COLLECTIVE RESPONSE to the CONSULTATION by the MENTAL WELFARE COMMISSION
on its Proposals for New System for Investigating Deaths of Patients who were subject to compulsory powers under the Mental Health Act 2003

This collective response summarises views of current/former service users and family carers who are affiliates of Psychiatric/Mental Health Rights Scotland (P/MHRS) or of the Tayside Mental Health Services Review Stakeholder Participation Group (TSPG).

The majority of the views were gathered at a discussion held on 10 February 2022.

Contributors (identified in order to avoid duplication with any individual responses) :

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(* separate responses know to have been submitted)

This response may be published.

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?

 (Emphatically) No!!!

The Commission is not trusted by service users and their families. It does not investigate their complaints about services. It does not intervene to protect patients. While it may investigate concerns it is not transparent about its reasons for not acting on them.

It has made little or no use of its statutory powers for safeguarding individuals.

It does not have a track record of uncovering the ugly truth, getting to the root of the problem, holding services to account and "challenging" them to adhere to professional best practice and human rights standards – including the guidance which it publishes.

Its visiting and monitoring investigations have failed to recognise deficiencies which subsequent inquiries by others have exposed; it has not learnt from that failure. (Compare Visiting Report to Carseview IPCU by Alison Thomson dated 27 January 2019 with David Strang's Report on Tayside MH Services dated 5 February 2020.)

It is too "cosy" with the services which it regulates and is viewed as shielding them from criticism. Possibly because its Executive Officers are health and care professionals. Their professional loyalty appears to be the cause of institutional bias.

It has a **conflict of interest** in regard to the investigation of deaths. It has a statutory duty to protect the health and welfare of living patients who are subject to the provisions of the Mental Health Act, and to monitor the use of compulsory measures. It cannot therefore be impartial in the investigation of deaths in which it might itself be implicated by having failed to investigate, expose and challenge deficiencies in service which might have contributed to those deaths – especially where concerns

had been raised with the Commission by staff or by relatives of the patient.

It appears to be **oblivious** of the glaring conflict of interest in its proposal that local services should continue to investigate the deaths of patients in their care. Such investigations will not be independent. This **lack of insight** by a supervisory body is concerning.

The Commission is definitely NOT suitable for this supervisory role.

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? Do you foresee any difficulties with this arrangement? How could such difficulties be addressed?

 Not sure

The Commission excels at publishing readable reports and distilling lessons from the cases it has reviewed. However:

(i) its reports do not expose the failings of the services which it regulates beyond those they have already acknowledged, and do not hold anyone to account;

(ii) an Annual Report alone will not provide sufficient detail to enable adequate public scrutiny of the operation of the system of investigations.

Each investigation report should be published in full in a form which protects the privacy of the families involved, unless they waive that right.

Recommendations should not be limited to those which the service has agreed with.

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? Do you foresee any difficulties with this arrangement? How could such difficulties be addressed?

 Not sure

The Commission's strength lies in the publication of readable, good quality guidance on human rights and professional best practice in mental health, and of detailed statistical monitoring reports. It could be relied upon to produce appropriate guidance and standards for the investigation of deaths.

However its experience is limited to monitoring visits and the review of local investigations. It does not appear to have any experience of initiating and carrying out critical investigations to expose hidden facts and to hold services to account. This aspect of the guidance could be provided by the Police or COPFS which do have such expertise.

The human rights and values aspect of guidance could be provided by the Scottish Human Rights Commission, which does not have the conflicts of interest possessed by the MWC. SHRC co-chaired the Review of the Response to Deaths in Prison Custody which reported in November 2021.

The same guidance and standards should apply uniformly to the investigation of deaths in state custody in all settings (police, prison, hospital, community).

Question 4: Do you have any comments on the revised process as set out above? Do you foresee any difficulties with this process? How could such difficulties be addressed?

1. It is a **glaring and unacceptable conflict of interest** for services to be entrusted with the investigation of deaths in their own care, even subject to guidance and review. Especially where the reviewing body has a professional bias and its own conflict of interest. Such investigations cannot be trusted to be independent.

2. It is difficult to judge the proposals because **insufficient detail** has been given to explain how the new system will operate. eg Will the Commission direct only those investigations by NHS Boards and Local Authorities? Or also those by the Health & Safety Executive and the COPFS? Will it decide whether an autopsy is to be made? How exactly will it assess the reliability of 'local' investigations if the only thing it sees is a report? Will it conduct an 'audit' of that report?

3. The proposal is fundamentally flawed. A radical re-think is required.

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? Do you have any concerns about this type of arrangement? How could your concerns be addressed?

 Partly/Not sure.

The role will be an **improvement**. A Family Liaison Officer is necessary as a 'single official point of contact' to enable the family to obtain information about the investigation and to have their questions and concerns addressed.

However :

(i) an employee of the Commission will not have sufficient independence to provide impartial advice and advocacy for the family because of the Commission's institutional bias and conflict of interest (see answer to Q1);

(ii) we are concerned that the role might create a barrier between the family and the investigation team, instead of enabling the family to participate, as much as they want to, in the planning and direction of the investigation;

(iii) families might also need **independent expert legal advice and advocacy** which could be provided more appropriately by an agency such as INQUEST in England & Wales – the provision of such assistance ought to be an integral part of the system;

(iv) service users and carers have not had any meaningful involvement in the development of these proposals by the Commission – this suggests that they are not likely to have any meaningful involvement in the investigations which the Commission will supervise under these proposals.

The Family Liaison Officer should be wholly independent of any organisation which has a statutory

duty under the Mental Health Act.

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

Partly/Not much.

The revised process of investigation will not be **independent** since those who are potentially culpable will be carrying out the investigation. Because of this it is difficult to see how **'local accountability'** (whatever that means) and **openness, honesty and transparency** could be guaranteed.

Meaningful involvement of families and carers is possible but not anticipated because of their lack of meaningful involvement in the development of these proposals and the lack of effort to engage with them.

Investigations will be **informed** by standards and guidance. But we doubt that the Commission will **ensure** that such standards are implemented in spirit and not merely as a 'box ticking' exercise.

The Commission's reports are invariably **clear and accessible**. However based on its past performance in failing to chase up missing details of deaths, and the 3 years it has taken to produce this incomplete and unsatisfactory proposal, we have no confidence that the investigation reports will be **timely**.

Question 7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics? Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.

No answer.

Question 8: Do you have any comments on the potential impacts of the revised process on children and young people? Please explain what you think could be done to minimise any negative impacts on children and young people.

No answer.

Question 9: Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant? Please explain what you think could be done to ensure that the new process fully complies with human rights standards.

Definitely Not.

The process does not meet the requirements of Article 2 ECHR. Investigations **will not be independent** of the local services which provided care and treatment. Therefore it cannot be guaranteed that a full explanation for the cause of death will be uncovered and that local services will be held accountable. Investigations will be not be open to public scrutiny – a brief summary in the Annual Report is not adequate for this.

Without independent legal advice it is not likely that bereaved families will be able to participate meaningfully in the investigation.

The Commission appears to be solely concerned with distilling **lessons**. Whereas what is important to bereaved families is **accountability** – ie full disclosure of the circumstances of death, an acknowledgement of responsibility or culpability where appropriate (not simply an expression of sympathy), and for culpable individuals and corporations to be disciplined or prosecuted. To them, the actual **implementation of specific recommendations** is required, not merely the identification of system-wide lessons and possible improvements.

If a system of investigations is fundamentally non-compliant with human rights it cannot be made compliant simply by "taking a Human Rights Based Approach" when carrying it out, like using a sticking plaster over a mortal wound.

Question 10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services? Please explain what you think could be done to minimise any negative financial or administrative impacts.

These proposals appear make no change to the fragmented nature of investigations of deaths in state custody, across the various settings (community, hospital, police, prison) and between different agencies (MWC, COPFS, Police, NHS Boards, Local Authorities/COSLA, HSE, Sheriff Court, SPS, HMIPS).

There could be considerable cost savings and administrative streamlining if the same system of investigation was applied across all settings, using common standards, all supervised and co-ordinated by a single independent body established for this purpose.

Question 11: Do you have any other comments or concerns in relation to the revised process?

1. The responsibility for investigation of all deaths in state custody should be in the hands of a body which is **wholly independent, both institutionally and professionally**, of the services under investigation. It should have judicial powers (and willingness to use them) to enforce change and hold individuals and organisations to account. That body should itself be under the critical supervision of an equal number of professionals and service users/carers – at least half of whom should have experience of a death in state custody.

2. What is the rationale for the restriction of investigations to those who were formal patients under the Mental Health Act? The following are in a similar position but not included:

(i) Many **informal patients** are detained *de facto*. They have agreed to be treated on a voluntary basis under the threat of being sectioned if they refuse or try to leave hospital. It is incongruous and unacceptable that the deaths of such patients should not be subject to the same level of scrutiny.

(ii) People who have applied for treatment of a mental disorder and have been assessed but turned away without treatment, and have died (often by suicide) within a few days.

(iii) People who have died while subject to the **guardianship** of the Chief Social Work Officer under the Adults with Incapacity Act 2000, or while **removed without consent** by the Local Authority to a 'place of safety' under the Adult Support & Protection Act 2007 or to a care or nursing home under s 13za of the Social Work (Scotland) Act 1968.

Why should these deaths not be investigated likewise?

Some of the above may fall under the criteria for a Fatal Accident Inquiry. However there is no guarantee of a proportionate investigation, and unlike the Commission the Sheriff has no powers to ensure that his recommendations from a FAI are implemented.

3. The cause of death on the **death certificate** should not be conclusive, because doctors are able to attribute a cause of death without any examination. The circumstances preceding death should always be reviewed. Even natural causes can be preventable.

4. The possibility should be considered that medication, or lack of provision of physical activity during a long detention, was a contributing factor – particularly in the elderly.

5. Everyone who dies should have the equivalent of a 'next of kin' to raise concerns and ensure that they are addressed. If there is no relative to fulfil this role, a close friend could act instead. As a last resort an independent lawyer with appropriate training (eg someone from INQUEST) could be appointed to take on the role at State expense.

6. Medical records should be open to inspection by the 'next of kin.'

7. Non-means-tested legal aid should be available to the 'next of kin' for legal advice and representation during investigations/inquiries.

8. The MWC and COPFS need to take seriously the offences of **ill-treatment** during state detention (s 315) and **giving false evidence** (s 318). Where criminal prosecution might have little prospect of success because of lack of corroborating evidence, the possibility of professional disciplinary procedures should be considered instead. Greater protection of the living is likely to result in fewer deaths.

9. Serious consideration should be given to setting up in Scotland a charity similar to INQUEST.

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Barry Gale, 15 February 2022