



Law Society  
of Scotland

# Consultation Response

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

February 2022



## Introduction

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The Law Society of Scotland is the professional body for over 12,000 Scottish solicitors.

We are a regulator that sets and enforces standards for the solicitor profession which helps people in need and supports business in Scotland, the UK and overseas. We support solicitors and drive change to ensure Scotland has a strong, successful and diverse legal profession. We represent our members and wider society when speaking out on human rights and the rule of law. We also seek to influence changes to legislation and the operation of our justice system as part of our work towards a fairer and more just society.

Our Mental Health and Disability sub-committee welcomes the opportunity to consider and respond to the Mental Welfare Commission (“MWC”) consultation: *Investigating deaths occurring during compulsory care and treatment under mental health legislation in Scotland*.<sup>1</sup> The sub-committee has the following comments to put forward for consideration.

## Consultation Questions

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**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?**

Yes  No  Not sure

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

**o Question 1b: How could such difficulties be addressed?**

Yes.

It is important that there is a consistent and coherent investigation system, and the Commission is well placed to ensure this, given its existing responsibilities to monitor the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”), its powers of investigation, and its expertise.

One potential issue is whether additional statutory powers are necessary. It would be important that all agencies co-operate fully with the Commission and are required to follow their guidance, produce information needed by the Commission or anyone conducting an investigation under their oversight, and ensure staff co-operate. We have not analysed the powers in Part 2 of the 2003 Act to determine if they are adequate, but this will need careful consideration.

<sup>1</sup> <https://www.mwscot.org.uk/news/new-consultation-investigating-deaths-during-compulsory-care-and-treatment-under-mental-health>

Another potential difficulty is the relationship with the general responsibility of the Crown Office and Procurator Fiscal service (COPFS) for the investigation of deaths, and the Lord Advocate's power to initiate a Fatal Accident Inquiry (FAI). Deaths during compulsory treatment may currently be subject to a discretionary FAI under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 and it is recognised that there may be circumstances where an FAI, which is held before an independent judicial body and at which interested parties can appear and be represented, is the most appropriate mechanism for investigation. It would however be important that there is no delay to any investigation under the MWC process pending a determination by the Crown as to whether an FAI should be held. It would also be important to avoid families and staff being subject to two distinct investigatory processes.

Similar issues may arise regarding investigations by the Health and Safety Executive (HSE) into breaches of Health and Safety legislation.

It may be possible to address these by a protocol between the MWC, COPFS and the HSE. This protocol should be informed by the same human rights principles as inform the Commission process.

Whilst outwith the scope of this consultation, we also believe that there are strong arguments for a mandatory judicial process for the investigation for deaths during compulsory treatment. This should be kept under review, and any future proposals should be informed by evaluation of the MWC scheme in due course.

**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  No  Not sure

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

**o Question 2b: How could such difficulties be addressed?**

Yes.

An annual report could be a valuable source of learning for services, pulling together common issues from different investigations, as well as important findings from individual reviews.

We are not clear from the consultation whether the outcomes of individual investigations will be routinely made public. We believe there should be a presumption in favour of publication. The EHRC framework on an effective investigation<sup>2</sup> specifies that the investigation and its results should be open to public scrutiny. The arrangements for publication of Significant Adverse Event Reviews (SAERs) are inconsistent across the country, with most SAERs being unpublished or hard to find. We appreciate that some aspects of an investigation may not be made public to avoid causing further distress to families, and that it may not be

<sup>2</sup> <https://www.equalityhumanrights.com/en/inquiries-and-investigations/preventing-deaths-detention-adults-mental-health-conditions-0>

appropriate to publish 'low level' reviews of, for example, predictable natural deaths. But where the investigation is more significant (e.g. where an independent chair has been appointed), some form of publication of findings should be the norm.

**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?**

Yes  No  Not sure

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

**o Question 3b: How could such difficulties be addressed?**

Yes.

See our response to Question 1 regarding the possible need for further statutory powers for the Commission, and an obligation on other bodies to have due regard to any Commission guidance.

Para 37 refers to SAERs. It is not immediately clear how far these reviews will follow existing SAER guidance. Consistency with normal SAER processes would be desirable, provided this does not undermine the purpose and human rights framework of the MWC process.

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

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

**o Question 4b: How could such difficulties be addressed?**

We generally support the outline process, but a number of details need to be filled in.

At para 39, we note the point made regarding postponing the investigation pending any criminal investigation or significant case review. On criminal investigations, see our earlier point (Question 1) regarding HSE criminal investigations and the need for a protocol to avoid delay and duplication of effort. We are not clear why the investigation should be postponed pending a significant case review. The investigation should *be* the significant case review.

We would like to see greater clarity regarding the criteria for determining what level of investigation should be conducted. As a general rule, we suggest that any death by suicide or accident should have a detailed review with an independent chair. At the other extreme, 'natural' and expected deaths would normally be subject to a more low-level investigation, with some discretion for sudden and unexpected deaths due to physical health conditions. However, even for natural deaths, consideration should be given to whether

physical health conditions may have been caused or exacerbated by medication, or deficiencies in health care.

We note the suggestion at para 38 that the Commission would undertake its own investigation 'exceptionally'. We accept that it would be disproportionate for the Commission to investigate every death itself, but we feel it may need to be more often than "exceptionally", and that criteria should be developed to identify some of the cases which may warrant a Commission investigation. These might include, for example, deaths involving restraint, victims of homicide, or where the known circumstances give rise to a substantial concern of a significant failure by the local service.

In the most serious cases, we suggest consideration should be given to using the Commission's powers under section 12 of the 2003 Act to initiate a formal Inquiry – either instead of or following the investigation. This might be an alternative to an FAI which would still ensure that there is public accountability where serious failings may have contributed to a death.

In relation to the matters to be reviewed, while it is important that any possible action which might have prevented a death is fully investigated, it may also be important to review the question of "quality of death": whether there was avoidable emotional discomfort for the person or for those reasonably needing to be appropriately and sensitively involved both before death and into the grieving process after death, linked to the appropriate handling of all practicalities.

**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?**

Yes  No  Not sure

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

**o Question 5b: How could your concerns be addressed?**

Yes.

We support the creation of a Liaison Officer, as outlined. There may also need to be communication and support *after* investigations, and there should be post-event assessment of how effective liaison was, and what improvements may be needed in future. Consideration could be given to developing a Charter or similar document to support the involvement of, and communication with, families and carers, similar to the Family Liaison Charter<sup>3</sup> prepared by the Lord Advocate under section 8 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

We believe it is important that families do not just have a point of contact, but are actively supported. Without this, many will struggle to engage effectively with the process, or to know what questions they should be asking.

In some situations this may include legal support, but they will also need emotional and practical support from people with relevant skills and expertise. The service offered by INQUEST to families affected by state deaths in England offers a possible model, although it would need to be adapted to this context. We also believe a body such as this could help to ensure the system of investigation remains effective and relevant.

**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?**

Yes  No  Not sure

**o Question 6a: Please explain your answer.**

Yes.

If the additional points we raise in this response are addressed, we believe the process can meet these values and principles. The most important issue which we believe requires further work is to ensure an appropriate level of independence – as discussed in the response to Question 4.

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

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

The overall obligation to take account of protected characteristics, and to accommodate them and respond to them appropriately, continues right through to death and beyond it in terms of both support to the bereaved and review of the process, whatever the procedures might be.

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

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

The paper does not discuss how the new process will align with the new system for investigating all child deaths.<sup>4</sup>

It is vital that we do not perpetuate a confused system of multiple and conflicting investigation processes. The aim should be one, fit for purpose, investigation in each case.

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

Yes  No  Not sure

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

Not Sure.

In addition to the PANEL principles, we would have liked to see specific reference to the Human Rights Framework for Adults in Detention set out by the Equality and Human Rights Commission in 2015,<sup>5</sup> and a detailed analysis of how the proposals fulfil the checklist set out under the State's Obligation to Investigate. We would also suggest that the list of relevant issues under the State's Obligation to Protect in that framework could inform the development of methodology for Commission reviews.

There will need to be further review of the extent to which a human rights approach is met once the proposals are fully formulated.

We also suggest the Commission undertakes an analysis of the proposals against the caselaw and guidance set out in the Council of Europe's Guidance on Article 2, particularly Part IV on procedural obligations.<sup>6</sup>

<sup>4</sup> See National Hub for Reviewing and Learning from the Deaths of Children and Young People ([healthcareimprovementscotland.org](http://healthcareimprovementscotland.org))

<sup>5</sup> See <https://www.equalityhumanrights.com/en/preventing-deaths-detention-adults-mental-health-conditions> and <https://www.equalityhumanrights.com/en/publication-download/human-rights-framework-adults-detention>

<sup>6</sup> See Guide on Article 2 - Right to life ([coe.int](http://coe.int))

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

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

We have not undertaken any financial assessment but would suggest that the overall cost of these reviews is small, set against the budgets of the NHS and local authority services, and the cost of a streamlined and effective system is likely to be both cheaper and more efficient than one with confused responsibilities where lessons are not learned.

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

The Commission will of course be aware that Article 2 can be engaged for people who are not detained – including in situations where a failure to assess needs, offer help or even detain may have contributed to the death

We appreciate why these deaths have not been included in this consultation, but many of the same issues apply. We do not suggest delaying the welcome development of this process to address a wider group of deaths, but we hope further consideration will be given to how they can also be more effectively investigated in future.

**For further information, please contact:**

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