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?
Question 1a: Do you foresee any difficulties with this arrangement?
Question 1b: How could such difficulties be addressed?

RCN offers qualified support for the Mental Welfare Commission (MWC) to take on this role, but we would require further detail to be able to offer unequivocal support.

We have questions regarding the MWC's role as outlined in the consultation document and we raise them in this submission, but we also expect there to be a subsequent consultation on the 'guidance and standards for local services' referred to at paragraphs 32, 33 and elsewhere in the consultation document.

Beyond any consultation on guidance and standards for local services; the MWC should also consult on the further detail of how its new role will operate, as that detail is developed. This detail will be crucial in enabling the RCN, and other stakeholders, to offer a robust view on whether the process will be operable in practice, and any challenges that may arise as a result of it, as per questions 1a and 1b. We would welcome assurances from the MWC that it will consult on this matter but if it does not intend to, RCN will seek to discuss that detail directly with it, in pursuance of representing the interests of our members.

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

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, but please see our response to question 1.

Question 4: Do you have any comments on the revised process as set out above?
Question 4a: Do you foresee any difficulties with this process?
Question 4b: How could such difficulties be addressed?

The proposals in the context of the 2018 review report
It is difficult to appreciate the impact of the proposed changes, or offer a robust view on their operability, in the absence of an understanding of progress against the other 'actions' proposed in the 2018 review report (summarised on pages 9 and 10 of that report). If the 'implementation group' recommended by the review exists, an update from that group would be helpful and welcome. For example, without knowing what stage the options appraisal under action 3 has reached, it is difficult to appreciate whether the proposals in this consultation risk creating a 'two tier system' of investigation of death, whereby the deaths

other 'actions' proposed in the 2018 review report (summarised on pages 9 and of those people subject to a CTO receive a greater degree of scrutiny than the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder and so are not subject to a CTO (see below for further comment on this point).

The extent of the problem that the new process is intended to solve

RCN Scotland's understanding of the main purpose of the proposed changes is that they are intended to ensure that all deaths of people subject to a CTO are investigated in a proportionate way, to the extent appropriate in the circumstances. We also understand that the MWC has encountered instances where the death of a person subject to a CTO has not been reported to the MWC under the current legal requirements and/or has not been investigated, and that there is an implication that, in the case of investigations, they have not taken place when they perhaps should have done. However, the statistics on current deaths of people subject to a CTO that are provided in the 2018 Review and in the consultation document, are of limited scope. See the 2018 Review pars. 9-11 and the consultation document pars. 17-20. Figures are not provided that indicate how many investigations take place now across <u>all</u> relevant deaths, regardless of where those deaths take place, and how many more investigations will take place under the new process if all such deaths are to be investigated. That makes it impossible to gauge how much greater the level and frequency of investigations could be. We do not go so far as to say that there is not a problem, but we are concerned that the inability of the MWC to map the true extent of it creates a risk of a disproportionate approach being taken.

From the statistics in the consultation document, it appears to be that, when it comes to the death of a person subject to a CTO under the 2003 Act who has died in hospital (as opposed to having died in the community), there is an average of 124 such deaths per year of which 7% (9) are not reported to the MWC under the duty to notify it of the revocation of a CTO for any reason, including death (consultation document par. 17, 2003 Act sec. 40). This seems to represent a straightforward failure to comply with the duty. Even though this evidence is confined, effectively, to the performance of Health Boards, we accept that it illustrates a problem with reporting.

This is a different matter, however, to the extent to which deaths (whether reported to the MWC or not) are being appropriately *investigated*.

The ND1 'Notification of Death' form, used by the NHS to report such deaths to the MWC, includes a question that reads 'Is the death subject to internal NHS review through adverse event investigatory?' *(sic)* i.e., a Significant Adverse Event Review (SAER). However, no statistics for how many such deaths were or were not 'subject to internal NHS review' are provided in the consultation document even though the MWC presumably holds that information. Although this information would only apply to deaths capable of being investigated by the NHS, and although the criteria for launching a SAER mean that not every death of a person subject to a CTO would require a SAER (just as not every death would require, for example a HSE or a police investigation) it would nevertheless be very informative as to the current extent of non-investigation.

The consultation document does not deal in any depth with the matter of why a death has not been investigated but if non-investigation currently results from an *appropriate* application of the relevant criteria (like those applicable to a SAER) there must be a risk that investigating all deaths

- is inherently disproportionate and/or
- risks creating an effective (if not acknowledged) 'no-investigation' option at stage 3 of the proposed process, which functions in practice in exactly the same way as the current criteria do and leads to no more deaths *truly* being 'investigated' (as opposed to being 'reviewed' at proposed stage 2) than is currently the case.

It would be helpful to understand whether the 'national adverse events framework' established by Healthcare Improvement Scotland (as referenced at par.21 of the consultation) has made any difference to the operation of SAERs both in terms of the number and type of deaths of people subject to CTOs being made subject to an SAER and to the problems with the perceived independence of the SAER process set out with some force in the 2018 Review.

Setting aside any failure on any organisation's part to comply with current reporting requirements, it is therefore important, prior to the introduction of the new process, to provide a robust evidence base for the changes proposed by establishing the total number of un-investigated deaths of people subject to a CTO across all settings. It is unfortunate that the 2018 review did not establish this figure but it can presumably be arrived at. We would encourage those organisations that keep the relevant data to more fully explore the data sharing possibilities, with a view to arriving at this important figure.

That said, we appreciate that it can be argued that the new process is justified on the basis that

- one un-investigated death is one too many (irrespective of the 'depth' of any investigation) and
- the consultation is about taking forward a recommended action from the 2018 review, and that recommended action is not, itself, being consulted upon.

If the new investigation process is established; it should eventually reveal the figure for un-investigated deaths, as well as bringing it down to zero in short order (because all deaths will be categorised as having been 'investigated' by virtue of stages 2 and 3). RCN Scotland therefore suggests that, once the MWC has possession of that information, and so understands the basis on which other organisations have decided to investigate or not, or to what depth, it reviews whatever criteria it initially uses to make a judgement at stages 2 and 3 of the new process as to the depth of investigation required. This would be done with a view to revising the criteria to more effectively ensure the proportionate and consistent approach desired.

To embed the concept of 'proportionality' in the new process, it should be specifically added to the list of values and principles underpinning the proposals (as set out at paragraph 50).

Existing quality assurance provision

Neither the consultation nor the 2018 report provide a systematic or comprehensive analysis of the *quality* of current investigations across all investigatory bodies. However, the 2018 report does provide an extensive critique of Health Boards' SAER processes on the basis of insufficient independence in terms of Article 2 of the European Convention on Human Rights (the Right to Life, as implemented via the Human Rights Act 1998) and, conversely, states that '(w)here there is review by the HSE, Police or where a FAI is held… independence is assured'.

RCN Scotland accepts that the MWC's proposed new role may be necessary to quality assure investigations and ensure consistency, regardless of investigating body. In keeping with our comments so far, we suggest that this consistency will rely on there being clear criteria setting out how the MWC will act proportionately (particularly when making a decision at stage 2 of the new process) depending on which other investigating body is involved in an investigation. If independence is currently assured with respect to certain investigating bodies this may be a signal that the MWC's involvement should always be limited when such a body is involved, as is implied in par. 39 of the consultation with respect to Crown Office involvement. In any case, and at the very least, the guidance promised at pars. 32 and 33 of the consultation needs to make clear in detail

- how the *powers* of the MWC at stages 3, 4 and 5 with respect to local services (which we take to be defined at par. 32) apply (or don't apply) to other investigatory bodies (for example, HSE) and
- how the *role* of the MWC, particularly at stages 2, 3 and 5, relates to the role of Healthcare Improvement Scotland and similar bodies (e.g., the Care Inspectorate) that themselves have a quality assurance aspect to their role.

There must be no unnecessary and unjustifiable duplication of investigatory activity by different bodies, and it seems that the MWC's new role is intended to help ensure that such duplication does not happen even if the MWC does not have, and will not be given, the express power to prevent any investigation by another body from going ahead. It is hard to justify the toll taken on families, carers and staff in having to participate in multiple investigations on the same matter, conducted more to satisfy the administrative requirements and technical-legal responsibilities of public authorities, than to provide any substantive justice or redress. This need to avoid duplication is particularly acute – but by no means exclusively so - when there is a police investigation. That is because:

- a police investigation is more likely to involve the most traumatic of circumstances
- by its very nature, a police investigation may impose requirements upon those involved, or cause them to take certain actions, which may directly affect the extent to which they are able to participate in other investigations (for example, if someone has been arrested on suspicion of having committed an offence)
- whilst the police may be concerned with certain different matters from those with which the MWC would be concerned, it is not immediately obvious that, if the police have investigated thoroughly, there would be sufficient value in a subsequent MWC investigation to warrant the upset that it would cause to those whom it would involve, who would have to relive their experiences all over again.

A two-tier system?

We note the 2018 Review's action 3 concerning 'an appropriate process of review for the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder'. It would be helpful to understand whether or not this process has been, or will imminently be, established and also, why it has not been extended beyond the deaths only of people who are in hospital in the way that the process for those subject to CTOs has been extended. In our view it should be established simultaneously with the MWC CTO process, and the matter of extension should be considered. If that does not happen there is a risk of creating a two-tier system where the deaths of people being treated by local services voluntarily in hospital and/or in the community but who are *not* subject to a CTO, are not investigated even though the impact on the families, carers and staff involved with that person will be as profound as the impact on the families, carers and staff involved with those people who *are* subject to a CTO. It would also mean that one set of bereaved families and carers would benefit from the support of a Commission Liaison Officer and another would not. We understand that there may be an issue with the scope of an extension as the group of 'people being treated voluntarily in the community' could be very large. Any consideration of extension should therefore consider criteria to proportionately and fairly limit its scope.

Professional nursing expertise

We welcome the inclusion of those with nursing expertise in the team conceived of at the proposed stage 2. Such expertise must also be present in any investigatory team. It is vital that the staff who may be involved in an investigation have faith that those investigating understand and account for their professional practice and specific circumstances, including the requirements of professional regulation and matters such as staffing levels, just as much as it is vital that families and carers have faith that their situation is properly understood and accounted for.

MWC: powers, recommendations, appeals, complaints
It must be made clear whether the MWC will be able to intervene in an ongoing investigation by a local service, as sanctioned at stage 3, if it becomes clear to the MWC long before stage 4 is reached, that the investigation is going to fail to investigate properly.

There is no explanation of what happens if the findings and conclusions of a MWC review or investigation under stages 3 or 5 differ fundamentally from the findings and conclusions of the investigating body (e.g., a Health Board) and whose findings and conclusions take primacy. This needs to be made explicit.

Our understanding is that, currently, if someone is dissatisfied with an investigation conducted by a local service into the death of a person subject to a CTO (or the lack of an investigation) they can ask the MWC to consider an investigation. Although this does not constitute a formal 'appeal' against any findings, conclusions or decisions of any local investigatory body, it provides a form of potential redress. However, it is not clear what route of redress or appeal exists if a person involved in an investigation (whether a family member, carer or member of staff) disagrees with any findings and conclusions of the MWC. This may be covered by the existing arrangements via the MWC's own complaints procedure and ultimately via the Scottish Public Services Ombudsman but, as this is a new process, it would be helpful for this to be made explicit.

It is not clear what 'follow(ing) up on recommendations' and 'escalation' under stage 6 actually involves. Our understanding is that, currently, there is no obligation, other than a moral obligation, on Scottish Government or any other organisation to act on recommendations made by the MWC. The proposed stage 6 does not seem to change that position. It is not clear how any recommendations under the new process will be enforced and if they can't be enforced their value is surely compromised. This stage of the process needs clarified and making recommendations enforceable should be considered.

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
Question 5a: Do you have any concerns about this type of arrangement?
Yes. Please see our comments in answer to question 4, on the risk of creating a 'two-tier' system and also, whilst we welcome the proposed Commission Liaison Officer (CLO) role we suggest that the CLO must ensure that they work in close concert with anyone from an investigatory body taking on a similar role, particularly to ensure that families and carers, and indeed staff, do not have to repeatedly relive negative experiences through having to liaise with several such people at once.
Question 5b: How could your concerns be addressed?
Please see our comments in answer to question 4, on the risk of creating a 'two-tier' system

Question 6: Do you agree that the revised process, described in Section 2, will meet the values and principles set out in paragraph 50 above?
Not sure.
Question 6a: Please explain your answer.
Please see our comments in answer to question 4, on the matter of proportionality, where we suggest that 'proportionality' is added to the list of values and principles (at paragraph 50) underpinning the proposals.

We also consider that 'staff' should be added to 'Involve families and carers in a meaningful way' on that same paragraph 50 list, just as it features alongside families and carers in the list of features of the process at paragraph 26 and as referred to throughout the 2018 Review document. It is unclear why it has dropped off the paragraph 50 list in the

consultation document when it is so clearly part of the 2018 Review's thinking. That omission could be taken to inappropriately imply a starting point for an investigation of staff fault or guilt. There is also merit in the inclusion, in the list of values and principles, of a form of words that would oblige the MWC to fairly balance the interests of all those involved in the process, so that no one's interests are unfairly prioritised over anyone else's.

Question 7: Do you have any comments on the potential impacts of the revised process on those with protected characteristics?
See next question.
Question 7a: Please explain what you think could be done to minimise any negative impacts on people with protected characteristics.
The process should be subject to a comprehensive Equality Impact Assessment, and regular equalities monitoring to identify if there is disproportionate representation of people with protected characteristics among any group involved with the process, including staff.

Question 8: Do you have any comments on the potential impacts of the revised process on children and young people?
No
Question 8a: Please explain what you think could be done to minimise any negative impacts on children and young people.
N/A

Question 9: Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant?
Not sure
Question 9a: Please explain what you think could be done to ensure that the new process fully complies with human rights standards.
The MWC is a 'public authority' for the purposes of the Human Rights Act 1998 and therefore, in conducting its business, including all aspects of investigations, owes its duties under the Act as much to the individual staff involved in an investigation (albeit not to their employing organisation) as to the families and carers of the person who has died. This is not acknowledged in paragraphs 53 to 55, where only families and carers are mentioned. It must be explicitly acknowledged in any future documentation dealing with, and any future practice that engages, this aspect of the MWC's role.

Question 10: Do you have concerns in relation to any financial or administrative impacts the revised process may have, especially for local services?
It seems likely that that the new process will add a further layer of bureaucracy and expenditure of resources to existing processes (all of which will remain in place). We nevertheless appreciate that this layer is added in the name of ensuring consistency of approach across all deaths and it is intended to be proportionate. In practice, whilst other bodies will have to provide more information to the MWC than they have to provide at present, particularly in order for the MWC to fulfil its proposed role at stage 2, it is not clear that this will lead to a sudden and significant increase in in-depth investigations. However, this is an obvious risk, and we would refer back to our comments on proportionality made throughout but specifically in our response to question 4.

If the new process results in more investigations, whether many more or merely a few, and of greater depth (and whether conducted by a body that currently has this role or the MWC itself, as per stage 3) this could impact on RCN members who may

- be involved in coordinating an investigation by virtue of occupying a senior post and/or
- experience greater levels and frequency of investigation with the time taken to participate increased. This may be especially true in the case of NHS Significant Adverse Event Reviews.

Minimising the unnecessary expenditure of resource, as well as avoiding subjecting RCN members and others to inappropriate and unnecessary pressure and stress is a further important reason why the concept of proportionality is so critical.

Question 10a: Please explain what you think could be done to minimise any negative financial or administrative impacts.
See our comments on proportionality made throughout but specifically in our response to question 4.
Question 11: Do you have any other comments or concerns in relation to the revised process?
No