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Hospital psychiatric detainees more at risk of preventable death. Deaths of more than 600 mentally ill detainees in England and Wales could have been avoided, says Equality and Human Rights Commission report

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Patients detained in hospital psychiatric wards are up to five times more likely to suffer a preventable death than mentally ill prisoners in the prisons of England and Wales, according to figures obtained by an official inquiry.

For the first time, the Equality and Human Rights Commission (EHRC) examined how civil liberties of detainees with mental health conditions were protected across the health, prison and police settings.

Its inquiry found that between 2010 and 2013 there had been 662 deaths among mentally ill detainees that could have been avoided.

The commission warned that in many cases it was “basic mistakes” that cost lives. It encountered “tragic cases” where there had been a failure to properly monitor patients and prisoners at serious risk of suicide – even when their records recommended constant observation.

In other instances, hospital staff had not removed “ligature points” on psychiatric wards despite the fact they are commonly used to attempt suicide.

While deaths in police cells often make headlines, there were only 17 “avertable” instances recorded – a rate of one needless death in every 300,000 occasions that custody was used as a place of safety.

In prisons, there were 295 preventable deaths between 2010 and 2013, a rate equivalent to up to one avoidable death per 1,000 mentally ill prisoners. In hospitals, the comparable figure is one death in about 200 patients detained.

Campaigners welcomed the report. The charity Inquest, which campaigns on the issue of deaths in custody, said: “When someone dies in the care of the state, the state must be held accountable for any neglect or ill treatment. Too many deaths are the result of repeated failings and ineffective learning.”

Despite the need for improvements in all public services, the commission’s report was clear that the biggest steps need to be taken to improve the conditions of patients who have been detained in hospital because of their mental health.

The commission said that while the Independent Police Complaints Commission (IPCC) is responsible for investigating all preventable deaths in police custody, and the prison and probation ombudsman has the same duties to those who lose their lives in prison, no equivalent mechanism exists for when someone dies during mental health detention.

The report warns that hospitals have “no independent body charged with ensuring that effective, independent investigations take place. Staff do not feel they can speak out openly and families feel excluded from investigations.”

Deborah Coles, the co-director of Inquest, said only last week the charity had warned that healthcare services were “prone … to be defensive and will close ranks if someone dies in their care”.

She told the Guardian she particularly welcomed the commission’s support for an independent body to investigate all deaths of detained patients in psychiatric hospitals rather than rely on

internal investigations by hospital trusts.

“At the moment, hospital trusts don’t learn the lessons of each tragedy. After a patient dies, the hospital trust effectively investigates itself over deaths that may have been caused or contributed to by failures of their own staff or systems.

“Families are excluded and fight to get basic information. Unlike trusts who have publicly funded lawyers to defend their policies, families struggle to find funding.

“Coroners attempting to probe the circumstances of such deaths do not have the pre-inquest support of an independent investigation making it difficult to fully investigate systemic failings or to provide insight or guidance on the prevention of future deaths.”

Coles said that in a recent case, Rebecca Overy, a teenager from Nottingham, was found collapsed with a ligature around her neck in an adult secure hospital – despite her parents warning that the unit appeared “more like a prison than a caring environment”.

The young woman, who had suffered from mental health problems since she was 13, had been in a children’s unit and was hoping to go to college but was abruptly transferred to an adult hospital with little warning.

The result was a rapid decline in her mental health with the coroner noting “42 incidents of self-harm … restraint on a substantial number of occasions. During this time she was repeatedly tying ligatures, swallowing batteries and choking on objects”.

Despite being at risk, there were reduced observations of the teenager – giving her time to prepare a ligature. She was found dead on 23 June 2013.

Her parents, Barry and Kathryn Wilson, are pressing to create a “Rebecca’s Law”, which would ensure that children cannot be moved to adult mental health units without effective transition.

Another area of concern raised by the commission is that attempts by the Department of Health to lower the risks to patients in the NHS have backfired.

It suggests that after the department banned face-down restraint of patients, police were increasingly called out by hospitals to deal with mental health patients and in some cases end up using “restraint techniques … deemed unsafe to be used by hospital staff”.

The commission said: “This has potentially very serious consequences as police techniques, including the use of face-down restraint and Tasers, are generally not appropriate for detained patients.”

Two people, it says, have died because police have ended up on hospital wards.

Mark Hammond, the EHRC chief executive, said that “where people with serious mental health issues should be placed for their own safety, and that of others, was an open question that needs further work”.

He added: “What we are saying is that there is a series of steps that we can take, some quite quickly, that over a couple of years should make real inroads into the numbers of preventable deaths.”

A government spokesman said: “It is vital that all services – NHS, prisons and the police – are honest and open when things go wrong and work with families and staff to prevent further tragedies. Many of these deaths could have been prevented with the right care and support.

“The government is working with NHS England and CQC [Care Quality Commission] to improve

the way these deaths are investigated and we've launched a zero suicide ambition for the health service.

"We are reviewing the way we care for high-risk prisoners and already work closely with police forces, the Independent Police Complaints Commission and other partners to prevent deaths in custody and to take action to minimise the risks to all detainees."

The College of Policing national co-ordinator for mental health, Michael Brown, said: "There is a growing demand on police officers and staff in helping those suffering mental health difficulties.

"While the police service should not be filling gaps in mental health services, we need to ensure that we give frontline officers and staff basic training in identifying signs and symptoms.

"Officers and staff also need to be equipped with the knowledge of where to divert vulnerable people into a healthcare setting so that they can receive expert care. That means not using police cells as a place of safety for those detained in distress.

"The College of Policing is leading a review nationally of police standards and training, including looking at the issue of restraint, as highlighted in the report published today."