SHRC
Scottish
Human Rights
Commission

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

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Introduction and response to questions

The Scottish Human Rights Commission ("the Commission") welcomes proposals to address the absence of an adequate system of investigations in mental health detention. We have repeatedly highlighted the discrepancy between the level of investigation which occurs in relation to deaths in police or prison custody as compared to mental health detention, as both must satisfy the state's obligation to investigate deaths in order to protect the right to life in terms of Article 2 of the European Convention on Human Rights (ECHR). We have made previous submissions on proposals for including deaths in mental health detention in the category of mandatory FAIs[1]. In particular, we have highlighted the absence of certain requirements of Article 2 in the current system of investigations, most evidently, independence, public scrutiny and involvement of the next of kin. We are pleased that the Mental Welfare Commission ("MWC") has undertaken the work to consider proposals for a new system of investigation. We believe there is significant potential in a role for the Mental Welfare Commission in addressing the gaps in Article 2 protection, however, there are a number of areas which require to be clarified in order to achieve compliance.

The Commission has carried out extensive work examining the adequacy of arrangements for investigation of deaths in the prison context as co-Chair, together with Families Outside and the Chief Inspector of Her Majesty's Prisons in Scotland, of the Independent Review of the Response to Deaths in Prison Custody ("the Deaths in Custody Review"), which reported in November 2021.[2] The review took a human rights based approach, involving extensive engagement with families bereaved through a death in prison custody, and was underpinned by human rights obligations. All of the review's recommendations have been accepted in principle by the Scottish Government. The report identifies a series of recommendations aimed at helping fulfil the procedural requirements of Article 2. As the obligations arising under Article 2 call for the same level of robust investigation in the case of deaths in mental health detention, we believe the findings of that report should be applied in so far as possible to the proposals, allowing for differences in institutional arrangements and other

particularities of context. The Key Recommendations of the report are annexed at the end of this submission. Throughout the submission, we have identified particular areas where they should be taken into account.

Human rights framework

Article 2 ECHR provides that "*Everyone's right to life shall be protected by law*". This includes positive obligations to protect individuals from real threat to life. These positive obligations include a procedural element which requires effective investigation of deaths to ensure the protection of life.

The procedural obligation has particular weight in circumstances where there is potential for State responsibility for the death. The European Court of Human Rights (the ECtHR) has found that:

> *"Where lives have been lost in circumstances potentially engaging the responsibility of the State, Article 2 entails a duty for the State to ensure, by all means at its disposal, an adequate response – judicial or otherwise – so that the legislative and administrative framework set up to protect the right to life is properly implemented and any breaches of that right are repressed and punished"*.[3]

The essential purpose of investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility[4]. Within those bounds, the Court has allowed flexibility as to the form of investigation.

There are, however, certain essential requirements:

- **Independence**: The investigation must be carried out by a body with both institutional or hierarchical independence, and also practical independence from those implicated in the events[5].
- **Effectiveness**: The investigation must be effective in the sense that it is capable of leading to a determination as to whether or not the behaviour or inactivity was justified and to the identification and punishment of those responsible. The authorities must take

reasonable steps to secure the evidence concerning the incident including, amongst other things, eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death[6].

- **Promptness and reasonable expedition[7]**
- **Public scrutiny**: there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory[8].
- **Involvement of next of kin**: the victim's next-of-kin must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests[9]. The ECtHR has found that investigations were not accessible to next of kin where, for example, the family of a victim had no access to the investigation or to key documents.[10]
- **Initiated by the State**: The authorities must act once the matter comes to their attention rather than leaving it to the next of kin to instigate[11].

In considering when the procedural obligation of Article 2 arises, there is a particular obligation to provide explanations for deaths in custody or detention, in recognition of the fact that people in custody are in a vulnerable position and the authorities are under a duty to protect them.[12] The Court has also recognised that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with.[13]

A similar investigative duty applies in respect of complaints of a breach of Article 3 ECHR, the prohibition of torture, inhuman or degrading treatment or punishment.

Gaps in the current system

The proposals (together with the 2018 Review which preceded them) identify a number of gaps in relation to the above requirements. These include the absence of a guarantee of independence in the way reviews are carried out, a lack of involvement of the next of kin, wide variation in

the promptness of a review and inadequate public scrutiny. Moreover, there is a great deal of inconsistency across the system.

Discrepancy in systems of investigation with other situations of state custody

From a human rights perspective, the starting point is that risks to life in situations engaging Article 2 require a level of investigation which meets the requirements set out above, regardless of whether the setting is a prison, police custody or mental health detention. Caselaw[14] has clearly established the positive duty of authorities to safeguard mental health patients from known risks to their life, in which circumstances the obligation to conduct an Article 2 compliant investigation arises (We will return to the question of distinctions between detained and non-detained patients below).

The Fatal Accident Inquiry (FAI) process is currently the principal way in which Scotland addresses the procedural requirement of the right to life in relation to deaths in prison and police custody. While mandatory FAIs take place in the case of those deaths, it remains discretionary to hold one in the case of deaths in mental health detention and they are rarely held. It is important to note that the present proposals do not propose any change to the role of FAIs, which would therefore continue to be rare. We believe that the discrepancy in the requirement for an FAI, as between deaths in prison and policy custody and in mental health detention, remains to be justified. While we support the need for independent investigation by a body such as the MWC, FAIs perform a distinct role as a judicial process, taking place under rules of evidence. As we found in the Deaths in Custody Review, an independent investigation would complement the FAI process as a useful and credible source of evidence surrounding the circumstances of a death in custody and support compliance with Article 2. It would not act as a substitute.

In the absence of regular FAIs, it is especially important to consider the robustness of proposals for an alternative system in terms of compliance with Article 2.

Comments on the revised process proposed by the Mental Welfare Commission

Question 9: Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant? [Yes / No / Not sure]

There are a number of benefits to the proposals in terms of increasing Article 2 compliance:

- **Independence and effectiveness**: The MWC appears to have the necessary degree of institutional and practical independence from Scottish Ministers, the NHS and health boards. It also appears to have a range of powers which would enable it to carry out an effective investigation, amongst those provided under ss.11-16 Mental Health (Care & Treatment)(Scotland) Act 2003. The Deaths in Custody Review highlighted the following essential features for an independent investigatory body:
    - Unfettered access to all relevant material;
    - Access to premises for the purposes of conducting interviews with employees, people held in detention and others;
    - The right to carry out such interviews for the purpose of the investigation.[15]

  It recommended that the body's functions and remit should be set out in statute and explicitly linked to human rights standards. The current powers of the MWC may require to be clarified, in statute, to ensure they are sufficiently comprehensive and directed towards this purpose. Subject to such clarification, where investigation is *carried out* by the MWC itself, it may be possible to satisfy the requirements of independence and effectiveness;
- **Promptness and reasonable expedition**: The proposals to fix timescales for the completion of reviews would significantly

improve this element. The Deaths in Custody Review recommended that any independent investigation should be completed within a matter of months, which should equally apply here[16];

- **Public scrutiny:** The preparation of reports shared with families and services and the preparation of an annual report would be advances in this area, however, we believe additional elements of public scrutiny may be necessary (addressed below). The Deaths in Custody Review recommended that the independent body should be tasked with a duty to collate, analyse, monitor, and make publicly available a report on the trends, systemic issues, recommendations, learning, and good practice arising from all deaths, and track progress with implementation.[17] The annual report would be an important vehicle for this duty;
- **Involvement of next of kin**: The proposal for a Commission Liaison Officer provides a significant opportunity to increase involvement of the next of kin, although we believe there may be further support required (addressed below). There is a wealth of information in Chapter 5.3 of the Deaths in Custody Review about the information and support that families would find helpful, which could be used to inform this role;
- **Initiation by the state**: Both the central role of the MWC and the improved reporting of all deaths to the MWC would assist in fulfilling this requirement. In addition, there would be increased consistency across the system.

We believe, however, that a number of gaps remain in achieving Article 2 compliance.

At present, the proposals for reviews at Stages 3 – 5 present the following issues in relation to Article 2 requirements:

- **Independence**: The proposals envisage that the vast majority of investigations would take place under the existing procedures of review by the local service or an SAER and only “in exceptional cases” that the MWC would opt to undertake its own investigation. Professor White’s review, from which these proposals arise, found that

> *"Evidence submitted to the review from staff suggested that there is often difficulty in securing independence at a local level. However, any NHS board review cannot be said to be independent in the way that Article 2 requires"*.[18]

We note that the MWC would provide oversight at Stage 3 and retains the option to follow up on a local investigation with which it is not satisfied at Stage 4, however, we are concerned that an after-the-fact review of a review carried out by bodies lacking Article 2 compliant characteristics is not sufficient to remedy the defect. As identified in the Deaths in Custody Review in relation to NHS and Scottish Prison Service reviews (DIPLARs):

> *"while no doubt useful, it represents the SPS/private prison and NHS-agreed account of events and their assessment of improvements needed. An investigation undertaken independent of any authorities involved in the death could only aid the FAI process by ensuring as far as possible that all relevant facts are brought to light and that any failings are identified and lessons learned."*[19]

We note that the MWC can advise the local service(s) that the investigation should be chaired by an individual approved by the Commission. We believe this should be the case in all reviews carried out by local services. The Deaths in Custody Review found a need for all internal (prison and NHS) reviews to be conducted by a truly independent chair, with knowledge of the health and social care environments, providing the assurance that all deaths in custody are considered for learning points.[20] This standard should also be applied to deaths in mental health detention.

- **Effectiveness**: In subsequent investigation by the MWC where the initial investigation was found to be lacking, the ability to secure and assess relevant evidence would be significantly diminished by reliance on the initial findings and the time elapsed since the death occurred.
- **Public scrutiny**: An element of scrutiny is provided by the publication of reports to family and services, however, the degree

of public scrutiny required in both local reviews/SAERs and MWC investigations may be more significant depending on the case. It may be necessary for some hearings to be held in public, as it is unlikely that there will be the opportunity for a public hearing by FAI. For example, in the case of *Paul and Audrey Edwards v The United Kingdom*[21], it was found that while publication can be sufficient to satisfy the requirement of public scrutiny, the vulnerability of the individual and the series of failures by public bodies who bore responsibility to safeguard his welfare, leading to his death, called for the widest possible exposure. In that case, there was no good reason put forward for an inquiry to be in private, given the medical histories of those involved were in included in publication.

- **Involvement of the next of kin**: It will be important to clarify, in both local reviews and MWC investigations, what specific role or rights family members will have to be involved in the process. For example, can they influence the terms of reference, submit questions or have access to documents? The Deaths in Custody Review recommended that the family should be given the opportunity to raise questions about the death with the relevant [SPS and] NHS senior managers, and receive responses. It also suggested that family involvement in an independent investigation (which, in terms of the present proposals, would be by the MWC) could include a requirement to invite families to comment on proposed recommendations and what will change as a result. It also recommended that families or next of kin should have access to free and immediate non-means-tested Legal Aid funding for specialist representation to allow for their participation in legal processes.[22] We believe these recommendations should equally be applied here.

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

The Deaths in Custody Review's key recommendation was that **"a separate, fully independent investigation should be undertaken into**

each death in prison custody". This is intended to support internal processes carried out by the NHS (and, in that instance, Scottish Prison Service) as well as the holding of an FAI. The report describes a number of features of that body including that "its functions and remit – including, for example the timescales for investigation, the parties that must be involved in an investigation, and related complaints/appeals processes – should be set out in statute and explicitly linked to human rights standards".[23] We believe this recommendation should be equally applied to deaths in mental health detention. If the MWC is performing the role of the independent body, it would require to have the same features identified in the report (set out at p.6 above) and, crucially, to carry out the role of investigation itself in more cases than appear to be envisaged by the proposals.

It is worth noting that the independent investigation proposed by the Deaths in Custody Review would be required in all deaths, including those of "natural causes", as human rights concerns may arise even in those cases:

> *"The Review was concerned at the lack of a rigorous process in the categorisation of deaths as being expected or foreseeable from natural causes. Given the lower level of scrutiny applied to these deaths [by SPS and NHS], it is essential that there are clear policies and procedures in place to ensure that only those deaths that properly fall within this category are documented as such.*
>
> *In addition, a natural cause death should not automatically be considered a foregone conclusion. Every death has the potential for both local and operational learning as well as providing pause for thought on institutional assumptions which may influence a person's life and illness trajectory, as well as allowing for consideration of systemic practices which may either consciously or otherwise influence decision making and actions"*[24]

The well-known case of Connor Sparrowhawk, in England, initially attributed by the NHS Trust to "natural causes" but, in fact, found to have been preventable, clearly demonstrates this point in the mental health context. As the Independent Review which followed Mr Sparrowhawk's

death said: “A death can be from natural causes and still be unexpected. It does not necessarily mean that there were no care delivery problems and that learning cannot be derived.”[25]

In our previous submissions, we acknowledged that a potential proportionate system of investigation of deaths in mental health settings may not require a mandatory FAI in all cases, instead comprising an initial investigation by an independent public body to rule out deaths from natural causes; in all other circumstances, a mandatory FAI would be triggered.

Similarly, a system administered by the MWC could take into account a proportionate response, in determining the process of investigation and the intensity of review required. A Key Recommendation of the Deaths in Custody Review was that this must be determined with regard to applicable human rights standards.[26] Such investigations must meet the requirements of Article 2 and would, in our view, therefore have to be carried out by the independent body, such as the MWC. In doing so, the MWC may itself conclude that a death was from natural causes and determine a less far-reaching review is necessary. Local reviews and SAERs would continue to be of assistance. We would consider that the most thorough of reviews should be carried out by the MWC in all deaths which are self-inflicted or involve the use of force, cases which, in England, are identified as engaging Article 2 and which require an enhanced inquest (a more thorough inquest and scrutiny by a coroner sitting with a jury, leading to a narrative verdict on “in what circumstances” the death occurred).[27] We would consider deaths following an incident of restraint to fall within this category.

Local reviews and SAERs should also ensure independence (in which they would be assisted by oversight by the MWC), the involvement of family members and adequate public scrutiny. We note that guidance on these matters is to be produced and we suggest that it includes clear instruction on what families can formally influence and how can they participate, as well how to ensure appropriate levels of public scrutiny throughout the review and through publication thereafter. The recommendations at paragraph 5.5.14 of the Deaths in Custody Review,

which detail how [SPS and] the NHS should carry out procedures like SAERs should be followed.[28]

We recognise that our comments suggest a much more significant role for the MWC as a primary investigator than the proposals contemplate. We believe this is necessary to meet Article 2 requirements and early recognition of the resource this would require for the MWC is essential.

Follow-up and escalation of recommendations remains crucial to establishing an effective system of preventing deaths. The proposals for the MWC to report on and follow up recommendations and to escalate to Scottish Government where necessary are positive and echo the findings of the Deaths in Custody Review, which found that the independent body should be tasked in statute with the duty to monitor the implementation of learning arising from investigations and FAIs effectively, including the dissemination of good practice. This should also be backed up by the ability to hold agencies to account, found by both the Deaths in Custody Review[29] and the Angiolini Review[30], in the form of a National Oversight Mechanism.

There remains the question of whether a system of investigation should extend to patients who are not detained. The Supreme Court has established that hospitals are under a duty to take reasonable steps to safeguard the right to life of mental health patients in their care, whether detained or not, if they knew or ought to have known that there is a real and immediate risk to their life. They observed that the difference between a patient who is detained and one who is not may be one of "form, not substance".[31] This position has been confirmed by the ECtHR, however, they consider that a stricter standard of scrutiny will be required for detained patients.[32] We believe therefore that a system of review should be extended to non-detained patients to establish whether there are any circumstances which might engage Article 2 and necessitate further investigation.

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

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

In order to aid public scrutiny and to identify trends which require action, it will be important to compile consistent data in the process of annual reporting. This must include data disaggregated by key features, in particular, protected characteristics (as set out in the Equality Act 2010). Data should be disaggregated as far as possible; for example, data on ethnicity should be aligned to census categories and data on disability should account for different types of condition or impairment. This would enable the identification of trends such as, for example, disproportionate deaths of certain racial groups or among people with learning disabilities. The collection of appropriately disaggregated data is required by Article 31(2) of the Convention on the Rights of Persons with Disabilities.[33]

The collection and use of such data will also support the MWC's and other relevant listed bodies', compliance with the Public Sector Equality Duty, guidance on which is available from the EHRC.

Annex: Key Recommendations of the Independent Review of the Response to Deaths in Prison Custody

Key Recommendation: A separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.

- The independent investigation should be instigated as soon as possible after the death and completed within a matter of months.
- The investigation process must involve the families or Next of Kin of those who have died in prison custody.
- The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR. All investigations must result in a written outcome.
- In determining the process of investigation and the intensity of review required, the independent investigatory body must have regard to applicable human rights standards, including those set out in the online Appendices.
- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant institutions requiring the completion, retention and production of relevant information in their possession.
- The independent investigatory body must be required to produce and publish reports analysing data on deaths in custody,

identifying trends and systemic issues, making recommendations and promoting good practice.

- The independent investigatory body should also be tasked, in statute, with the duty to monitor and report on the implementation of its recommendations. The views of bereaved families or Next of Kin should be taken into account in this process.
- Families or next of kin of those who have died in custody should have access to full non-means-tested legal aid funding for specialist representation throughout the processes of investigation following a death in custody, including at the FAI.

[1] Available at https://www.scottishhumanrights.com/media/1421/consultationonproposalstoreformfatalaccidentinquiries.docx and https://www.scottishhumanrights.com/media/1272/faibillwrittenevidenceapril2015.docx
[2] *Independent Review of the Response to Deaths in Prison Custody*, November 2021, Available at Independent Review of the Response to Deaths in Prison Custody | HMIPS (prisonsinspectoratescotland.gov.uk)
[3] *Öneryildiz v Turkey* (2005) 41 E.H.R.R. 20 at para 91
[4] *Jordan v United Kingdom* (2003) 37 E.H.R.R. 2 at para 105
[5] *McKerr v United Kingdom* (2002) 34 E.H.R.R. 20
[6] *Nachova v Bulgaria* (2006) 42 E.H.R.R. 43
[7] *McKerr v United Kingdom* (2002) 34 E.H.R.R. 20
[8] ibid
[9] *Al-Skeini and Others v. United Kingdom* no 55721/07, 7 July 2011
[10] *Armani Da Silva v United Kingdom*, no. 5878/08, 30 March 2016
[11] *Ilhan v Turkey* (2002) 34 E.H.R.R. 36
[12] *Salman v Turkey* (2002) 34 E.H.R.R. 17
[13] *Herczegfalvy v Austria* (1993) 15 E.H.R.R. 437 at para 82
[14] *Savage v South Essex NHS Trust* [2008] UKHL 74 and *Rabone v Pennine Care NHS Foundation Trust*, 2012 WL 382571
[15] *Independent Review of the Response to Deaths in Prison Custody* , p.75
[16] *Independent Review of the Response to Deaths in Prison Custody* , p.77
[17] ibid
[18] *Review of the arrangements for investigating the deaths of patients being treated for mental disorder*, December 2018, at p.21
[19] *Independent Review of the Response to Deaths in Prison Custody*, p.76
[20] *Independent Review of the Response to Deaths in Prison Custody* , p.60
[21] (2002) 35 EHRR 19
[22] *Independent Review of the Response to Deaths in Prison Custody* , p.76
[23] *Independent Review of the Response to Deaths in Prison Custody* , p.75
[24] *Independent Review of the Response to Deaths in Prison Custody*, pp.64 & 65
[25] *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*, December 2015, available at FINAL REPORT of the Review of MH and LD deaths at Southern Health NHSFT-16.12.15 (england.nhs.uk)
[26] *Independent Review of the Response to Deaths in Prison Custody* , p.81
[27] Coroners and Justice Act 2009
[28] *Independent Review of the Response to Deaths in Prison Custody.* p.68
[29] *Independent Review of the Response to Deaths in Prison Custody* , p.76
[30] *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*, Rt. Hon. Dame Elish Angiolini DBE QC, January 2017 available at Report of the Independent Review of Deaths and Serious incidents in Police Custody (publishing.service.gov.uk)
[31] *Rabone v Pennine Care NHS Foundation Trust*, 2012 WL 382571
[32] *Fernandes de Oliveira v Portugal*, Application no. 78103/14, 31 January 2019
[33] "The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights."