# Deaths in Detention Reviews

Following a wider government review[[1]](#footnote-1), the Scottish Ministers asked us to

*…develop a system for investigating* ***all deaths of patients*** *who, at the time of death, were* ***subject to an order*** *under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether* ***in hospital or in the community****, including those who had their detention suspended).*

### Listening to the personal experience of families and friends

A vital part of the project will be listening to the personal experience of families and friends.

If someone you know has died in the last five years (from April 2015) who was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995 at the time of death we would really like to hear about **your experience with NHS or other public bodies following their death.**

You can participate and share your views in a range of ways. We can speak with you on the phone or meet one-to-one. Later in the project there will be opportunities to attend meetings with us at local health boards. If you are interested in this opportunity to help us towards developing a system for reviews of deaths in detention then please complete the contact form and indicate how you might like to be involved.

We plan to host a ‘Family Listening Day’ for bereaved families and carers to hear their views and experiences in autumn 2020. Please see the attached sheet for more information.

At any meeting you are welcome to have someone with you to support you if you wish (e.g. a family member or friend).

We would like to encourage people from a variety of geographical areas and diverse cultural backgrounds to be in contact with us.

# Background

When legislative changes were being made through the Mental Health Act 2015, concerns were raised with Ministers that there was not a consistent approach across Scotland to decisions or procedures on whether to review, and how to review, deaths of people who were being detained for care and treatment under these Acts.

While these decisions will always be taken on an individual basis, depending on the circumstances of a person’s death, Ministers wish all Scottish authorities to work to the same system.

### The current system

From October 2019 – December 2020 we will focus on how the process works now, current systems and practices, and the experience of families and carers. We will clarify how information on **all** deaths of people who have been detained for the care and treatment of their mental health are currently being recorded and reported. We will examine data from the last five years about all such deaths in detention. We will work closely with Healthcare Improvement Scotland, the Scottish Government’s section 37 review group and the National Suicide Prevention Leadership Group. We will hear from a range of organisations, including health boards, the Crown Office and the Procurator Fiscal Service (COPFS).

### Working towards a new system

We aim to share draft proposals for the new system by spring 2021. We will discuss the draft proposals with professional organisations and families and carers.

### Proposals to Scottish Government

#### May 2021 – June 2021

We aim to produce a proposed revised system, and deliver a business case and a plan for implementing that system across Scotland to Ministers.

The new system, once approved by Ministers, will be adopted by all of Scotland’s NHS health boards, Healthcare Improvement Scotland and the Mental Welfare Commission.

**Deaths in Detention Reviews - contact form**

|  |
| --- |
| **Your Personal Details** |
| First Name: |  |
| Last Name: |  |
| Title (Mr, Mrs, Ms, Miss, Other) |  |
| Home address: |  |
| Postcode: |  |
| Email: |  |
| Telephone number(s) |  |

|  |
| --- |
| **It would be helpful to have some information about the person who died** |
| First Name: |  |
| Last Name: |  |
| Title (Mr, Mrs, Ms, Miss, Other) |  |
| Date of Birth / Age |  |
| Date of death: |  |
| Where they died:(health board, hospital, ward, community) |  |

|  |
| --- |
| **What relationship did you have with the person who died?** |
|  |

|  |
| --- |
| **Please tell us how you would like us to contact you** |
| 🞏 Telephone  | 🞏 Meet in our Edinburgh office |
| 🞏 Skype | 🞏 Meet somewhere else |
| 🞏 Email |  |
| Please let us know what dates and times are best for you and we will do our best to speak with you then. |
|  |

|  |
| --- |
| **We will be holding a Family Listening Day at a central venue** |
| Would you like to know more? | * Yes, I would like to know more
* Yes , I would like to take part
* No, not at this time
 |

|  |
| --- |
| **By completing your name below and emailing the contact form, this will be accepted as your signature.** |
| Print name: |  | Date: |  |

### Please complete this form by:

**Email**: mwc.review@nhs.net

**Telephone:** Lynn McBean / Liza Noble - 0131 313 8777

**Post:** Mental Welfare Commission for Scotland

Thistle House, 91 Haymarket Terrace, Edinburgh EH12 5HE

**Data Protection Statement**

The Mental Welfare Commission for Scotland will use the information you provide in this contact form to inform you about the engagement activity related to Death in Detention Reviews (like the Family Listening Day planned for the 15th May 2020). We will not share your contact details with any other body or institution without your informed and express consent, all the information will be stored securely and will not be retained for longer than necessary.

If you change your mind about taking part in engagement events or the Family Listening Day and want your data to be deleted, please let us know by sending us an email to the following secure address mwc.review@nhs.net marked “For the attention of the Information Governance Manager.”

The final proposal to the Scottish Government (and any other report prepared during Deaths in Detention Review) may be illustrated with anonymised personal experiences and data extracted from them. We will removed any personal details that would allow any individuals to be identified.

# Deaths in Detention Reviews - Family Listening Day

2020 - central venue, Scotland

### Purpose

Following a wider government review[[2]](#footnote-2), the Scottish Ministers asked us to

*…develop a system for investigating* ***all deaths of patients*** *who, at the time of death, were* ***subject to an order*** *under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether* ***in hospital or in the community****, including those who had their detention suspended).*

A vital part of the project will be listening to the personal experience of families and friends.

We have invited INQUEST to run a ‘Family Listening Day’ for bereaved families and carers to hear their views and experiences.

### About INQUEST

INQUEST is a charity which provides free and independent advice to bereaved people following a death in state care or detention in England and Wales. They are entirely independent of government. They work to empower bereaved people to exercise their legal rights, and to ensure that their collective experience is heard by policymakers, parliamentarians and the wider public. Alongside families, they aim to improve the investigation processes following a death and help effect meaningful change to prevent future deaths. They are now working on a project in Scotland to share their expertise and provide independent support to help families contribute to significant reviews such as this.

Learn more about INQUEST: [www.inquest.org.uk/about-us](http://www.inquest.org.uk/about-us)

### Who is invited

If someone you know has died in the last five years (from April 2015) who was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995 at the time of death we would really like to hear about your experience with NHS or other public bodies following their death.

### Format of the day

The Family Listening Day will bring together a group of bereaved families to discuss their experiences and insights on all aspects of the investigation process following deaths involving mental health services. It will be an opportunity to share your experiences, and ideas on what good practice looks like and how best to support and involve families in these processes. It will be a safe, confidential environment and an opportunity to meet others who have similar experiences. The group will be facilitated by experienced members of INQUEST staff and we will have an informal session at the beginning of the day to explain more about our work and the day.

Lunch, tea and coffee breaks will be provided and there will be time at the end of the event for further conversation. A record of the key findings and recommendations will be taken by note takers and a report of the day made available to participants and the Mental Welfare Commission. Quotes will be anonymous, but families’ experiences and suggestions will be on record and form an important part of Deaths in Detention Review.

Learn more about previous family listening days by INQUEST: [www.inquest.org.uk/family-listening-days](http://www.inquest.org.uk/family-listening-days)

### Support on the day

We recognise that discussions around bereavement and loss can be difficult and distressing. Emotional support will be available to all participants throughout the day. There will be quiet areas you can go to if you wish.

You are welcome to bring someone with you to support you if you wish, such as a family member or friend).

### Practical arrangement for attending the day

We will do everything we can to enable you to take part in the Listening Day.

Please contact Lynn McBean, our project officer, in advance to discuss reimbursement of reasonable expenses.

### Contact details:

Lynn McBean, Project Officer, Deaths in Detention Reviews

0131 313 8777

mwc.review@nhs.net

1. The Scottish Government (Dec 2018) *Review of the arrangements for investigating the deaths of patients being treated for mental disorder*. <https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/4/> [↑](#footnote-ref-1)
2. The Scottish Government (Dec 2018) *Review of the arrangements for investigating the deaths of patients being treated for mental disorder.* <https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/4/> [↑](#footnote-ref-2)