mental welfare commission for scotland

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?

SAMH welcomes the opportunity to respond to this consultation on proposals to investigate deaths occurring during compulsory care and treatment under mental health legislation in Scotland. The rights of people receiving compulsory care and treatment, and their families is a key concern for SAMH. People subject to compulsory treatment are often vulnerable and have significant restrictions on their liberty. The State, under domestic and international human rights law have a particular duty to protect their rights, including the right to life. Ensuring a robust, coordinated and proportionate review of all deaths during compulsory care has potential to simplify the existing arrangements which the 2018 Section 37 of the Mental Health Act 2015 review found to be inconsistent, at times lacking independence and confusing for families.[1] Critically a well-functioning system of investigation will allow learning to be gained and shared across the mental health sector to improve the quality of care and treatment and increase patient safety.

For context, SAMH has engaged in this issue for a number of years. Ahead of the Section 37 review SAMH provided evidence during the parliamentary scrutiny of petition PE1604 ("Inquests for all deaths by suicide in Scotland"[2]). While we were not persuaded that an inquest should take place in all cases of suicide or deaths during compulsory treatment, as many are a result of progressive and terminal illnesses such as dementia, we agreed that improvements in the review of deaths – both of people in receipt of compulsory treatment and those whose compulsory treatment had recently been suspended – was urgently required.[3] SAMH was represented in the membership group of the 'Review of the arrangements for investigating the deaths of patients being treated for mental disorder' (Section 37 Review). We endorse the recommendation of the review group. We warmly welcome the proposals in this consultation which aim to implement the recommendations of the Section 37 review. We particularly welcome that people who have died whilst receiving

[1] Scottish Government Review of the arrangements for investigating the deaths of patients being treated for mental disorder 2018

[2] Scottish Parliament PE01604: Inquests for all deaths by suicide in Scotland 2016

[3] Scottish Parliament SAMH Letter to the Public Petitions Committee PEO1604 October 2016

compulsory care in the community, as well as those whose compulsory care has been suspended are included in the scope of the proposals.

We agree with the proposed role of the Mental Welfare Commission as the body to initiate, direct and quality assure the process of investigating deaths during compulsory treatment. The Commission, while accountable to Scottish Ministers carries out its functions independently from both the Scottish Government and NHS. It is also best placed to direct and coordinate reviews due to its significant existing legal powers in regards to protecting the welfare of people receiving compulsory treatment. Including powers to investigate and hold inquiries where a person has been unlawfully or improperly detained or may be, or have been, subject to ill-treatment or other deficiency in care or treatment.

In regards to potential difficulties, the enhanced role of the Commission will require adequate funding and staffing to ensure it can carry out its enhanced role in a timely and acceptable manner.

The proposed review process includes directing a range of local investigative processes (e.g. a local service led review; a Significant Adverse Event Review (SAER) etc.), with different time scales for review depending on the circumstances of the death. This could lead to confusion amongst relevant agencies and importantly families of the deceased. Clear guidance for both local services and families will need to be produced, with families supported throughout the various review options.

Question 1b: How could such difficulties be addressed?

Adequate funding of the Commission in line with enhanced responsibilities. Rigorous financial modelling, based on past data on trends of deaths of people in receipt of compulsory treatment will be required to determine anticipated workload.

As set out above, due to the various options for review depending on the circumstances of the death, rigorous guidance and ongoing support for families and relevant services will need to be produced.

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

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

SAMH strongly supports the proposal for the Commission to report annually on the results of investigations. This will significantly increase opportunities for learning from deaths to be shared and implemented across the mental health service sector compared to current more adhoc information sharing arrangements. Consistent reporting and data collection also has potential to quickly identify any trends or emerging issues in regards to deaths and by extension patient safety. This, alongside the Commissions enforcement and escalation powers in regards to recommendations following reviews of deaths will allow informed and rapid responses to be to concerns about patient safety.

One of the key issues highlighted by the Section 37 review was the incompleteness of existing data on deaths of people subject to compulsory treatment. The review found that not all deaths were being investigated, especially in cases where deaths were not recorded as 'unavoidable' or 'unexpected'.[4] It is critical that these proposed arrangements ensure that every death of someone in receipt of compulsory treatment is proportionately investigated. Improvement to the notification arrangements from health boards and other relevant bodies to the Mental Welfare Commission will be required to ensure the commission is made aware of all deaths irrespective of circumstances around the death.

Question 2b: How could such difficulties be addressed?

We note and welcome in the consultation document that the Commission is currently engaged with partners in work to improve the notification process of deaths, with the creation of a new Notification of Death Form (ND1).[5] The adherence to the updated notification process will need to be closely monitored to ensure compliance. In particular, the full involvement/notification of the family of the deceased in the new notification process should be monitored. This is to ensure family members are provided timely information about the notification of death and proposed review in a supportive manner, with the opportunity to be fully involved in the review process.

In regards to annual reporting of the results of investigations, the Commission should ensure this contains demographic information. Including, but not restricted to ethnicity, age and other protected characteristics. Reporting and analysis of demographics will facilitate timely identification of any demographic trends and inform subsequent recommendations and actions to address this.

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?

SAMH welcomes the proposal to develop guidance and standards for use by local services when undertaking a review. Third sector service providers involved in supporting people in receipt of compulsory treatment should be fully included in the development of the guidance. Importantly we believe families who have previously been bereaved should also be consulted in the development of the guidance and standards to ensure concerns, such as the inconsistency of opportunity for family involvement highlighted in findings from the 2018 review, are addressed.

We welcome in the Commission's proposals that a key area for the guidance will be advising on 'maximising independence in the local investigative process'. To ensure human rights compliance (Article 2 of the European Convention on Human Rights, Human Rights Act 1998) it is critical that local investigations are independent of the people and institutions implicated by the events under investigation. Local independence was highlighted in the 2018 review as

[4] Scottish Government Review of the arrangements for investigating the deaths of patients being treated for mental disorder 2018
[5] MWC Notification of Death Form (ND1)

a key challenge for NHS Boards undertaking Adverse Event Reviews – this was a key concern for family members and carers of the deceased.[6]

We recognise that at a local level ensuring complete independence (for example from the NHS board as a whole when undertaking an Adverse Event Review) may be challenging, but all efforts should be taken to ensure any local review process is objective. We believe that the proposed role of the Commission in stage 4 and stage 5 of the new review process – i.e. to ensure local compliance with a local review's terms of reference and assess progress of subsequent local recommendations – will act to increase objectivity and independence. Monitoring and reporting of independence of local reviews should be a key aspect of the Commission's focus as the new process is implemented. This should include gathering family and carer experiences and views in regards to perceived objectivity and independence of local reviews.

Question 3b: How could such difficulties be addressed?

See answer to 3a.

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

SAMH welcomes the revised process. In particular, we welcome the inclusion of clear timescales for the undertaking of the various forms of local review. The inconsistency in timeliness of local investigations was highlighted as a key concern in the 2018 Scottish Government review, and a cause for instances of not involving families and cares in local investigations. We are clear that family members and carers of the deceased should always be included in the review process (where they want to be involved) and the need to adhere to a timely process should never be used to limit or exclude family involvement.

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

The 2018 review highlighted staff capacity and competing demands resulted in lengthy investigations (including up to two years).[7] It will be important that local workplace planning fully takes into account expected demands arising from involvement in local investigations, with staff resourced to fully take part.

As the proposed processes involves a variety of local reviews and escalating steps (depending on circumstances of the death and findings from the initial local investigation) it will be essential that families and carers are kept fully informed about, what may be a complex process, at all times. All opportunities for family involvement should be maximised, with this viewed as a joint responsibility for the Commission and local investigation bodies (for example Health Board)

Question 4b: How could such difficulties be addressed?
See answer to 4a

[6] Scottish Government Review of the arrangements for investigating the deaths of patients being treated for mental disorder 2018
[7] Scottish Government Review of the arrangements for investigating the deaths of patients being treated for mental disorder 2018

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?

We strongly support the creation of a Commission Liaison Officer role. As the 2018 review found communication with families and carers was too often inconsistent and confusing, with families needing to engage with a variety of local agencies and service providers. The Commission Liaison Officer will hopefully ensure that families have a single point of contact during (and following) an investigation. We are hopeful that this will minimise distress for families during a very difficult period.

Question 5b: How could your concerns be addressed?

NA

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 are satisfied that the proposals set out will maximise family and carer involvement and represent a significant improvement to the current confusing and at times distressing process of investigating deaths under compulsory care and treatment.

We also welcome the emphasis on independence and local accountability in values and principles set out in paragraph 50 of the consultation. As set out in answer 3 we note the challenges in ensuring local independence, but believe the enhanced role of the Commission in verifying the terms and reference and actions of local reviews, alongside the power to intervene and approve the chairs overseeing investigations, will act to maximise independence.

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

As set out above SAMH believe rigorous data monitoring and publications including by demography and protected characteristics should be a priority for monitoring the impact of the revised process. This is to allow any trends related to demography to be rapidly identified and importantly, addressed – both locally and by the Commission.

We note that the Commission's 2021 report - Racial Inequality and Mental Health in Scotland: A call for action – found unacceptable differences in application of the mental health act by ethnicity.[8] We endorse the recommendations of the Commission's report. It is essential that any differential treatment by ethnicity in regards to investigations of deaths is quickly identified and mitigated against. We believe early engagement with people with experience of protected

[8] MWC Racial Inequality and Mental Health in Scotland 2021

characteristics and their families is undertaken by the Commission while the new process is implemented to ensure it is operating (locally and nationally) in an equitable manner.

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

See answer to question 7.

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

Children may be impacted by the investigative process in a number of ways. For example, the child may be the deceased person themselves or may be a family member of the deceased. The death of a child is an extremely traumatic event for family members and others involved in the child's life. All sensitivity must be taken when undertaking an investigation with appropriate bereavement and mental health support provided to family members.

Where the child is a family member of the deceased (for example the person who died may be their parent or sibling) the wellbeing of the child must be a priority. Children and young people in these cases may have important information to support the investigation process. They must be fully supported when engaging in an investigation, including through access to appropriate advocacy, bereavement and mental health support. The role of the Commission Liaison Officer will be key in this regard.

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

See answer to question 8

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

☒ Yes ☐ No ☐ Not sure

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

See previous answers, particularly on maximising local independence and family/carer involvement.

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

To ensure timely local reviews and to maximise independence local workplace planning must include demands arising from the revised investigative process. Ongoing monitoring of the revised process should include early focus on workforce demand and resourcing for staff (statutory and third sector) engagement with the investigative process.

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

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

No.

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.