Investigating deaths occurring during compulsory care and treatment under mental health legislation in Scotland

A consultation on the Mental Welfare Commission for Scotland's proposals

December 2021

Table of contents

1. Introduction and background ... 1

Background ... 1
Aim of this consultation ... 4

2. Summary of revised process proposed by the Commission ... 5

The role of the Commission in the revised process ... 5
Description of the revised process ... 6

3. Involving families and carers ... 9

4. Other matters for consideration ... 11

Values and principles ... 11
Consideration of equality groups, and children and young people ... 11
Human rights ... 12
Financial and administrative impacts ... 12
Any other views ... 13

5. Responding to this consultation ... 14

List of questions ... 14
Other ways of sharing your views ... 15
Handling your response ... 15
Next steps ... 16
Comments and complaints ... 16

Annex 1: A human rights-based approach to reviewing deaths ... 17

Important terms used in this document

Mental health legislation in Scotland

This document refers to three laws which concern people with a mental health condition or learning disability.

- The Mental Health (Care and Treatment) (Scotland) Act 2003 (referred to as 'the 2003 Act') allows for legal orders to be made for the compulsory treatment and / or detention of a person with a mental health condition or learning disability.
- Part VI of the Criminal Procedure (Scotland) Act 1995 (referred to as 'the 1995 Act') allows for the assessment, treatment and detention in hospital of a person with a mental health condition or learning disability who has committed an offence.
- The Mental Health (Scotland) Act 2015 (referred to as 'the 2015 Act') made some changes to the 2003 Act to help people with a mental health condition or learning disability to access effective treatment quickly and easily. This Act strengthened measures in the 2003 Act to enhance people's rights and promote their involvement in their own treatment. The 2015 Act also made changes to the 1995 Act in relation to mental health orders in criminal cases.

  Section 37 of the 2015 Act set out a requirement for Scottish Ministers to undertake a review of the arrangements for investigating deaths of people who were in hospital for the treatment of a mental health condition or learning disability.

Investigation vs review

Section 37 of the 2015 Act refers to the arrangements for investigating deaths and therefore this document frequently uses the term 'investigation' in relation to the proposals discussed here. The term 'investigation' will be used interchangeably with the term 'review'.

To avoid confusion, the term 'Review' (capitalised) is used to refer specifically to the Scottish Government Review of the arrangements for investigating deaths of patients being treated for a mental disorder – the report of which was published in 2018. The term 'mental disorder' is used in the Scottish Government Review report to reflect the language used in mental health legislation in Scotland. Section 328 of the 2003 Act defines a **'mental disorder'** as any mental illness; personality disorder; or learning disability, however caused or manifested.

1. Introduction and background

1. This consultation paper outlines the key elements of a proposal for a new system in Scotland for investigating the deaths of all people who, at the time of their death, were subject to an order under mental health legislation in Scotland. The relevant legislation, in this case, is the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) and part VI of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act).

2. This proposal is put forward by the Mental Welfare Commission for Scotland (the Commission). It has been developed in response to an action arising from a Scottish Government Review (published in 2018) of the arrangements for investigating the deaths of people being treated for a mental disorder.[1]

3. This proposal relates to all people who have died whilst on a compulsory treatment order in the community or in hospital, or who were compulsorily detained on other orders in hospital for assessment and treatment, including those whose detention in hospital was suspended at the time of their death. For ease of reference, these deaths will be referred to in this paper as 'deaths during compulsory treatment'. This proposal does not cover people who were admitted to hospital or treated in the community on a voluntary basis.

Background

4. People in Scotland may receive care and treatment for mental health condition or learning disability in a variety of settings – both in the community and in hospital. When a person dies in hospital, there may be an investigation into their death in some circumstances. This investigation is usually undertaken by the local service(s).[2] The nature and complexity of the investigation will depend on a number of factors including (i) whether the death was unexpected or unexplained; (ii) staff action, or inaction, which may have contributed to the death; and (iii) organisational policies, procedures or practices which may have contributed to the death.

5. Section 37 of the Mental Health (Scotland) Act 2015 set out a requirement for Scottish Ministers to undertake a Review of the arrangements for investigating deaths of people who were in hospital for the assessment and treatment of a mental health condition or learning disability. The remit of this Review was subsequently extended to also examine the processes for investigating the deaths of people being compulsorily treated in the community.

6. The aim of the Review was to establish whether the current arrangements for investigating the deaths of people being treated for a mental health condition or learning disability are adequate, and how well local organisations support and engage with the families and carers of people who have died.

[1] Elsewhere in this document, we use the term 'mental health condition or learning disability' instead of the term 'mental disorder', except in cases where reports or legislation are being directly quoted.
[2] In certain situations, the Mental Welfare Commission may be involved in the investigation of deaths of people who have been compulsorily treated or detained in hospital.

Findings of the Scottish Government Review

7. The report of the Review was published in 2018. Its main finding was that the deaths of people being treated for a mental health condition or learning disability are currently not being investigated consistently in a way that can be guaranteed to be independent.

8. The Review found that **not all deaths** are investigated, especially in cases where the deaths have not been recorded as 'unavoidable' or 'unexpected', despite the fact that the people who died may have spent long periods of time subject to orders under the 2003 Act or part VI of the 1995 Act.

9. The Review also found that there is wide variation in the time taken to carry out investigations – from a few weeks to as much as two years – and that families and carers are often excluded from the process.

10. The Review recommended that **every death** where the person was subject to an order under mental health legislation should be subject to a proportionate level of review. The investigation process should be timely, should have a sufficient element of public scrutiny, and should involve families, staff and carers.

11. Several actions arose from the Review – the first of which was that:[3]

> *'The Scottish Government will ask the Mental Welfare Commission for Scotland 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).*
>
> *This process should take account of the effectiveness of any investigation carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.'*

Why was the Mental Welfare Commission asked to take on this task?

12. The Commission was established by the Mental Health (Scotland) Act 1960, with changes made to its constitution and functions by the 2003 Act and the Public Services Reform (Scotland) Act 2010. It is accountable to Scottish Ministers but carries out its work and produces reports independently from Scottish Government.

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[3] The proposals set out in this paper specifically address action 1 from the Review. However, the proposals also touch on (some of the) other Review actions and may contribute to broader developments in a positive way.

13. In carrying out its functions, the Commission is required by section 4(2A) of the 2003 Act to act in a manner which seeks to protect the welfare of persons who have a mental health condition or learning disability. It has extensive powers to carry out investigations and make recommendations into an individual’s case. These powers apply to people detained in hospital and to those who are in the community. The Commission can inquire into and make recommendations relating to any individual’s case, including in circumstances where a person may be, or may have been, subject or exposed to ill-treatment, neglect or some other deficiency in care or treatment. Investigations can be carried out while the individual is alive and also following death.

14. Section 16 of the 2003 Act gives the Commission the power to require that any individual’s records, including medical records, be presented to it for inspection.

15. Section 11 of the 2003 Act gives the Commission power to investigate a person’s case and to make recommendations in cases where a person has been unlawfully or improperly detained or may be or have been subject to ill-treatment or other deficiency in care or treatment.

16. Section 12 of the 2003 Act gives the Commission the power to hold an inquiry for the purpose of carrying out an investigation. The chair of such an inquiry has the power to require people to attend to give evidence, administer oaths and examine witnesses under oath. Inquiry proceedings are equivalent to court proceedings and refusal to attend or give evidence at an inquiry is a criminal offence.

Findings from the Commission’s development work

17. The 2003 Act requires that when a person with a mental health condition or learning disability comes to the end of a period of compulsory treatment or detention in hospital, healthcare providers must notify the Commission – including in cases where treatment / detention has ended as a result of the person’s death. In 2021, the Commission worked with Public Health Scotland to identify all deaths during compulsory treatment: in the past six years (from 2015 to 2021), there have been an average of 124 such deaths per year.

18. Following further examination of this information, the Commission found that on average, around 7% of deaths per year are **not** reported to the Commission – therefore data available to the Commission currently represents only a subset of deaths among people who were being treated for a mental health condition or learning disability at the time of their death.

19. Of those whose deaths **were** notified to the Commission the cause of death was reported as follows:

    - Natural cause or ‘expected’ death (41%)
    - Sudden or unexpected deaths (due to physical health causes) (33%)
    - Suicide (8%)
    - ‘Other’ causes, including accidents (2%)
    - ‘Unascertained’ (1%)
    - No information provided (16%).

20. In order for any new system to be effective, the notification process will require to be improved so that **all** relevant deaths are reported to the Commission; not just a subset as is currently the case. Work to improve the notification process is currently underway.[4]

21. The Commission has now undertaken further work to develop proposals for a new system for investigating the deaths of people who were being treated compulsorily for a mental health condition or learning disability at the time of their death (including those whose compulsory treatment was recently suspended). These proposals have been developed internally (using an informal literature review and after considering approaches adopted in other jurisdictions) and also through discussions and engagement with:

    - Family members and carers (of individuals who died whilst in treatment for a mental health condition or learning disability)
    - NHS boards, local authorities, and other mental health care and treatment services
    - Healthcare Improvement Scotland (HIS), which has developed a national adverse events framework to support a consistent national approach to the identification, reporting and review of adverse events (including suicides whilst in care) and to allow best practice to be promoted across Scotland
    - The Crown Office and Procurator Fiscal Service (COPFS), which receives reports of deaths in certain circumstances, and has a role in investigating sudden, suspicious, accidental and unexplained deaths

22. The Commission would now like to consult more widely on its proposals.

Aim of this consultation

23. The aim of this public consultation is to seek views on the Commission's proposals for a new system of investigating the deaths of people who, at the time of their death, were subject to compulsory treatment under mental health legislation in Scotland.

24. The consultation contains 11 questions that invite comment – including concerns and suggestions for improvement – on different aspects of the proposals.

25. The consultation will run from 7 December 2021 to 15 February 2022.

[4] A revised version of the ND1 'Notification of Death' Form is now available.

2. Summary of revised process proposed by the Commission

26. The Commission has been asked to develop a revised process for investigating deaths during compulsory care and treatment under mental health legislation in Scotland. As set out in the 2018 Scottish Government Review (see previous section), the revised process should:

    - Take account of any investigation carried out by other agencies
    - Reflect the powers of the Commission
    - Include appropriate elements of public scrutiny
    - Involve families, carers and staff
    - Have clear timescales for investigation, reporting and publication.

27. In addition, the design and testing of the new system should involve and be informed by the views of carers, families and staff with direct experience of existing systems.

28. The revised process is described below.

The role of the Commission in the revised process

29. We propose that, in the revised process, the Commission should be responsible for **initiating, directing, and quality assuring** the process of investigating **all** deaths during compulsory treatment. This will include cases where a person died within one month of having their compulsory treatment or detention order revoked. This will mean that the Commission will take an active role from the outset in every case.

30. The Commission will also have a role in **synthesising and distilling the learning** from these investigations; **authoring an annual report** to summarise the findings of the investigations; and **disseminating the main messages** to the relevant audiences including local services, families and carers. The Commission will also have a role in **ensuring that any follow-up actions from local investigations are implemented** and in **escalating cases to Scottish Government and Ministers**, as appropriate, where recommendations are not implemented satisfactorily.

31. The rationale for proposing this role for the Commission is that the organisation – as described above (see paragraphs 12-16) – is in a unique position in relation to:

    - the powers it has to (i) carry out investigations into an individual’s case, (ii) require that any individual’s records, including medical records, are presented to it for inspection and (iii) hold an inquiry for the purpose of carrying out an investigation
    - its independence.

The development of guidance and standards

32. To fulfil this new function in relation to the revised process, the Commission will develop – early in 2022 – guidance and standards for local services. Local services

will include NHS, local authority, Health and Social Partnerships, third / independent sector and private sector care providers – all of which may be involved in the investigation of deaths.

33. The guidance will cover such issues as: (i) ensuring that the level of review is proportionate to the circumstances of the person's death; (ii) involving a range of other (non-NHS) organisations in the investigation; (iii) advising on steps to maximise independence in the local investigative process; (iv) good practice in relation to the commissioning of external expert reviews; (v) putting in place arrangements to ensure that family concerns and questions are responded to; and (vi) following up on how learning and recommendations are implemented.

Question 1: Do you agree that the Commission should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases? [Yes / No / Not sure]

Question 1a: Do you foresee any difficulties with this arrangement?

Question 1b: How could such difficulties be addressed?

Question 2: Do you agree that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations as described in paragraph 30 above? [Yes / No / Not sure]

Question 2a: Do you foresee any difficulties with this arrangement?

Question 2b: How could such difficulties be addressed?

Question 3: Do you agree that the Commission should develop guidance and standards for use by local services when undertaking investigations into deaths during compulsory treatment? [Yes / No / Not sure]

Question 3a: Do you foresee any difficulties with this arrangement?

Question 3b: How could such difficulties be addressed?

Description of the revised process

34. The stages of the revised process are set out below. It should be noted that, unlike the situation which pertains at present, the revised process requires that **all** deaths during (and shortly following) compulsory care and treatment are investigated.

Stage 1

35. The Commission will be notified by local services of the death of a person who was subject to the 2003 Act at the time of (or within one month of) their death.

Stage 2

36. An initial review of the circumstances surrounding the death will be undertaken by a team assembled by the Commission for this purpose. The team will include psychiatric, social work and nursing expertise, administrative and analytical support, and a Commission Liaison Officer (CLO). (The role of the Commission Liaison Officer is described in more detail in Section 3 below.) The Commission will also ensure that

the team includes specialist expertise where this is required. For example, where the death involves a person with a learning disability, the team would include an individual who has specialist expertise in this area.

Stage 3

37. Based on this initial review, the Commission will inform the relevant local services about the level of investigation that should be conducted and will set out the terms of reference for the investigation and the timescale for completion. The timescales will depend on the circumstances of the individual case. They may range from 3–6 months for a (reasonably straightforward) review by the local service, to 6–12 months or more for a Significant Adverse Event Review (SAER) involving a range of agencies and disciplines. (Further details about the timescales for reviews will be set out in the guidance and standards, which the Commission will develop in early 2022 – see paragraph 32 above.) Note that at this stage the Commission may advise the local service(s) that the investigation should be chaired by an individual approved by the Commission.

38. Exceptionally, at this stage, the Commission may undertake its own investigation. The Commission will take this step if it considers it is inappropriate (for whatever reason) for the local service(s) to carry out the investigation.

39. There is another possibility at this stage, namely, where the death is subject to an ongoing criminal investigation, the Commission will discuss with the Crown Office and Procurator Fiscal Service (COPFS) the type of investigation which is required; in certain cases, this may need to be postponed until any criminal investigation or significant case review has concluded.

Stage 4

40. Following completion of the investigation by the local service(s), the team assembled by the Commission will assess whether (i) the agreed terms of reference for the investigation have been met and (ii) the actions identified for follow up by the local service(s) are being satisfactorily progressed. The Commission's team will set specific timescales to follow up on any actions arising from the investigation.

Stage 5

41. A range of possible options may then be pursued at this stage as follows:

    - If the team at the Commission are satisfied both with the investigation and with the follow up actions by the local service(s), then the team will prepare a report to be shared with families and the service(s).
    - If the team at the Commission is not satisfied that the local investigation complied with the terms of reference which had been set, then the Commission may undertake its own further investigation, which could involve requesting case files, interviewing staff and other key individuals and publishing findings – either as part of an annual report, or as a separate stand-alone report.

Stage 6

42. The Commission will produce an annual report, with a focus on the lessons learned. All investigations conducted (whether by local services or by the Commission itself) will be summarised and reported on an anonymised basis (i.e. no details will be included which would allow for the identification of individuals).

43. The Commission team will follow up on recommendations made at a local and national level and have a clear escalation policy to the Scottish Government when it considers that local services have not complied with recommendations made or there has been an unacceptable response to recommendations made.

Question 4: Do you have any comments on the revised process as set out above?

Question 4a: Do you foresee any difficulties with this process?

Question 4b: How could such difficulties be addressed?

3. Involving families and carers

44. It was acknowledged in the Scottish Government Review that families and carers offer a perspective on the circumstances surrounding a person's death that others do not have. The Review report emphasised the importance of ensuring that in future, all investigations relating to the death of a person during compulsory treatment should involve families and carers in a meaningful way. This is currently not consistently the case.[5]

45. The Review explained that the key reason why families and carers wished to be involved in the investigations was so that lessons could be learned, and others could be protected in the future.

46. The Review suggested that one specific element to assist with improving the involvement of families and carers would be to create a 'single point of contact' for them in relation to all investigations / reviews.

47. The Commission therefore proposes to develop a new role of a Commission Liaison Officer. The Commission Liaison Officer will be involved in the initial review of any death which occurs during compulsory care and treatment (see paragraph 36 above). The role will involve:

- Providing continuity of contact with the family and carer(s) from the outset of the investigation through to its completion
- Keeping the family and carer(s) fully informed about the progress of the investigation
- Explaining any legal requirements and processes which underpin the investigation – including the role and powers of the various contributors to the investigation, and any specific issues relating to possible criminal prosecutions
- Ensuring that any questions, points or contributions which the family and carer(s) wish to ask or make are communicated – and responded to – in a timely fashion
- Signposting family and carer(s) to appropriate support services (e.g. bereavement counselling)
- Developing and promoting standards for good practice in engaging with families.

48. The post will require the holder to display sensitivity, compassion, respect, empathy at all times, and to take account of any special communication requirements that family members or carers may have.

[5] A survey of family members and carers conducted for the Review received 42 responses. Approximately half of the respondents to this survey had a family member or friend who had died whilst being treated compulsorily under the 2003 Act. The survey findings showed that just under half of respondents (48%) said they were not kept informed about the progress of the investigation, more than one-quarter (29%) were not offered a meeting with anyone as part of the investigation process, and almost two-thirds (62%) that they were not involved enough – or that their views were not sufficiently taken into account – during the investigation.

Question 5: Do you think that the role of Commission Liaison Officer, as set out above, will help to improve the involvement of, and communication with, families and carers during investigations of deaths? [Yes / No / Not sure]

Question 5a: Do you have any concerns about this type of arrangement?

Question 5b: How could your concerns be addressed?

4. Other matters for consideration

49. There are a range of other issues which the Commission wishes to seek views on as set out below.

Values and principles

50. The Commission believes that in order for its proposals to be in line with its duty (as set out in the 2003 Act) to act in a manner which seeks to protect the welfare of persons who have a mental health condition or learning disability, the revised process must:

- Be independent
- Deliver local accountability
- Involve families and carers in a meaningful way
- Be informed by standards and guidance based on good practice
- Be characterised by openness, honesty and transparency
- Provide clear, accessible and timely reporting

Question 6: Do you agree that the revised process, described in Section 2, will meet the values and principles set out in paragraph 50 above? [Yes / No / Not sure]

Question 6a: Please explain your answer.

Consideration of equality groups, and children and young people

51. The revised process will be subject to an Equality Impact Assessment (EQIA). An EQIA will help to determine any potential impacts the process could have on individuals with protected characteristics and how any impacts could be mitigated. The protected characteristics, defined in the Equality Act 2010, are: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

52. There will also require to be an assessment of any potential impact of the revised process on children and young people.

Question 7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics?

Question 7a: Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

Question 8: Do you have any comments on the potential impacts of the revised process on children and young people?

Question 8a: Please explain what you think could be done to minimise any negative impacts on children and young people.

Human rights

53. The revised process for reviewing deaths during compulsory treatment will take a human rights-based approach – that is, every effort will be made to put the human rights of families and carers at the centre of the process. Human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life. They can never be taken away, although in certain circumstances, they can sometimes be restricted. These basic rights are based on shared values like dignity, fairness, equality, respect and independence, and they are protected by law.

54. The PANEL principles have guided the development of the Commission's proposals. The PANEL principles require that consideration is given to **P**articipation, **A**ccountability, **N**on-discrimination and equality, **E**mpowerment and **L**egality. (See Annex 1 for details of how the PANEL principles have informed the revised system of reviewing deaths during compulsory treatment.)

55. Consideration has also been given, specifically, to Articles 2, 3 and 14 of the European Convention on Human Rights, which provide for the right to life (Article 2), the right to freedom from torture and inhuman or degrading treatment (Article 3), and the protection from discrimination in respect to these rights (Article 14). Article 14 is closely related to the Convention on the Rights of Persons with Disabilities which requires that there should be no discrimination in how laws, policies and procedures affect people with disabilities as compared with other people. (See Annex 1 for details.)

Question 9: Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant? [Yes / No / Not sure]

Question 9a: Please explain what you think could be done to ensure that the new process fully complies with human rights standards.

Financial and administrative impacts

56. During the Commission's development work, we heard that local services generally intend to be open, transparent and honest with families during reviews of deaths during compulsory treatment. However, local services identified a range of barriers to full involvement of families in local review processes. These include a lack of dedicated resource to liaise with families, a lack of administrative time for recording minutes, and gaps in training and support to staff dealing with difficult emotional issues.

57. The revised process will include the creation of a new post of Commission Liaison Officer, which will be hosted by the Mental Welfare Commission. This post will provide a dedicated resource to liaise with families throughout the review. However, local services will also need to ensure greater involvement of families and carers in the review process and – depending on the nature of the review – the involvement of a

wide range of other services or agencies. This may result in financial, administrative, or other impacts for the local service(s).

Question 10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services?

Question 10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.

Any other views

58. Please let us know of any other concerns you have, or any other comments you would like to make.

Question 11: Do you have any other comments or concerns in relation to the revised process?

5. Responding to this consultation

We are inviting responses to this consultation by **15 February 2022.**

The consultation is being run by Griesbach & Associates (Dawn Griesbach and Jennifer Waterton) on behalf of the Mental Welfare Commission using SmartSurvey.

You can view the consultation questions and respond online at https://www.smartsurvey.co.uk/s/InvestigationOfDeathsDuringCompulsoryTreatment/

If you wish to work on your response offline before submitting it online, you can download a Word version (download here) of the consultation questions.

If you are unable to submit your response online, please complete a copy of the Respondent Information Form (see "Handling your Response" below) and send this with your response (in Word or PDF format) to:

Dawn Griesbach
Griesbach & Associates
d.griesbach@griesbach-research.co.uk

Please ensure that your response is submitted no later than 11.59pm on **15 February 2022**.

List of questions

- **Question 1:** Do you agree that the Commission should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 1a:** Do you foresee any difficulties with this arrangement?
  - **Question 1b:** How could such difficulties be addressed?

- **Question 2:** Do you agree that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations as described in paragraph 30 above?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 2a:** Do you foresee any difficulties with this arrangement?
  - **Question 2b:** How could such difficulties be addressed?

- **Question 3:** Do you agree that the Commission should develop guidance and standards for use by local services when undertaking investigations into deaths during compulsory treatment?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 3a:** Do you foresee any difficulties with this arrangement?
  - **Question 3b:** How could such difficulties be addressed?

- **Question 4:** Do you have any comments on the revised process as set out above?
  - **Question 4a:** Do you foresee any difficulties with this process?

- Question 4b: How could such difficulties be addressed?

- **Question 5:** Do you think that the role of Commission Liaison Officer, as set out above, will help to improve the involvement of, and communication with, families and carers during investigations of deaths?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 5a:** Do you have any concerns about this type of arrangement?
  - **Question 5b:** How could your concerns be addressed?

- **Question 6:** Do you agree that the revised process, as described in Section 2, will meet the values and principles set out in paragraph 50 above?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 6a:** Please explain your answer.

- **Question 7:** Do you have any comments on the potential impacts of the revised process on those with protected characteristics?
  - **Question 7a:** Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

- **Question 8:** Do you have any comments on the potential impacts of the revised process on children and young people?
  - **Question 8a:** Please explain what you think could be done to minimise any negative impacts on children and young people.

- **Question 9:** Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant?

  ☐ Yes ☐ No ☐ Not sure

  - **Question 9a:** Please explain what you think could be done to ensure that the new process fully complies with human rights standards.

- **Question 10:** Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local service(s)?
  - **Question 10a:** Please explain what you think could be done to minimise any negative financial or administrative impacts.

- **Question 11:** Do you have any other comments or concerns in relation to the revised process?

Other ways of sharing your views

The Commission will be running a small number of engagement events in mid-January for people who may be affected by these proposals. Details of these will be announced on the Commission's website in mid-December.

Handling your response

If you respond online using SmartSurvey, you will be asked to complete a Respondent Information Form to enable us to handle your response correctly. In relation to this

consultation, **no responses from individuals will be published**. This is to protect the safety and confidentiality of (potentially) bereaved respondents. However, **all responses from organisations will be published** unless the respondent specifically requests that their response not be published. The names of all organisational respondents will be listed in an annex to the analysis report, irrespective of whether they request that their response not be published.

If you are unable to respond online, please complete and return a Word version of the Respondent Information Form (download the form here). The form should be sent to Dawn Griesbach, Griesbach & Associates together with a copy of your response in Word or PDF format. If you ask for your response not to be published, it will still be included in the analysis, but will not be available to be viewed publicly. Please be aware that the Mental Welfare Commission is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps

Where organisational respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public. All responses will be analysed and considered together with other evidence available to us when finalising the new process for investigating deaths during compulsory treatment.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to: Andy Grierson ci.mwc.didconsultation2021@nhs.scot

Annex 1: A human rights-based approach to reviewing deaths

The PANEL principles have guided the development of the Commission's proposals for a revised system of reviewing deaths during compulsory treatment as follows:

- **Participation:** The Commission has involved – and will continue to involve – families and carers in the development of the revised process.
- **Accountability:** The Commission will oversee the process and monitor whether and how the rights of families and carers are being upheld. The Commission will also intervene when things go wrong.
- **Non-discrimination and equality:** An Equality Impact Assessment for the process will be developed. Steps will be taken to ensure that the process of communicating with families and carers (verbally and in writing) is tailored to their individual needs and requirements. There will be no discrimination against any individual as a result of their age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.
- **Empowerment:** The Commission will develop standards of good practice in engaging with families and carers. This will include the development of materials to explain to families and carers their rights to be involved in the investigation process; what they can expect from the process (including timescales); and how they can complain when things go wrong.
- **Legality:** The proposed investigation process seeks to uphold international human rights standards as set out in the European Convention on Human Rights. The Articles from the ECHR which are most relevant to the process are:
    - Article 2 **(Right to life):** All people have the right to life. In addition, if a member of a person's family dies in circumstances that involve the state, that person may have the right to an investigation. Article 2 also requires the state to investigate suspicious deaths and deaths in custody.
    - Article 3 **(Freedom from torture and inhuman or degrading treatment):** All people have the right to be protected from mental or physical torture, inhuman treatment,[6] and degrading treatment.[7] Article 3 requires the state to investigate credible allegations of such treatment.
    - Article 14 **(Protection from discrimination in respect of these rights and freedoms):** Article 14 is based on the core principle that all people, no matter who they are, enjoy the same human rights and should have equal access to them. This Article is closely related to the Convention on the Rights of Persons with Disabilities, which has been effect since 2008. This convention requires that there should be no discrimination (whether intended, indirect or unintended) in how laws, policies and procedures affect people with disabilities as compared with other people.

[6] This includes serious physical assault; cruel or barbaric detention conditions or restraints; serious physical or psychological abuse in a health or care setting.

[7] Degrading treatment causes humiliation or treats people in undignified ways; it undermines the principle of the innate value and dignity of all human beings.