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

## Section 2: Summary of revised process proposed by the Commission

Q1. Q1: 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

Q2. Q1a: Do you foresee any difficulties with this arrangement?

• Recruiting staff to take part in this will be difficult. Currently, reviewing adverse events is in many cases an additional piece of work that is taken up by clinicians. Over the past year we have experienced many people step back from doing reviews due to clinical work pressures. The alternative is potentially more concerning – that staff reduce their clinical commitment to focus on reviews. Given that psychiatry and psychology are hard to recruit to specialties for all disciplines, this may create service delivery problems. A balance of clinical work and reviews is needed.
• We have strived to establish a "learning culture" locally, which encourages the reporting and review of adverse events. This is now going well, staff on the whole feel safe reporting when things go wrong, they have a good knowledge of how events will be reviewed, and are willing to take part fully knowing that a just and fair approach will be taken and that the purpose of the review will be learning and improvement. A review carried out by MWC direction may not have the same appearance to staff, especially if the term "investigation" (which implies a legal process) is used instead of review. This may lead to decreased staff engagement in both the process and the wider adverse event review reporting system
• Staff support is critical during the review process. Literature on 2nd victims is well established and we do all that we can to support those involved. 3rd victim (the reviewer) support is still in its infancy but we believe this is very important. We provide a range of support locally (peer groups, group feedback, management support) that we would not wish to be undermined.
• Use of the MHA may decrease, especially in older adults. In recent years detentions have increased and there is debate over whether this is more unwell people, or more people afforded their right rather than being de-facto detained. If it is the later, then there is a risk that the prospect of scrutiny in the deaths of such individuals may result in a reversal of this trend.

Q3. Q1b: How could such difficulties be addressed?

• Recruiting staff will continue to a challenge which requires a national focus
• MWC will need to clearly communicate their aims and objectives from the review process
• Local services will need to observe the effect on incident reporting.
• Continue to monitor trend data for detention rates

## Section 2: Summary of the revised process proposed by the Commission

Q4. Q2: 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 of the consultation document?

Yes

Q5. Q2a: Do you foresee any difficulties with this arrangement?

• For smaller cause of death groups (for example suicide, listed as 8%), it may be difficult to preserve anonymity.
• There is a danger that this information could be seen as a "league table", and that boards with more adverse event reviews is providing poor care, when in fact one with fewer reviews may not have a reporting culture and lack psychological safety.

Q6. Q2b: How could such difficulties be addressed?

• Using a rolling average over 3 or 5 years
• A strong narrative and context setting will be important

## Section 2: Summary of revised process proposed by the Commission

Q7. Q3: 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

Q8. Q3a: Do you foresee any difficulties with this arrangement?

• Such guidance and standards would need to not conflict with, and ideally concur with, other bodies guidance and standards for example HIS/ihub, RCPsych and existing SAER processes in Health Boards and Health and Social Care Partnerships. We would agree that there is also the opportunity for improvement through standardisation.

Q9. Q3b: How could such difficulties be addressed?

• Focused work on this will make it achievable.

## Section 2: Summary of the revised process proposed by the Commission

Q10. Q4: Do you have any comments on the revised process as set out in Section 2, paragraphs 34 to 43, of the consultation document?

Yes, please see 4a

Q11. Q4a: Do you foresee any difficulties with this process?

Yes, there are several potential issues, each with suggested actions where these are applicable:
Stage 1
• These events will be rare in the life of a clinician and may even be rare in the life of a management team. There reporting system locally needs to be fit for purpose so that all adverse events are reported and there is a system in place for then screening these for the MWC criteria. This could be addressed with additional admin support in those Boards that require it.
• There is no system in Scotland for automatic notification of death of any person (detained or not) to the treating psychiatrists or MHO. Thus it can be longer than a month before a person is aware a detained person has died. A more considerable issue is if a person has been detained and then discharged from follow up as the psychiatrist may only learn of the death several years later via the National Confidential Enquiry. We are not sure how this could be addressed.
Stage 2
• Several psychiatric specialties are small and therefore the people involved will know each other, through professional bodies or national work. People who step forward for this type of work also step forward for other work, and thus the chance of knowing people involved is high. This could effect the impression of impartiality. This could be tackled by using a robust disclosure in interest type system.
• The initial review process needs a time limit and protected time (and resource) for those involved to undertake this. Robust guidance on what is expected is required.
Stage 3
• Time scales for this work is far in excess of Lanarkshire timescale (which is that reviews are to be completed within 90 days of the event). Longer reviews are difficult for families and staff involved (as laid out in the consultation paper) and mean that there are fewer reviewers available to undertake the other reviews that need to be completed locally. We suggest these timescales need to be shorter and more clearly defined.
• Guidance is needed on how teams should be selected, the training that is required for each team member, if shadowing is permitted.
• Specific information on the setting of terms of reference is needed, and how existing action plans and review findings should be referenced.
• The family views and questions need to be included in the process – see comments below regarding liaison person
• Guidance is needed on what to do if a complaint is received to avoid duplication of effort and additional unnecessary distress– locally our process is that the parts of the complaint outwith the scope of the review are answered and the rest is paused until the review is complete.
Stage 4
• It is normal practice in our board for a draft to be presented and discussed with the management team prior to sending the final draft to the commissioners at which point they will often raise queries and it is only after they are satisfied that the review is marked as completed. We need similar guidance over the exact process for the completion of the reviews in this situation.
• Guidance is needed on who the reviewing team approach with problems and questions – this is a common occurrence locally, but as above, to preserve impartiality advice may be best coming form the MWC.
• We would recommend that actions follow the SMART format
Stage 5
• Repeat questioning and interviewing over a prolonged time is harmful for families and staff. Given that, in the proposed process, an initial review (of unclear timescale) and a full review (up to 12 months) will have taken place and then another MWC review will take place this process could take several years, and more if an SCR or SFIU investigation takes place. This is not desirable and is further case for a reduction in the timescales involved.
Stage 6
• No additional comments

Q12. Q4b: How could such difficulties be addressed?

• See above

## Section 3: Involving families and carers

Q13. Q5: Do you think that the role of the Commission Liaison Officer will help to improve the involvement of, and communication with, families and carers during investigations of deaths?

Not sure

Q14. Q5a: Do you have any concerns about this type of arrangement?

• We have no doubt that a single link person during the process is of benefit (both families and to staff) and we encourage teams to do this already.
• In longer reviews however it is more likely that the link person will move jobs and thus there will be multiple link persons.
• The liaison officer has several clear benefits – they may be seen as impartial in particular. However, our experience is that families dislike increasing the "distance" from the clinical team and it may be seen as defensive or evasive.
• Questions from the family should be fed into the review to inform the terms of reference – usually the review team do this, but its not clear in the document if this would still be the case. If it is delegated to the Liaison Officer there is the benefit of less people to engage with, but there may be a degree of miscommunication with the team. The same is true for when and how the review is fed back to the family – which should be done in a way that the family have immediate access to a person who can answer questions about the review and process.

Q15. Q5b: How could your concerns be addressed?

• A clear SOP in this area would also be helpful.
• The family provide written questions or confirm a written account of a meeting with the liaison officer.

## Section 4: Other matters for consideration

Q16. Q6: Do you agree that the revised process, described in Section 2 of the consultation document, will meet the values and principles set out in paragraph 50?

Yes

Q17. Q6a: Please explain your answer.

*No Response*

## Section 4: Other matters for consideration

Q18. Q7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics?

• No comments

Q19. Q7a: Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

• Digital inclusivity needs to be considered
• Consultation with patient and carer groups with an interest in this area

Q20. Q8: Do you have any comments on the potential impacts of the revised process on children and young people?

• No comments

Q21. Q8a: Please explain what you think could be done to minimise any negative impacts on children and young people.

• No comments

## Section 4: Other matters for consideration

Q22. Q9: Do you agree that the revised process for investigating deaths during compulsory treatment (as described in Section 2 of the consultation document) is human rights compliant?

Yes

Q23. Q9a: Please explain what you think could be done to ensure that the new process fully complies with human rights standards.

*No Response*

## Section 4: Other matters for consideration

Q24. Q10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services?

• There will be an impact and it would be challenging to absorb this within current resources.
• There is likely to be more email exchange, communication and time taken to liaise with external bodies which currently does not happen. There is currently no available staff time for this.
• It is difficult to find appropriately qualified and experienced staff to conduct reviews due to time constraints. If more time is needed, the willing resource we have to do this may decrease as those conducting reviews feel under pressure (this has been observed locally over the last year).

Q25. Q10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.

• While extra funding for staff carrying out reviews may be helpful, it is doubtful this would make a difference as we cannot employ new staff due to lack of applicants. Funding extra time of this sort for existing staff is likely to see them decreasing their clinical time, which will directly lead to adverse outcomes.
• Extra funding for administrative functions (writing of reports contacting staff, taking minutes) would release staff time and may free up the capacity required
• Extra training in a standardised format may bring benefits to both the MWC commissioned reviews and as an additional benefit those skills could also help improve other local reviews

## Section 4: Other matters for consideration

Q26. Q11: Do you have any other comments or concerns in relation to the revised process?

• We would take issue with the use of review and investigation being used interchangeably, although can appreciate the challenges in writing the consultation paper with both terms being used previously. Linking to earlier comments, we need to establish a safety culture in our organisations, where individuals feel safe to come forward with concerns. Recent enquiries have highlighted the dangers to patients when staff do not feel able to come forward. "Reviewing Care" and "Investigation" are perceived very differently by staff, and we are likely to see more staff hold back or remove themselves completely if we are not cautious with our language, while acknowledging that there are separate investigation processes via HR if someone has acted inappropriately. We also need to be mindful of the impression that this gives to staff considering coming into the service, particularly where private practice or other specialities are an option and we need to demonstrate that we help people in organisations learn and improve, not investigate them.

## Respondent Information Form

Q27. Name of person submitting the response

Adam Daly

Q28. Email address of person submitting the response

adam.daly@lanarkshire.scot.nhs.uk

Q29. Are you responding as an individual, or on behalf of an organisation?

I am responding on behalf of an organisation

## Respondent Information Form - individual responses

Q30. Are you a family member or carer of a person who has died whilst being treated under mental health legislation in Scotland?

*No Response*

Q31. Do you wish your response to be published?

*No Response*

## Respondent Information Form - Organisational responses

Q32. Organisation name

North Lanarkshire Health and Social Care Partnership

| Q33. Organisational responses will be published unless otherwise requested. Please tick the box below if you do NOT want your organisation's response to be published. Note that the name of your organisation will be listed as a respondent to the consultation even if you request that your response not be published. |
| --- |
| *No Response* |