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?

There is a need to be able to demonstrate transparency and openness with this arrangement.

Q3. Q1b: How could such difficulties be addressed?

Anonymised results of each case could be shared.
There is a need for a wide range of expertise and representation on the Commission.

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?

There will be a need for full cooperation from all organisations and individuals involved as well as transparency and openness about the findings and recommendations. This may be difficult if those under review feel that their judgement and actions are being questioned. This could lead to a culture of fear and inaction.

Q6. Q2b: How could such difficulties be addressed?

Training and development will be required to ensure that the culture in all relevant organisations is one of learning and improvement. The Commission will need the power to ensure that the publication of results and recommendations is not blocked by organisations involved and that progress is monitored and reviewed regularly.

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?

The interpretation of any guidance may vary from individual to individual and from region to region.

Q9. Q3b: How could such difficulties be addressed?

Examples of best practice could be created and training given. There could be a named high-level individual responsible for coordinating and quality assuring local input to reviews across all services.

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?

No

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

Action plans to address recommendations need to be widely visible with clear actions, timescales, outputs and impacts.

Q12. Q4b: How could such difficulties be addressed?

Guidance and training needs to be given on how to create a meaningful action plan. There will be a need for the Commission to independently monitor action plans and check progress. The Commission should have the power to challenge organisations when progress is slow.

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?

Yes

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

I think this will be a useful addition and will help families understand the process. However I am doubtful whether this individual will have the status to challenge the Commission and advocate on behalf of families.

Q15. Q5b: How could your concerns be addressed?

There could be an experienced independent individual appointed to the Commission whose role is to champion families and advocate on their behalf.

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.

I agree, as long as these principles are not taken for granted and success against them is reviewed/audited independently at regular intervals.

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

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

No comment

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

The revised process should encourage learning and improvement and help future generations of children and young people.

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

Regular independent reviews and ongoing monitoring.

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 a further strain on resources when staff are needed to prepare material for reviews.

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

Ongoing improvements as a result of reviews could lead to longer term savings. Perhaps there could be a centralised fund, held by the Commission to support local work required during a review.

Section 4: Other matters for consideration

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

I hope that the revised process will raise the profile of the importance of reviews and encourage a consistent level of high quality and degree of thoroughness in the way that cases are investigated. I hope the process will ensure that recommendations for improvements are embedded into action plans which are delivered in a timely and efficient way and that progress is independently monitored.
I also hope that the new process will allow for the full involvement of families who wish it, at every stage, from the development of the review brief through to the creation and implementation of the action plan. This will help families to see that lessons have been learned from their experience and will contribute to improved care for future generations.

Respondent Information Form

Q27. Name of person submitting the response
[redacted]

Q28. Email address of person submitting the response
[redacted]

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

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?
Yes

Q31. Do you wish your response to be published?
Yes, publish response without name