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PRESS RELEASE
For immediate release 27 April 2012

INQUEST OPENS INTO THE DEATH OF MENTAL HEALTH CAMPAIGNER JANE ANTONIOU

10am Monday 30 April 2012 before HM Coroner for Barnet, Andrew Walker, sitting at 29 Wood Street, Barnet, Hertfordshire EN5 4BE

The inquest into the death of Jane Antoniou (known as Janey Antoniou) will commence on Monday 30 April 2012. It is listed for two weeks.[1]

Early on 23 October 2010 Janey Antoniou, a well known mental health campaigner, was found unresponsive in her room on the Eastlake Ward, Northwick Park Hospital, Harrow, with a ligature around her neck. Resuscitation was attempted but she failed to regain consciousness. At the time of her death, Jane was detained under section 3 of the Mental Health Act 1983.

An investigation into the circumstances of Janey Antoniou's death was conducted by Central and North West London Mental Health NHS Foundation Trust, the same Trust that had responsibility for her care. Objections by her husband, Dr Michael Antoniou, to the lack of independence of that investigation were rejected by the Trust. This is the subject of separate judicial review proceedings, which are currently stayed pending the conclusion of the inquest.

Dr Antoniou welcomes the inquest as a first opportunity to independently examine the facts surrounding his wife's death and to explore whether she received appropriate levels of care. This includes in the assessment of her risk of suicide and the management of her mental health crisis.

Dr Michael Antoniou is being represented by INQUEST Lawyers Group members Paul Bowen QC of Doughty Street Chambers, instructed by Tony Murphy of Bhatt Murphy Solicitors. He is supported by INQUEST caseworker Victoria McNally and Heather Hewett of Rethink Mental Illness, where Janey was a valued colleague.

Notes to editors:

Dr Michael Antoniou or his representatives will not be making any comment to the media while the inquest proceedings are ongoing. An obituary for Janey Antoniou can be read online here: http://www.independent.co.uk/news/obituaries/janey-antoniou-2134027.html

In contrast to all other custody settings, no organisation exists to independently investigate pre-inquest the deaths of those who die in mental heath hospitals. There is no equivalent of the Independent Police Complaints Commission or Prison and Probation Ombudsman to investigate those deaths.

Detailed statistics for the number of deaths of those detained under the Mental Health Act were published for the first time in 2011 by the Independent Advisory Panel on Deaths in Custody. A report of its statistical analysis can be found at http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/10/IAP-Statistical-Analysis-of-All-Recorded-

[1] Please note that the court is not sitting on Tuesday 1 May 2012

Deaths-in-State-Custody-Between-2000-and-2010.pdf. It should be noted that the statistics refer only to the death of patients sectioned at the time of death and do not include those who died whilst 'de-facto' detained i.e. those voluntarily admitted where sectioning would have occurred if they had attempted to leave.

From that report:

- 5998 total deaths in state custody were recorded between 1 January 2000 and 31 December 2010. Deaths of those detained under the MHA accounted for 61% of that number.
- Between 1 January 2000 and 31 December 2010, there were 1,444 self inflicted deaths in state custody. 501 deaths were of patients detained under the MHA, of which 61% were male and 39% female.

INQUEST provides a general telephone advice, support and information service to any bereaved person facing an inquest and a free, in-depth complex casework service on deaths in custody/state detention or involving state agents and works on other cases that also engage article 2 of the ECHR and/or raise wider issues of state and corporate accountability. INQUEST's policy and parliamentary work is informed by its casework and we work to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring.

Please refer to INQUEST the organisation in all capital letters in order to distinguish it from the legal hearing.

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