

Appendix 1:



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

List of consultation questions

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

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

Each local area already has a process for deciding and commissioning an appropriate level of review, and a quality assurance process. In addition, for completed suicides the Health and Safety Service are also notified to ensure the nature of the incident is considered with regard to the Health and Safety at Work Act 1974 and to support any investigations undertaken by the Health and Safety Executive. The proposed changes will potentially cause confusion for staff, patients and families, especially if a two tier system is introduced that is not in alignment with local policy.

Specifically:

- The proposal would create a different system for a very small subset of Serious Adverse Event Reviews (SAERs). This moves away from the drive from the National Adverse Events Framework to ensure that all reviews are carried out in the same way and to the same standard. From the consultation, it is not clear how this would sit within that framework.
- It also risks significant confusion at a local level. The proposal lacks clarity as to the implication for existing SAER and other policies.
- It risks creating a two tier system, resulting in inequality. For example, there is a risk that local services will have to prioritise investigations of deaths during compulsory treatment over deaths of patients who are not subject to compulsory treatment
- There could be occasions when there is disagreement between the Mental Welfare Commission (MWC) and the local service on the level of investigation required and its terms of reference. It is not clear how this would be resolved.
- The additional process proposed will add further time delays to a process that is already challenging to accommodate within acceptable timescales.

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- It is important from a governance and learning perspective that responsibility for SAERs remains with the Health Board. To move this responsibility to MWC will result in either a duplication of governance and quality assurance processes or create a system with a less clear governance structure.
- If a patient or family decided to challenge a report that had been commissioned by MWC, or if an independent expert deemed a MWC report inadequate, it is not clear how this would be managed.
- MWC does not have experience commissioning or quality assuring such reports, whereas in local Health Board structures there is considerable expertise in this regard.
- MWC does not have local knowledge to adequately ensure key issues are covered in the report or the right team is assembled- it is not clear how or if this will be delegated back to local Health Boards.

Question 1b: How could such difficulties be addressed?

It is not clear what problem or existing difficulties would be solved by carrying out this change. It would be helpful to have additional information on the background to this proposal.

To address the difficulties highlighted above, one suggestion would involve:

- Continuing with existing processes which are used for all SAERs in all clinical specialties.
- For patients who have died whilst in compulsory treatment, the SAER terms of reference could be drawn up locally first and then agreed with MWC.
- At the final stage of review, a draft report could be shared with MWC for external quality assurance.

MWC could also retain the ability in some cases to add one of their own staff to the investigation team if greater independent scrutiny was felt to be necessary. This would allow for independent input to reports without the need to duplicate existing structures and create new clinical governance arrangements.

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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

However this would depend on recognition of the issues raised in response to Question 1 above.

There could be benefits of an annual report summarising learning from across all areas and providing the opportunity for national themes to be identified, but this should not be at the cost of local annual reports and the identification of local learning themes. Indeed, such a report could already be collated from information supplied by Health Boards' clinical risk departments.

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

Healthcare Improvement Scotland (HIS) requests learning summaries from outcome 3 or 4 SAER reviews. In addition, National Confidential Inquiry reports cover all suicides/homicides in the UK. So the existence of these more comprehensive feedback mechanisms suggests there would be limited value of an additional reporting structure focussed on a subset of deaths fitting fairly specific criteria.

Question 2b: How could such difficulties be addressed?

See above.

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

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

Comprehensive standards for the completion of SAERs already exist within "Learning from Adverse Events through Reporting and Review- the National Framework for Scotland" (HIS 2018) and these should form the basis of each Health Board's SAER policy.

Additional guidance would lead to confusion for staff and inconsistency as there would then be two sets of guidance for different patient groups.

Question 3b: How could such difficulties be addressed?

By adopting the system suggested under Question 1, MWC could review reports using existing well-established standards.

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

A patient death is a traumatic event for all involved and it could be made even more anxiety provoking if the immediate review is undertaken by the MWC who then decide on the level of investigation required and the timescales– with the possibility that the review is then not as effective as it might have been in other circumstances.

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

Decision making is potentially being taken away from local teams for one group of patients, even though the Health Board is still responsible for and answerable to legal challenges regarding findings and actions.

There needs to be much more clarity about MWC's role if the local area agree an appropriate level of review and this differs from MWC's view. What would be the process for conflict resolution?

In terms of MWC assembling an investigation team, it is difficult to envisage how this could be achieved without going through local service management anyway, thus duplicating existing process.

The suggested timeframes are in fact longer than current standards (3 months to completion).

There is no definition of a 'reasonably straightforward' review within the proposal.

There is mention of an initial review, to decide on the nature of/need for the full review, which has the potential to be overly bureaucratic.

The process as described does not take into account the considerable experience and local knowledge that local services have about commissioning and quality assuring SAERs. With respect, MWC may not have sufficient expertise in commissioning SAERs- their own wider-ranging reviews are undertaken far less frequently. From their website, it would appear that MWC has published 22 reviews in the last decade; in contrast NHS GGC completed 118 SAERs in mental health alone in 2017-18.

At Stage 5, there is a proposal that a different report (separate to the one from the investigation) will be prepared by MWC to be shared with families and the service staff. It is not clear what this is intended to achieve, but it will potentially add delay to the process. It also suggests that the family and staff members involved in the original incident (and as written, service managers) will not receive the original report of the investigation, which will likely lead to concerns about transparency and FOI requests for the original report.

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Again this whole process is related to a specific set of circumstances, while all other SAERs will be dealt with in the normal way, creating confusion for families and staff.

Question 4b: How could such difficulties be addressed?

Using the process described under Question 1 will address a lot of these difficulties.

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

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

One concern is that this duplicates the Board's responsibility to liaise with families and keep them informed. We recognise that there is room for improvement with family and carer involvement—one of the challenges with this at present is the time it takes to do it well. While every effort is made to contact relatives, often they decline to be involved, or do not respond. It is unclear if MWC would have more success in engaging more relatives.

It would also be hard for the Commissioning Liaison Officer (CLO) to achieve genuine and meaningful engagement with families without significant resources. While in principle it may be a progressive step, it is difficult to see how one person could provide an elevated level of support to over 120 families/carers each year. The CLO would also need robust supervision given the type of work involved.

Fulfilling this role also depends on a detailed understanding of local services, policies and procedures in order to best address the concerns that family and carers may have. Again, it is hard to see how someone from MWC would be able to work with the family in this way as effectively as is envisaged in the proposal. And how does it leave a family feeling when the CLO is unable to answer many of the specific questions they may have?

Robust communication between the review team and the CLO would be required to avoid any confusion/sharing of incorrect or out of date information.

If local teams are also liaising with families, this could put additional stress on families and there is potential for mixed messages and miscommunication.

Question 5b: How could your concerns be addressed?

Rather than a specific CLO for each review, MWC could:

- Offer an advice service for families who wish it and talk them through review processes in general.
- Assess if additional support is needed first on a case by case basis, in discussion with families and the clinical team.

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

Question 6a: Please explain your answer.

We would argue that local areas already hold these values and principles.

We are concerned that the following principles in paragraph 50 will not in fact be met:

Independence: It is not clear where a relative would go if they were unhappy with the MWC investigation process.

Timely Reporting: It is not clear how the revised process will meet this principle as any reports that MWC produce will still depend on reports completed by the local service. As noted elsewhere, the revised process may actually add to the time taken for completion. Local services would also need additional resources.

Transparency: If the family receive a different report to the original investigation report, transparency will be questioned.

Local Accountability: The process creates disconnect with local standards and governance.

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

As noted above, there is a risk that the deaths of other patients, including those with protected characteristics, are given less priority for investigation or less time is devoted to those investigations because of the need to devote more time to deaths during compulsory treatment.

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

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

Comments above apply equally to this group.

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

Comments above apply equally to this group.

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

Yes No Not sure

However, there remains the concern about creating a separate/two tier system with an impact on equality as a result (see responses above). It is not clear how the rights of informal patients are being considered here.

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

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

Completing reviews within acceptable timeframes is already challenging for local services and the pandemic has added to this. The proposed process introduces new layers of bureaucracy, new posts and a requirement for MWC staff to develop new skills (potentially for minimal tangible benefit to investigate a subset of deaths). As such, significant additional clinical and administrative resources would be required to avoid further time being taken away from the provision of direct clinical care.

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

See previous answer.

Additional targeted resource for the current system could be used effectively instead.

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

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We agree that all deaths of individuals detained in hospital and/or subject to compulsory treatment should be reported to MWC. We recognise and support the general aim to improve quality and consistency across the system and the fundamental importance of the timely completion of quality reviews, effective shared learning and meaningful family involvement and feedback.

However, we are concerned that these specific proposals will not contribute significantly to achieving these goals and may instead add burden to existing systems- with the additional potential for duplication of effort and confusion around process and governance arrangements.

It would be helpful to have much more detailed information about the background to this proposal and whether other options have been considered. A key question is whether this approach will actually solve the core issue that is driving the desire for change- and if there is data to back this up.

An alternative improvement plan could see MWC being more involved in reviewing SAER recommendations and action plans and using its independent status to have ongoing dialogue with families about satisfaction with timeframes and level of communication with the investigating authority. Further benefits may come from working more closely with medical records and other administrative systems to ensure that reporting deaths to MWC is improved and that all areas are compliant with this.

In summary, the level of involvement from MWC that is being proposed is not seen to be helpful or proportionate and we do not support MWC assuming decision-making, commissioning and sign off of reviews.

If you are unable to respond online, please complete and return a Word version of the Respondent Information Form ([download the form here](#)). The form should be sent to [Dawn Griesbach](#), Griesbach & Associates together with a copy of your response in Word or PDF format. If you ask for your response not to be published, it will still be included in the analysis, but will not be available to be viewed publicly. Please be aware that the Mental Welfare Commission is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.