Clackmannanshire & Stirling
Health & Social Care
Partnership

Purpose of the response

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

This proposal is put forward by the Mental Welfare Commission for Scotland (the Commission). It has been developed in response to an action arising from a Scottish Government Review (published in 2018) of the arrangements for investigating the deaths of people being treated for a mental disorder. The proposal relates to all people who have died whilst on a compulsory treatment order in the community or in hospital, or who were compulsorily detained on other orders in hospital for assessment and treatment, including those whose detention in hospital was suspended at the time of their death. For ease of reference, these deaths are referred to in the paper as 'deaths during compulsory treatment'. The new system proposal does not cover people who were admitted to hospital or treated in the community on a voluntary basis

The report of the Review was published in 2018. Its main finding was that the deaths of people being treated for a mental health condition or learning disability are currently not being investigated consistently in a way that can be guaranteed to be independent

Question 1: 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?

- CSHSCP welcome a consistent, independent review of all people who die whilst on a Compulsory Treatment Order.

Question 1a: Do you foresee any difficulties with this arrangement?

- CSHSCP do not foresee any difficulties with this proposal in principal however it maybe suggested local knowledge of process / procedure and systems would be a disadvantage to inform the review process.

Question 1b: How could such difficulties be addressed?

- To invite a local staff member on to the review team meanwhile ensuring their clarity of their role as a review team member.

Question 2: 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 above?

- Yes – CSHSCP would welcome this proposal, this report is one way of ensuring learning is shared nationally and themes identified to service delivery, people's outcomes and strive to

- Improve family and carers experience of being involved in such processes and ensure robust continually audit and review processes are in place.

Question 2a: Do you foresee any difficulties with this arrangement?

- CSHSCP do not foresee any difficulties

Question 2b: How could such difficulties be addressed?

Question 3: Do you agree that the Commission should develop guidance and standards for use by local services when undertaking investigations into deaths during compulsory treatment?

- CSHSCP agree that the commission should develop guidance and standards in collaboration with service users, family, carers and partners.

Question 3a: Do you foresee any difficulties with this arrangement?

- Nil to highlight

Question 3b: How could such difficulties be addressed

- Nil to highlight

Question 4: Do you have any comments on the revised process as set out above?

- CSHSCP would welcome recommendations set out by the MWC and a clear esculation process to SG

Question 4a: Do you foresee any difficulties with this process?

- Nil to note

Question 4b: How could such difficulties be addressed?

- Nil to note

Question 5: Do you think that the role of Commission Liaison Officer, as set out above, will help to improve the involvement of, and communication with, families and carers during investigations of deaths?

- CSHSCP are truly committed to the involvement with families, carers and partners during the review process and beyond to shape, mould and improve service delivery.

Question 5a: Do you have any concerns about this type of arrangement?

- Nil to note

Question 5b: How could your concerns be addressed

- Nil to note

Question 6: Do you agree that the revised process, described in Section 2, will meet the values and principles set out in paragraph 50 above?

- Yes - CSHSCP believe that when these values, principles and standards are set and agreed these will offer the opportunity of national benchmarking whilst ensuring high standards are met with a continually adopting a continuous improvement cycle with robust underpinning values and principles.

Question 6a: Please explain your answer

- As above

Question 7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics?

- CSHSCP are of the understanding that with all appropriate EQIA in place this offers the protections described.

Question 7a: Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

- As above and taking into account any unintentional impact

Question 8: Do you have any comments on the potential impacts of the revised process on children and young people?

- Nil to note as above

Question 8a: Please explain what you think could be done to minimise any negative impacts on children and young people.

- Nil to note as above

Question 9: Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant?

- CSHSCP agree the new proposed process would be compliant as outline in the paper

Question 9a: Please explain what you think could be done to ensure that the new process fully complies with human rights standards

- As the MWC have been guided by the PANEL principles this has and will continue to ensure the new process will be fully compliant

Question 10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services?

- The development of a family liaison officer would be a welcomed introduction and ensure families and carers are truly involved in the process.
- There will likely be an short term impact upon administrative time whilst embedding this new process and system however despite this short term impact the long term impact would be a positive one ensuring all reviews:

- Take account of any investigation carried out by other agencies
- Reflect the powers of the Commission
- Include appropriate elements of public scrutiny
- Involve families, carers and staff
- Have clear timescales for investigation, reporting and publication

Question 10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.

- Consideration of a national review team charter that all boards sign up too and provide support to the national review team.

08th February 2022

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