1. Yes. The proposal appears to reflect the commitment of the Government as set out in the Review and meets the need for an independent body to be responsible for investigation of all relevant deaths.

1a An obvious difficulty is that adding a layer will inevitably add to the potential for delay. From the viewpoint of relatives (and other carers), speedy resolution is very important. Delay in concluding an enquiry inevitably causes some degree of emotional distress. In many cases, relatives will have no cause for concern about the circumstances of death. Any prolonged investigation may cause more distress than it saves. In short, achieving a quick end to the investigative process is a worthwhile aim in itself.

1b The need for speedy resolution must be imbued as part of the system from the outset. There is a role for thorough investigation but that must not be an end in itself. If there is no realistic likelihood of any important lesson emerging at the end, the need for closure is probably more important. In some situations, of course, it may not be possible to assess the likelihood of useful lessons until there has been a full investigation. But I assume that there will be many cases where there is sufficient evidence from experience to allow a confident conclusion that there is no sufficient likelihood of any new discovery to justify delay in concluding the process.

Where relatives have no cause for concern about the circumstances of death, it is thought that there will rarely be any separate public benefit justifying any elaborate process for investigation. Accordingly, a suitable triage system from the outset will be fundamental. I comment further in relation to the Stages below.

Where there is delay relatives should be entitled to specific detailed information as to the causes of delay and the predicted time-scale. In other words there must be no place for the mindset which allows relatives to be fobbed off with remarks such as "these things take time". I think the proposal for a CLO should go far to deal with that problem.

2. Yes. MWC should disseminate the lessons learned. I think there has been difficulty in the past in ensuring that the results of one health board's lessons in good practice are passed to all other boards. It is not always easy to see where lessons have been understood and acted upon. Having a central agency responsible for this should make this easier.

2a One difficulty is that of having too much information. Important points can easily get lost in reports of more routine matters. "Annual Reports" are seldom seen as priority reading. There may be a role for them in relation to the general public interest but there is little purpose in routine reporting to professionals if there is nothing for them to learn from it. Some lessons may be little more than proposals for marginal improvement. Flooding professionals with this level of message runs a real risk of obscuring the more important lessons.

2b So there may be a need to distinguish between formal annual reports in the public interest and specific reporting of lessons for professionals. There is no need to wait for a year-end before intimating important lessons.

3. Yes. Where parts of the investigation are carried out by a local body the MWC will remain responsible for the investigation as a whole. This will indeed require them to spell out

the parameters of the delegated investigations and the standards expected. It seems clear that they will need to publish standards against which the quality or adequacy of such local services can be measured and publish guidance as to how these standards are expected to be attained.

3a Specifying the detail of what such local services must provide and guidance as to how it is done is very likely to give rise to problems. It is difficult to comment further at this stage.

3b The Review Implementation Group may well be able to comment usefully as standards and guidance are developed. Points of detail will arise in relation to many - if not all - attempts to specify the role of such local investigation and as to whether such detail is to be specified in the standards or left to guidance.

4. Stage 1 The breakdown of causes of death (at para 19) does not attempt to comment on experience of deaths which need investigation and those which can reasonably be seen as straightforward. The views of relatives will always be an important factor in determining the scale of investigation required in relation to death from natural causes.

The form ND1 "Notification of Death" appears to cover the essentials. However, I would suggest that the part dealing with relatives be given a separate heading with questions designed to encourage more involvement with relatives. The present question "Have the circumstances been discussed" could be replaced by a heading requiring detail of discussions with relatives. This would make it clear that such discussion is positively expected to have occurred. That said, the timing of such discussion must be considered. Relatives should not feel rushed. In some cases it might be necessary to leave this to the stage when a CLO can have such discussions.

Instead of a reference to the "nearest relative" there might be space requiring consideration of any conflict of relatives. Mental health issues often run alongside family tensions and it may not always be easy to identify appropriate relatives. Detail of the nature of the relatives' involvement with the deceased could be required. This could involve specific questions as to whether they had been visitors, whether they had been involved in discussions about care of the patient prior to the death. Setting out full detail of interaction with relatives might be difficult depending on their personalities and reactions but it is worth directing attention to the need for full involvement with relatives from the outset of the investigative process. Particularly where there is an obvious caring relative who has had recent dealings with the deceased and an opportunity to discuss circumstances of death fully and has no concern about these circumstances, there may be no need for further investigation.

Instead of asking whether the relatives had expressed concern there could be a question designed to make it clear that the person reporting should expressly raise this matter with relatives to find out whether they wish further investigation of the circumstance surrounding the death. Indeed, it might be worth making express provision for a declaration by the appropriate relatives to confirm that they are either satisfied with the explanations they have been given or wish the MWC to make further enquiries. In short, there should be no doubt that this is an important part of the process. It may be quite time consuming but should be seen as an important factor in determining whether and, if so, what further investigations will be carried out.

Although it is worthwhile trying to standardise reporting there may be a benefit in having separate Forms for reporting different categories of death. Suicide and accidental death may be thought always to call for independent investigation and reporting the detail of the views of relatives may be of less importance in such cases. I do not have any direct experience of these matters but assume that in cases of apparently natural death there may well be concerns about whether the medical care has been adequate. Full discussion with relatives may be very important in determining whether any further investigation is needed.

The short point is that, in many cases, there will be no need for elaborate investigation and no real need for involvement of MWC. Finding a reliable basis for that decision is important.

Stage 2. Involvement of a "team" will not be necessary in every case. Where the ND1, or equivalent, discloses no apparent need for further investigation, a single responsible person could have the role of deciding whether further investigation is required or whether to remit to the team for consideration of the level of further enquiry required.

Stage 6 While the MWC may well wish to provide an annual report of its overall activities, important lessons may be lost or delayed if such a report is seen as the main method of communication. As noted above, I think that it is worth considering a system of specific notice of important lessons as the preferred approach. Accordingly, at the end of each full investigation there should be a formal requirement to give consideration as to how lessons should be disseminated.

5.Yes. A single point of contact to explain what is going on in relation to investigation will be a great benefit.

5a. The appointment of a Commission Liaison Officer will not be a substitute for good caring liaison with relatives immediately after the death. The institution involved should designate someone to be responsible for contact in the very early stages. As noted above, the reaction of relatives may be critical in determining the extent of investigation required in any specific case. But relatives must be treated compassionately for their own sake too. The idea of a single point of contact for the investigation stage is separate from the need for caring contact in the immediate aftermath.

Another concern is that a single point of contact based in MWC in Edinburgh will often be remote and practical arrangements will need to be considered. I do not know whether it is envisaged that the CLO will travel to offer relatives a face to face meeting. The cost of this might well be justified by the saving of distress and by the saving on investigative time if relatives are able to discuss things fully and pronounce themselves satisfied. Discussions in connection with the ND1 may be too soon for relatives to reach a considered view and full discussion with the CLO might lead to different conclusions.

If the CLO is not to travel, relatives might be offered cover for their own travel costs or, in suitable cases, specific provision made for them to talk to the CLO by zoom facility. Many people will now be able to do this from their own homes or with the assistance of relatives - or a charity such as Support in Mind - but thought should be given to such matters of detail in every case.

6. I have no particular concerns on this head.

7. and 8. I cannot usefully comment on these questions.

9 I have no specific concerns under this head.

10. There will inevitably be significant additional cost for MWC.

10a Proper attention to detail at the outset with adequate time spent to attend to the needs of relatives should allow identification of cases which require investigation and help minimise expenditure on those that do not.

11. I have nothing to add at this stage.

J M McGhie 12-2-22