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?

Not sure

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

We agree in principle that the Commission should have responsibility for this process. Experience of complaints suggests that each investigation is likely to present different and individual characteristics and challenges so the same approach on each occasion may not be appropriate, and the involvement of the Commission may need to be different, depending on the circumstances. There may also be questions about how independent a quality assurance process is of an investigation where there has been substantial direction and investigation by the Commission.

Q3. Q1b: How could such difficulties be addressed?

It would be helpful if the Commission could set out some broad principles that would support retaining flexibility in the level of its involvement in individual cases, and how they will ensure independence in the quality assurance process. We recommend that quality assurance is undertaken by those not involved in directing and initiating investigations. Ideally this would sit within a separate team, ensuring that they have appropriate knowledge, experience and expertise (either as a permanent team member, or by bringing experts into the team for specific QAs).

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?

No

Q6. Q2b: How could such difficulties be addressed?

No Response

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?

Guidance and standards should ideally take into account, reflect and make reference to relevant standards already in place and not repeat or create overlapping standards; for example: significant adverse event reviews and for responding to complaints. It is important that it is clear to organisations, and family and friends which process is being used and why, and what steps they can take if they are unhappy about the approach being taken.

Q9. Q3b: How could such difficulties be addressed?

The MWC should ensure that it understands all the relevant processes and engages fully with appropriate organisations to ensure that there is broad agreement about how related/ overlapping standards and procedures should interact and how information will be shared between systems.

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

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

The MWC should ensure that it understands all the relevant processes and engages fully with appropriate organisations to ensure that there is broad agreement about how related/ overlapping standards and procedures should interact and how information will be shared between systems.

Q12. Q4b: How could such difficulties be addressed?

The MWC should ensure that it understands all the relevant processes and engages fully with appropriate organisations to ensure that there is broad agreement about how related/ overlapping standards and procedures should interact and how information will be shared between systems.

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?

Asingle point of contact and support for families is good practice and we welcome this initiative. In our experience, families appreciate direct contact with those directly conducting investigations and making decisions. this role should not detract from the importance of ensuring families are also able to have that contact.

Q15. Q5b: How could your concerns be addressed?

The Commission Liaison Officer would not replace but enhance direct contact with decision-makers and investigators.

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?

Not sure

Q17. Q6a: Please explain your answer.

The procedure has the potential to meet those values and principles but it is not clear how they will be realised in practice.

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 Response

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

No Response

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

No Response

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

No Response

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?
No Response

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?
No Response

Q25. Q10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.
No Response

Section 4: Other matters for consideration

Q26. Q11: Do you have any other comments or concerns in relation to the revised process?
No Response

Respondent Information Form

Q27. Name of person submitting the response
Valerie Malloch

Q28. Email address of person submitting the response
Valerie.malloch@spso.gov.scot

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
Scottish Public Services Ombudsman

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