Department of Health

Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services

November 2015

Introduction

1. This advice provides detail for NHS organisations on the factors to be taken into account when deciding whether an independent investigation needs to be carried out to satisfy (in whole or part) the State's obligations under Article 2 of the European Convention on Human Rights. NHS England and NHS bodies are public authorities who must comply with the Human Rights Act 1998 and the European Convention on Human Rights. NHS bodies implicated in serious incidents may be considered to be 'State agents' for the purposes of Article 2.

Context

2. In the NHS, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents that affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. The procedures to be followed when managing a serious incident are set out in the NHS England Serious Incident Framework – Supporting learning to prevent recurrence (the Framework) published in March 2015.

3. This advice, when read in conjunction with the Framework, replaces the DH guidance issued in 2005 (Independent Investigations of adverse events in mental health services).

Article 2 of the European Convention on Human Rights

4. Article 2 imposes a procedural obligation on the State to conduct an investigation in circumstances including:

- where the person has died while detained (for example under the Mental Health Act 1983); or has attempted suicide while so detained and has sustained serious injury (or potentially serious injury);

- where the State owed a duty to take reasonable steps to protect the person's life because the person was under the State's control or care and the State knew (or ought to have known) there was a real and immediate risk to the person's life. This could include voluntary psychiatric patients (eg Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2); and
- where the person was killed by an agent of the State.

5. An investigation conducted for the purposes of Article 2 is intended to open up the circumstances, correct mistakes, identify good practice and learn lessons for the future so as to prevent recurrence of similar incidents.

6. To satisfy this procedural obligation, the State must initiate an investigation that is reasonably prompt, effective, carried out by a person who is independent of those implicated, provides a sufficient element of public scrutiny and involves the next of kin to an appropriate extent.

7. A coroner's inquest is the means by which the state ordinarily discharges the procedural obligation – indeed inquests often go beyond the strict requirements of Article 2. The inquest will often be assisted by earlier investigations (independent or otherwise).

8. However, where a person detained under the Mental Health Act 1983, or a person in state control or care (in the sense set out at paragraph 4, the second bullet point, above), has attempted suicide and has sustained serious injury (or potentially serious injury), there will be no inquest because an inquest may be held only in the event of a death. In those circumstances, an investigation must be carried out to satisfy the State's obligations under Article 2.

9. Article 2 imposes a general positive duty on the State to have a system to protect life. An investigation should be considered where it may be necessary to examine the causation of a serious incident or multiple serious incidents (e.g. a cluster of suicides) that could indicate systemic failures to protect life. Such an investigation could look at the role of the wider commissioning system or configuration of services (involving multi-agencies/organisations).

10. NHS bodies should consider taking their own legal advice on whether, in a particular case, it would be appropriate for those carrying out the investigation to be employed by or be accountable to an entirely separate organisation than that which was responsible

for providing the care in which the incident occurred (a Level 3 investigation under the Framework). Where this is required, it is the responsibility of the commissioners of the care in which the incident occurred to commission that investigation. Alternatively, it might be appropriate for the investigation to be carried out by someone employed by the NHS body responsible for the care in question, provided that person is independent of those implicated (a Level 1 or 2 investigation under the Framework).