We wanted to know more, and turned to the Chief Operating Officer, Paul Miller.

MILLER: I think it's important to point out that there are many times when our staff, who work very hard, prevent self-harm and suicide taking place on our wards, and the level of, the level of suicides we have in our area is similar to other areas.

NORTHAM: How do you know that?

MILLER: We know from national benchmarking data, about the prevalence of suicides across the whole country.

NORTHAM: So the number of suicides since the beginning of 2010 is in line with national figures, is it?

MILLER: The Louis Appleby report confirmed that the number of suicides taking place in our Trust is no different to many other trusts across the country.

NORTHAM: That was for the previous decade, 2000-2009, his figures. I am asking you about this decade.

MILLER: This decade is only two or three years old, erm, certainly in 2011 and 2012 we probably were higher than the national average.

NORTHAM: So when you said you were in line with the national figures, you meant in the previous decade, not in the past three years?

MILLER: I would have to refer to what Louis Appleby said in his report, and I am more than happy to get a copy of that to clarify exactly what he said.

NORTHAM: Well I have read it and he is talking about the previous decade, 2000-2009.

MILLER: Okay, you are better informed than I am on exactly what he said, but we are not sitting here thinking that we are completely different to other parts of the country in terms of the prevalence of these cases.

NORTHAM: But you don't know that for the last three and half years.

MILLER: I can't answer your question, I am sorry.

NORTHAM: So we've tried to find other ways of putting the record of recent deaths at the Bradgate Unit into a reliable national context for the years since 2010. Experts have told us there's no straightforward way to do this in the absence of up-to-date national figures.

ACTUALITY IN OFFICE

NORTHAM: What we have been able to do is to compare Leicestershire with other areas of the country with similar or greater populations. File on 4 submitted Freedom of Information requests to a range of NHS Trusts. Kent & Medway Trust, for example, tells us that its number of self-inflicted deaths in the past three and a half years is one. For Hertfordshire, the number is four. For Birmingham and Solihull, it's five. And for Cheshire and Wirral, it's two. Contrast them with the Leicestershire total of ten - the highest we've found.

Which raises one key question about the Bradgate Unit - whether the recurrent failings are now a thing of the past. We have spoken to staff working there who tell us, anonymously, of their continuing concerns. This is what one of them said to us:

READER IN STUDIO: On a busy acute ward, a lot of patients don't get very much time with staff at all. On a nursing level, you feel like you are dealing with the next crisis or the next admission or the next discharge and all the paper that goes along with those things. You can't be doing all the paperwork in the office and at the same time assessing the risks on a one-to-one level by having a conversation with somebody.

NORTHAM: The Leicester City Clinical Commissioning Group, the new paymaster for NHS services, also seems to harbour doubts. At its meeting in June this year, it offered this less than reassuring judgment of the Trust running the Bradgate Unit:

READER IN STUDIO: There is currently insufficient assurance that practice has improved and lessons have been shared and learnt across the Trust.

NORTHAM: The independent body which monitors hospital standards in England is the Care Quality Commission. A year ago, the Leicester Coroner referred the Bradgate Unit to the Commission for further investigation because of its recurrent failings. Last December, the CQC published an inspection report, which said that nursing staff complained that after 'adverse events' they didn't receive any clear recommendations from senior management. The CQC also said that the NHS Trust concerned had reviewed all recent suicides and recommended improvements to communication between staff. If this didn't quite seem to measure up to the Coroner's criticisms, then Deborah Coles of Inquest says it fits a nationwide pattern which raises questions about the CQC's effectiveness in these cases.

COLES: The current mechanisms we have for both investigating and inspecting psychiatric hospitals is failing. Worryingly, the CQC has no statutory remit to investigate deaths of mental health patients. It is concerned with regulation and monitoring of standards, so what it can do, if the Trust alerts it to the fact that deaths have occurred, it can make a visit and it can conduct an inspection. My concern, however, is that its role in this area has been disappointingly ineffective, both in the collation of the deaths that actually occur of mental health patients, but I think more specifically the lack of rigorous scrutiny where things have gone wrong.

NORTHAM: The CQC has come under sustained national criticism this year over its reports on hospitals. It inspected the Bradgate Unit in October 2011 and found that it met 'all the essential standards of quality and safety'. The next month, Gagan Sandhu was able to abscond and hang himself in what the Coroner called a 'gross failure' of care. One Leicestershire MP has taken a close interest in the CQC's reports on Bradgate. Stephen Dorrell, who chairs the Commons Health Select Committee, concludes that the inspectors have frequently done a poor job.

DORRELL: This, of course, is a subset of a much bigger issue around the CQC. The CQC has made it clear that it is changing the way in which it carries out inspections. It absolutely needs to do that and the chairman of the CQC himself, the new chairman has acknowledged that it hasn't been fit for purpose. Although it's also fair to remind ourselves that the CQC has done regular inspections of the Bradgate Unit, has found failings there and has then gone back to examine whether those failings have been addressed. Now clearly the track record of the Bradgate Unit suggests that the CQC were satisfied too easily and shouldn't have given the assurances that it did.

NORTHAM: We wanted to put these points to the Care Quality Commission. Nobody was available for interview. In a statement, the CQC tells us it acknowledges that its inspection model in 2011 was 'flawed'. It now says that the absconsion and death of Mr Sandhu the following month 'showed the Unit was still not safe'. And the CQC tells File on 4 that, following an inspection within the past few weeks, it is now contemplating measures against the Bradgate Unit.

READER IN STUDIO: As a result of further concerns, we are considering our regulatory action, including whether to issue a warning notice, which would put a legal obligation on the provider to make improvements.

NORTHAM: Last week, a judicial review began in the High Court which could have a profound effect on the investigation of suicides and other unnatural deaths in mental health settings. At its heart is the claim that all investigations should be conducted from the start by an independent body, rather than leaving it to the NHS to investigate itself. This follows a study by the Government's Independent Advisory Panel on Deaths In Custody, which examined a selection of NHS investigation reports to see if they comply with human

NORTHAM cont: rights law. The conclusion, from the Panel's legal expert, Professor Philip Leach, was that they don't.

LEACH: One of the key principles is where you have a problem within an institution, you cannot have people from the same institution investigating that problem, it's a key human rights principle.

NORTHAM: But that is what's happening?

LEACH: That is what's happening. Independent investigations are very rare. They seem to be being carried out in cases of homicide and occasionally where there are clusters of problems, clusters of suicides, but that is not good enough, there may be a necessity to carry out an independent investigation in any case where there is a possibility that the state is at fault, for whatever reason.

NORTHAM: And if they are not compliant with that requirement of the human rights law, does that mean that these investigations are in themselves unlawful?

LEACH: They are breaching the current legal requirements. It means that there is no accountability where mistakes are being made, and perhaps even more fundamentally than that, lessons are not being learned and that needs to change. There is no body that carries out systematic monitoring of these reports, that is one of the problems. The reports are not made public. So it's quite possible that the Trust may itself learn lessons, but we need to have a system where nationally all other mental health providers learn those lessons.

NORTHAM: The case before the High Court centres on an individual death in a psychiatric hospital, this time in Harrow, west of London. It was the death three years ago of a prominent mental health campaigner.

CLIP FROM 'ALL IN THE MIND' – RADIO 4

ANTONIOU: There's between three and seven voices, both male and female, and they talk to each other about me and then they tell me things to do, and there are a lot of swearing and it's pretty horrible.

NORTHAM: Janey Antoniou had a long history of self-harm and detention in psychiatric hospital. Her risk of suicide was well-recognised. Nonetheless, one morning, during a spell in Northwick Park hospital in 2010, where she was sectioned, she was found in her room strangled by a dressing gown cord the staff had somehow missed. Her husband, Michael, wanted to know exactly what had gone wrong in the hospital's observation and supervision procedures. But he found the NHS investigation of her death didn't answer all his questions.

MICHAEL ANTONIOU: I was not consulted or approached to give evidence at all by the Trust at any point during their investigation. We were never informed of the progress of their internal investigation. We found that the Trust was very defensive, they actually took on an adversarial rather than collaborative stance and they really were just very very defensive and you felt they were withholding information from you, to be quite honest, if I can be blunt.

NORTHAM: Dr Antoniou told us that he was particularly concerned that one vital witness statement came to light only after the inquest. His solicitor in the High Court case is Tony Murphy.

MURPHY: What's striking about Mrs Antoniou's case is that she was somebody who was very vulnerable, who was being checked every hour or supposed to be checked every hour because she presented a risk of self-harm. Yet when she was found, the attending doctor found her body to be stiff and cold and blue in colour. It appeared that rigor mortis had set in. And he expressed at the scene the concern that in fact she may have been dead for a number of hours. Now that raises the obvious worry that she hadn't been checked every hour. Now instead of that triggering an independent investigation pre inquest, which we would say is required even by the existing guidance in those circumstances, no independent investigation followed.

NORTHAM: The NHS Trust responsible for Northwick Park hospital has told File on 4 that its investigation of Janey Antoniou's death was thorough. But it doesn't feel able to comment further while a judicial review is underway. The Government believes that the independence of investigations is guaranteed by the Coroner's inquest which follows the NHS internal investigation. Last week it moved to speed up inquest timetables so that most should be completed within six months of a death. But Tony Murphy's argument in the

NORTHAM cont: judicial review is that this introduction of independent scrutiny should begin the moment a self-inflicted death is discovered in a psychiatric hospital.

MURPHY: The problem with the current system is that those who gather the bulk of the evidence are the same people who are responsible for providing care to the deceased. And it's very difficult to have confidence in that system, because the evidence-gatherers therefore inevitably, if only unwittingly, have a motive not to uncover the full truth. And the difficulty with that is that once you then present that evidence at an inquest in front of a Coroner, and once that Coroner has to deal with that evidence, he or she is essentially dealing with the fruits of a poisoned tree, because evidence may have been missed, evidence may not have been followed up, and so the short point is that internal investigation is not working.

NORTHAM: A judgment in the judicial review isn't expected until the autumn. It's nine years since the parliamentary Joint Committee on Human Rights advocated a fully independent system of investigations. No Government, including this one, has moved to make this happen. The present Minister responsible for care and support, Norman Lamb, wasn't available for interview. In a statement to File on 4, he says that NHS England and the Care Quality Commission are considering how they can further ensure that all deaths of mental health inpatients are reviewed and lessons identified. He links this explicitly to the wider question of public trust in the NHS.

READER IN STUDIO: We have to make sure that lessons can be learned from patients' deaths to improve care in the future. Families have to be confident that we have a robust system in place to ensure that individuals and providers can be held to account where poor care is identified.

NORTHAM: The Minister doesn't go on to explain how this is supposed to come about while investigations remain in the hands of the NHS itself. In Parliament, the chairman of the Health Select Committee, Stephen Dorrell, sees public confidence as a central issue for the NHS as a whole. Mental health, he argues, needs transparency.

DORRELL: Professional accountability for services delivered by clinicians working in psychiatric units seems to me to be just as important as it is for other professionals working elsewhere in the health and care system. The one thing that undermines

DORRELL cont: public confidence more quickly, more surely and more rightly than anything else is the sense that any part of the NHS is a secret garden where the truth isn't allowed to escape. The truth will sometimes be uncomfortable, but it's never as uncomfortable as hiding the truth.

SIGNATURE TUNE