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?

Healthcare Improvement Scotland (HIS) welcomes these proposals, in line with the recommendations made in the Scottish Government's 'Review of the arrangements for investigating the deaths of patients being treated for mental disorder' (2018), which will ensure a consistent approach to and consideration of all deaths in this setting.

It will be important to ensure clear alignment between agencies where there is a potential overlap between respective roles and responsibilities – for example in relation to the deaths of children and young people, and deaths in prison custody.
HIS, in collaboration with the Care Inspectorate, co-hosts the National Hub for Reviewing and Learning from the Deaths of Children and Young People ('the National Hub')*, which was implemented on 1 October 2021. From that date, reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of continuing care or aftercare at the time of their death. There is the potential that some deaths occurring during compulsory care and treatment under mental health legislation in Scotland will fall within the review criteria for the National Hub.

The National Hub's National Guidance states that:
'When an organisation is notified about the death of a child or young person there should be clear governance arrangements and processes in place to determine the appropriate review mechanism. Engagement must take place early in the process with any other organisations involved in the child or young person's care to reach a decision about the most suitable review process. All organisations and agencies involved should work together to undertake one single review wherever this is possible and appropriate. The rationale for deciding which review process should be carried out should be clear, take into consideration any statutory, legal or national requirements, and be reached in a timely manner.'

The Independent Review of the Response to Deaths in Prison Custody**, published in November 2021, recommends that an independent investigation should be undertaken into each death in prison custody. Prisoners can be detained under the Mental Health (Scotland) Act 2015 and transferred into and out of hospital to prison. It is therefore important that arrangements are in place to avoid duplication or overlap of investigations, and to be mindful of the impact on families and other individuals involved.

*More information on the National Hub is available here: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/deaths_of_children_reviews.aspx

**More information on the Independent Review of the Response to Deaths in Prison Custody is available here: https://www.prisonsinspectoratescotland.gov.uk/publications/independent-review-response-deaths-prison-custody

Q3. Q1b: How could such difficulties be addressed?

We would recommend that comprehensive engagement takes place with lead reviewers from Significant Case Reviews (SCRs), Significant Adverse Event Reviews (SAERs) and other methods of review/investigation that currently exist to ensure that subject matter expertise is effectively utilised. This could be achieved via an expert reference group, learning from existing best practice and consideration of the elements of what a 'good' review looks like as well as consideration of a human factors approach.

One example of good practice is the following guidance for Learning Reviews for Children and Young people; it will be useful to link the different national approaches together where possible: https://www.gov.scot/publications/national-guidance-child-protection-committees-undertaking-learning-reviews/documents/

It is important that all organisations involved in such reviews work together on information gathering to ensure processes can meet a range of requirements (e.g. around data sets) for a joined up approach and avoid unnecessary duplication of effort (e.g. deaths during compulsory treatment and those which may fall within the National Hub's criteria), and we would be keen to work with the Mental Welfare Commission on this.

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?

Yes.

Q9. Q3b: How could such difficulties be addressed?

Existing frameworks should be utilised as potential guiding principles. The expert reference group mentioned in the response to question 1b should be multi-disciplinary where existing processes for investigating deaths are reviewed, and these processes should make reference to each other (for example, as seen in the Adverse Events Framework). Furthermore, subject matter expertise in compulsory care and treatment under mental health legislation is required.

The National Hub has developed National Guidance* for reviewing the deaths of children and young people in Scotland. This guidance sets out the process NHS boards and local authorities should follow when responding to, and reviewing, the death of a child or young person. It would be helpful for the Commission's guidance and the National Hub's National Guidance to make reference to each other for any deaths occurring during compulsory care and treatment under mental health legislation in Scotland that fall within the National Hub's criteria and we would be keen to work with the Commission on this.

*The National Guidance is available here: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/deaths_of_children_reviews.aspx

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?

The revised process needs to take account of the impact that pressures arising from the Covid-19 pandemic has had and may continue to have on reviews and investigations. Any delays in an investigation or review should be clearly and concisely communicated to families, carers and staff involved in these reviews as soon as possible.

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

No Response

Q12. Q4b: How could such difficulties be addressed?

No Response

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?

Effective involvement of and sensitive, timely communication with families is imperative and a Commission Liaison Officer could assist with this. However, there can be overlap of liaison officers (for example, police liaison officers) if there are parallel processes following a death, which could be confusing for families and carers, if not effectively co-ordinated and managed.

Q15. Q5b: How could your concerns be addressed?

Clearly defined roles and responsibilities are required along with agreed structures of liaison between any involved agencies. Information sharing agreements between agencies should be confirmed at the earliest opportunity. Healthcare Improvement Scotland and NHS Education for Scotland are developing guidance following recent research to support patient and family engagement during Significant Adverse Event Reviews (SAERs) which may be of relevance here. Scottish Government's development of the Patient Safety Commissioner role will also be relevant.

The National Hub's National Guidance* for reviewing the deaths of children and young people in Scotland includes guidance on engaging with family and carers which could support this arrangement.

*The National Guidance is available here: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/deaths_of_children_reviews.aspx

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.

We agree that that all deaths during (and shortly following) compulsory care and treatment should be investigated. This ensures a consistent approach for families and carers and accounts for other parallel processes which are taking place. However, more clarity is required regarding increased timescales.

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.

These should be considered and mitigated by the planned Equality Impact Assessment.

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.

As mentioned earlier, Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, co-hosts the National Hub for Reviewing and Learning from the Deaths of Children and Young People, which was implemented on 1 October 2021. There is the potential that some deaths occurring during compulsory care and treatment under mental health legislation in Scotland will fall within the review criteria for the National Hub.

It is important that all organisations involved in such reviews work together on information gathering to ensure processes can meet a range of requirements (e.g. around data sets) for a joined up approach and avoiding unnecessary duplication of effort (e.g. deaths during compulsory treatment and those which may fall within the National Hub's criteria), and we would be keen to work with the Mental Welfare Commission on this.

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.

The European Convention on Human Rights is referenced which should ensure compliance. If an expert reference group is convened, expert advice should be obtained regarding this.

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?

Yes. From an NHS healthcare staffing perspective, it can be challenging to complete reviews within required timescales due to limited staff availability. This would also be a challenge for the proposed process for deaths in this category. Professional training is also a requirement for staff taking part in reviews, especially for the understanding of the significance of their contribution.

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?
It is positive to see that themes of openness, transparency and the importance of effective family/carer engagement are at the centre of this consultation. It is also relevant to highlight the use of expertise at stage 2 of the proposed new process to take into account specific factors (such as learning disability); this is sometimes lacking in existing review/investigation processes.

Respondent Information Form

Q27. Name of person submitting the response
Julia Simac

Q28. Email address of person submitting the response
julia.simac@nhs.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
Healthcare Improvement Scotland

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