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?

As noted within the consultation some areas have robust processes in place to achieve this. In our local board area the process for investigating unexpected deaths of people known to mental health services, regardless of legal status is well established, however we have two distinct processes via SAER (health) and ICR/SCR(local authority). We would keen to ensure that any new process initiated does not create further investigation process. We would also be keen that the quality of the investigation process is the same across all areas.

Q3. Q1b: How could such difficulties be addressed?

Preferably we would have one process for initiating, directing and quality assuring the process for investigating deaths across health/local authority including for those during compulsory treatment. Could the National Care Service provide potential to consider 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?

Potential issues in relation to dissemination of the annual reports ad ensuring key messages are not lost. Would need to consider issues of identifiability and confidentiality

Q6. Q2b: How could such difficulties be addressed?

Easy to read/summary support provided with key messages.

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?

As noted in response in Q1A

Q9. Q3b: How could such difficulties be addressed?

As noted in response in Q1B

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?

Would want to ensure a partnership response and involve local service in decision making on level of review.

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

The process relies on service being aware of service user death to report this to the MWC. For those recently removing legislation, and/or no longer open to services this may not be known at all, or in a timeous matter. Therefore requires consideration.

Re Stage 3 (37) How the commission identifies specific "individuals" to approve. Locally we have really robust processes to identify a chair for reviews and this can be challenging, due to a variety of factors. Would the commission appoint these individuals or would this be left to the local service to arrange from a list of approved individuals?

Q12. Q4b: How could such difficulties be addressed?

Would expect that with an unexpected death Police Scotland would be involved and therefore able to advise local services of unexpected deaths through our local notification process.
Would need to consider a similar robust reporting/notification process with partners inform service of "expected" deaths, other than potential reliance on primary care who may not always be aware of service contacts and therefore may fail to contact.

Develop local links and leads for identification of reviews.

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?

Current Terms of reference for all SAER in the local area promote a family contact as part of the local review team. They are responsible for linking in, meeting with and keeping families informed as described for the role of the Commission Liaison Officer. We need to ensure that there is no duplication of role at local level and that family not being contacted by more than one source. Would be keen to not lose the connection between the review team and the family that the family contact provides.

If the Commission Liaison Officer is overseeing many different reviews, will they have the detailed knowledge required to provide informed timeous updates to family.

Q15. Q5b: How could your concerns be addressed?

Setting clear boundaries around the role of the local family contact to ensure engagement at a local level balanced against Commission Liaison Officer role.

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 proposal provides independent overview, but given reviews will still be undertaken locally, it cannot be stated that they will fully be independent.

"deliver local accountability" is an assumption that services are not achieving on this principle and therefore while the revised process would deliver on this it may already being achieved.

Our local process has more ambitious timescales for completion. This could potentially deescalate our time scales and local governance.

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?

The process has been developed to investigate any death occurring during compulsory care and treatment. As this is applicable to all then there should be no adverse impacts on protected groups.

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

As the proposal sets out that it will be subject to an Equality Impact Assessment there is no further suggestions

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

The process has been developed to investigate any death occurring during compulsory care and treatment. As this is applicable to all then there should be no adverse impacts on children and young people.

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

As the proposal sets out that it will be subject to an Equality Impact Assessment there is no further suggestions.

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.

There is no information in the process that would suggest that investigating deaths in this way would infringe on the human rights of families and carers. Everyone involved in the application of this process nationally and locally should receive training and support to ensure compliance with this approach. There should be regular review and engagement with families and carers to provide assurance that a human rights-based approach has taken place.

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?

The local requirement to undertake these reviews will have minimal impact on current resources as it is unlikely to increase the activity around SAER already taking place (the majority of these death already investigated through SAER). However as noted in the consultation there is a lack of dedicated resource available for dedicated administration/minute taking and this is usually absorbed by existing service allocation.

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

Allocation of funding by the MWC to local services for dedicated reviewer capacity as well as associated administration needs.

Section 4: Other matters for consideration

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

Respondent Information Form

Q27. Name of person submitting the response
NHS Ayrshire and Arran

Q28. Email address of person submitting the response
aa-uhb.ceo@aapct.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
NHS Ayrshire and Arran

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