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?

- The responses to this consultation are informed by INQUEST's four decades of working with bereaved people after state related deaths and discussion with members of our Lawyers Group. In the context of deaths in mental health and learning disability settings we have documented the lack of public information about the number and circumstances of deaths and the closed nature of the investigation processes.

- INQUEST has contributed to various independent reviews and advisory boards concerned with deaths in these settings and held Family Listening Days to hear directly from bereaved people about their experiences of the investigation processes that follow.

- **It is disappointing to see that the Mental Welfare Commission (MWC) have not seized the huge opportunity of this process to recommend the establishment of a new independent investigatory body. It is INQUEST's view that firstly that there should be an independent investigatory body for mental health deaths to carry out the initial investigation and information gathering but also secondly that the Fatal Accident Process (FAI) should include deaths of detained and non-detained patients.**

- INQUEST notes the observations of the Scottish Human Rights commission to this consultation which we support and the planned reforms to the way in which deaths in prison are investigated. It is iniquitous that deaths of those in mental health detention should not receive the same independent scrutiny.

- It is also clear that in Scotland there is an urgent need for review and fundamental reform of the FAI process – the excessive delays but also the need to maximise the meaningful involvement of bereaved people, ensure legal aid is available for their representation in the same way as the State is represented through publicly funded lawyers, as well as ensuring that their preventative role is fulfilled. [1]Research from

[1] https://www.sccjr.ac.uk/projects/deaths-in-custody-15-years/

Glasgow University revealed that in nine out of ten FAI's undertaken into prison deaths there were no recommendations made to improve practice or prevent deaths.

- INQUEST has long standing concerns about the lack of a properly independent investigation system across the UK. At present, there is a lack of scrutiny, oversight, and accountability of mental health services as a result of which, people will mental ill health are being failed. Bereaved families across the UK have described a culture of defensiveness, delay and denial, a lack of independence, openness and transparency and a failure to acknowledge failings and to enact meaningful change to policy and practice.

- Unfortunately, the system proposed in the consultation document, whilst going some way in addressing some of the concerns highlighted by INQUEST's work, does not sufficiently address a number of failings in the current system and nor does it ensure a system that is compliant with Article 2 of the European Convention on Human Rights.

- The current proposal envisages the majority of investigations being undertaken by the NHS responsible for the care of the deceased which means that such investigations will fundamentally lack independence and will not comply with Article 2 (see answers to question 9). It undermines family and public confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its own staff and systems. The introduction of oversight by the MWC does not remedy this problem, not least because the MWC will not in fact be undertaking the investigations and they cannot be seen to be sufficiently independent in any event, for the reasons set out below.

- Our experience of working with families shows that there is a consistent failure of NHS Trusts and private providers (where relevant) to meaningfully engage bereaved families in investigations. Families commonly express their impression from early in the process that things are being covered up.

- Families' faith in the effectiveness and robustness of the post-death investigation process is often undermined by the fact that they are not involved from the outset. Families are routinely not informed that investigations are being carried out, the investigator's background, role within the Trust and role within the investigation process. Families are often not provided with the Terms of Reference from an early stage, including not being able to input into the scope of the investigation or have an opportunity to raise concerns about their loved ones' care and treatment.

- The perceived lack of transparency and scrutiny is reinforced by the routine lack of significant or serious consequences arising out of investigations. As set out in response to question 5, the role of the role of Commission Liaison Officer does not go far enough in ensuring the effective participation of bereaved families.

- When undertaken by the organisation that was responsible for caring for the deceased, it is common for investigations to be treated as an 'internal' process with an inward focus without sufficient sense or priority being given to the outward facing

responsibilities of the Trust in terms of the family, the need for public accountability and the preventative role of the investigation in the context of national learning. Families describe their sense that the overriding priority for Trusts in the investigation is one of damage limitation and deflecting criticisms. Despite a 'Duty of Candour' intended to introduce and strengthen the need for openness, this sits at odds with the continued experience of a closed investigation and a perceived lack of transparency. The current proposal does not address these concerns.

- Given the close working relationship of the MWC to the NHS and that its staff management is drawn from a variety of disciplines from the NHS, we would argue that the proposed new system is not sufficiently independent. However well-meaning and good these individuals are, they are immersed in the organisational culture and with colleagues working in the NHS. This makes an independent objective view very difficult.

- Ultimately, the lack of effective scrutiny of deaths in mental health detention frustrates the ability of NHS organisations and staff to learn and enact fundamental changes to policy and practice to protect mental health patients and prevent future fatalities.

Question 1b: How could such difficulties be addressed?

- Too many families report the approach after a death being one of reputation management, and a lack of transparency, despite a required 'duty of candour' for health and social care workers. We need a more open and learning culture that could help safeguard the safety of in patients.
- The overriding need for independent investigations sits at the heart of improving the structure and quality of the investigation system. Without these, bereaved families will continue to report overriding concerns of bias and a conflict of interest that drives the process.

- **In our view Independent Investigations should apply to all self-inflicted in-patient mental health deaths, deaths involving the use of force/restraint, all deaths of children and all other unnatural or premature deaths.** INQUEST has found that many so called 'natural deaths' are far from natural and are unexpected and preventable. The MWC could play an important role in ensuring these are properly investigated.

- **They should also be undertaken in cases where a number of deaths have occurred, or a pattern has been identified as this would allow the identification of wider system issues and thematic review.**

- Investigations largely fail to set cases within the national context or recognise the bigger picture. Investigations should be set within the context of previous deaths and learning (including other investigation findings/civil actions etc.) and Trusts should be required to identify other similar deaths as part of an investigation. Such requirements

would go some way towards reassuring bereaved families that NHS Trust are truly committed to improving systems, policies, procedures and crucially the quality of care for patients, thereby preventing future deaths from occurring in similar circumstances.

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

- Subject to the significant concerns regarding the independence of investigations and their non-compliance with Article 2, we agree that an annual report would assist in the process of accountability and learning. There needs to be far greater visibility of deaths of inpatients, both the data and systemic issues arising out of investigations documenting any themes and patterns. Both quantitative and qualitative data is crucial in raising greater understanding of the issues arising in these deaths. This is important for both detained and voluntary patients and to ensure that deaths of children and young people are also reported on.

- Increased visibility is needed with the annual publication of figures. Clear annual public reporting should include a relevant breakdown of data disaggregated by age, gender, ethnicity, disability, date of death, place of death, cause of death, and hospital/Trust/Board. Access to centralised data on the deaths occurring in mental health setting enables further public scrutiny.

- An annual report should include the monitoring of patterns, institutions, repeat issues etc.

Investigation reports should be published and made publicly available. Good practice exists in the context of England and Wales and the role of the Prison and Probation Ombudsman and their publication of all investigation reports on their website thereby providing greater public scrutiny and transparency.[2]There should be greater use of learning bulletins and thematic reviews.

- Recommendations from investigations should be collated and reported on what action has been taken in response. (See comment on the INQUEST NOM proposal below).

- To aid greater parliamentary scrutiny this annual report should be tabled in Parliament perhaps through a parliamentary health committee to aid debate and aid public accountability.

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

[2] https://www.ppo.gov.uk/document/fii-report/

- The quality of data – there needs to be a statutory requirement on the part of Trusts/hospitals to provide regular disaggregated data paying particular attention to protected characteristics.

- The question of independence and reporting back on investigations – this will be dependent on the quality and rigour of the investigation undertaken. It must also include family feedback on the investigation processes but the proposal is silent on this and any evaluation and feedback processes planned.

Question 2b: How could such difficulties be addressed?

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

- The separate and expert skills needed to conduct a quality investigation need to be recognised. Too often the task of conducting investigations is treated as an add-on to the jobs of clinicians. A separate resource is needed to develop the specialist skills and approach needed to fulfil this responsibility.

- More is needed around written guidance, templates etc. setting out how a good investigation should be conducted and what a report should contain. Too much is left to the discretion of the Trust who appears to approach the process without any clear structure or consistency around what a good investigation report should look like. This approach leads to a significant inconsistency in the quality of post-death investigations. The lack of guidance and inability to appeal in instances of poor or inadequate investigations has the effect of undermining public confidence in the effectiveness of such investigation processes.

- Best practice standards are essential and provide an opportunity to quality assure the investigations undertaken. However, a key component of any investigation must be the input of the family's questions and concerns and any guidance and standards must evaluate the family liaison undertaken and opportunities families were given to effectively participate and have their concerns addressed. Consideration should also be had to introduction of statutory guidance which would require Trusts to carry out investigations in a timely manner, unless exceptional circumstances apply. Such guidance would also require regular and meaningful updates are provided to families.

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

- Organisational culture and doing things in their way without interference or oversight. The inconsistency of approach and the practices, diversity of policies and standards and the complex framework of the NHS.

Question 3b: How could such difficulties be addressed?

- The implementation of statutory guidance setting out the above in clear and unequivocal terms.

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?

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?

- Whilst a greater focus on family liaison is very welcome, this role must be about ensuring that families are equipped and empowered with the knowledge, advice, and information about the investigation process and how to properly participate. This is about ensuring that they know their legal rights. Central to this is advising them of their rights to engage a solicitor to support them through the investigation process. INQUEST would also urge the MWC to support the call for non means tested legal aid to be made available for families to be represented and supported through the investigation process.

- Based on the information available in the proposal, it does not appear that the role of CLO will in fact enable full and effective participation of families and therefore, will not enable an Article 2 compliant investigation to take place. For example, in this proposal there is no opportunity to publicly test the evidence adduced as part of the investigation and establish any disputed facts. It is also unclear whether families will have an opportunity to input into matters such as which witnesses will be questioned or missing potentially relevant evidence, given the lack of a public forum for examining these deaths.

- The CLO role must ensure that Hospitals/trusts provide families with the opportunity to shape the terms of reference of the investigation, to document their questions and concerns and enable them to play an effective part. It is not about being nice to families, of tea and sympathy but empowering them to play a part as equal partners, and receive a clear, honest, compassionate, and sensitive response. Meaningful involvement can play a vital role in their bereavement process.

- The new role must be centred around transparency and communication. Policies and protocols should be developed to clearly define this role and expectations. Families should be able to input into the terms of reference.

- Family involvement is not just about questions of openness but about treating families and carers as important sources of information and evidence about their loved one.

- Families need to be given access to all medical records and evidence, including the evidence of witnesses. It is not good enough to ask them for questions just at the beginning as they cannot meaningfully engage in the process at that stage – they need access to all documents and an opportunity to feed in further thoughts/concerns as the investigation progresses and be invited to offer comments on the draft investigation report.

- Families/carers must be placed at the centre of the investigation process and services must be sensitive to families' needs including for example, faith and cultural traditions, disabilities, literacy levels or second language considerations.

- Clear and agreed time scales are vital. Families need to be updated regularly and in the way they request – (letter, in person, with support worker) and informed of action that is to be taken in response to any concerns identified and given a regular update on progress and deadlines for when draft reports will be shared and sufficient time for families to feedback any concerns, additional questions they want raised. There needs to be continuity of support from the immediate aftermath of the death – advice on post-mortems, access to the body to the conclusions of the investigation processes (and FAI).

- Families need to be updated at the end of the investigation on what actions are being taken to ensure that any learning is acted upon, and this should be followed up to report on progress.

- Training for staff working with bereaved people is vital, this is skilled work that should be recognised as such, and support put in place involving bereaved people who have been through the investigation processes, and they should be remunerated for their input. Training should also include working within an anti-racist and anti-discriminatory framework and with vulnerable groups such as children.

Question 5b: How could your concerns be addressed?

- INQUEST is concerned about the dearth of advice and support to families bereaved after a death in custody and detention in Scotland and the lack of an independent organisation like INQUEST to offer independent advice and support.

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.

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

- Collation and publication of statistical data. As in England and Wales, reporting and monitoring of deaths that occur have been problematic in Scotland – from MWC information a clear gap in data with at least 7% not reported and another 16% no information given. There is a lack of coherent source of statistical data which makes it difficult to produce a clear analysis – particularly important regarding age, gender, race, disability and also institution/Trust. It seems the MWC are well placed for this to enable consistency, more effective oversight and understanding.

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

- Clearer understanding of how racism and discrimination can become institutionalised with organisational culture and practice. For example, the well documented use of force against Black and racialised people, the treating of self-harm and suicidal ideation as 'manipulative' behaviour and the use of oppressive measures such as seclusion.

- The impact on girls and women who have experienced domestic violence and abuse – use of male staff, strip searching, over medication and lack of access to gender and trauma informed therapeutic services and treatment.

- Understanding Autism, its links to co-morbid mental health conditions, self-harm, and suicidal ideation, and how to communicate with autistic children and adults.

- Training and involvement of people in the promotion of anti-discriminatory, trauma informed and culturally competent practice.
- Clearer understanding of how racism and discrimination can become institutionalised with organisational culture and practice. For example, the well documented use of force against Black and racialised people, the treating of self-harm and suicidal ideation as 'manipulative behaviour and the use of oppressive measures such as seclusion.

- Girls and women who have experienced domestic violence and abuse – use of male staff, strip searching, over medication and lack of access to gender and trauma informed therapeutic services and treatment.

- Protocols for dealing with racist and discriminatory conduct by staff and other patients.

- Complaints processes for reporting concerns to form part of any induction processes for patients and their families.

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

- If voluntary patients are excluded from this process, then it is difficult to see how there will be any proper scrutiny and public learning and awareness of child deaths and the many issues raised about their treatment and care.

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

- Child informed practice (and considering above).

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

☐ Yes ☒ No ☐ Not sure

- INQUEST has serious concerns that these proposals are not Article 2 compliant as the investigation is not independent (as already discussed in question 1), they do not appear to allow for effective participation by the families and with the NHS carrying out the investigation with no fatal accident inquiry there is no element of public scrutiny.

- In the case of Savage v South Essex NHS Trust (2008) UKHL, the House of Lords recognised that where mental health patients are detained under mental health legislation the authorities have a positive duty under Article 2 of the ECHR to safeguard them from taking their own lives. This in turn creates a parasitic duty under Article 2 to investigate when such deaths do occur.

- In the context of England and Wales, the Coroners and Justice Act 2009 introduced clauses which impose a duty on coroners to conduct a more thorough investigation into deaths in mental health detention and stipulates that deaths in mental health detention which are '*violent, unnatural or where the cause of death is unknown'* should be scrutinised at inquests before a coroner sitting with a jury.

- This is the latest in a series of developments that have strengthened the legal framework that protects the lives and safety of in patients in England and Wales. Patients on mental health wards are at a particularly significant risk of suicide - for many it is the reason for their admission- and are often extremely vulnerable because of their mental health. The responsibility for their treatment and care is often total and can involve the use of force and compulsory medical treatment.

- As has been recognised, there is currently no independent system for investigating the deaths of mental health patients in Scotland. This lack of independence hampers the ability to root out issues of system neglect or misconduct and jeopardises the welfare of future patients by failing to address such concerns. In Scotland this is exacerbated by the failure of the FAI to scrutinise these deaths which raises serious questions about whether this failure is in breach of Article 2 of the Human Rights

Act. (See question 1 response). The current situation effectively means that there is no public scrutiny at all of highly vulnerable people dying in the care of the state.

- It is also concerning to see that the investigation of the deaths of those voluntary, non-detained patients are not included in this proposal.

- In February 2012, the Supreme Court held that hospitals owe an Article 2 duty to non-detained mental health patients in certain circumstances. Therefore, the complete exclusion of such patients from the current proposal is likely to be in breach of the government's obligations under Article 2.

- This exclusion denies oversight and monitoring of this group of patients. Those who are admitted to mental health settings are at a significant risk of self-inflicted death, whether they are formally detained, or informal patients and those deaths are equally preventable. Policy on suicide prevention does not distinguish in terms of category of in-patients. Informal patients may be subject to the same coercive and restrictive measures as detained patients and restriction of their freedom of movement. These measures include locked doors on wards, highly structured activities, close levels of monitoring and observation, restrictions on access to items and the use of restraint and seclusion. This group is also disadvantaged by the lack of legal safeguards available to non- detained patients.

- Following the deaths of in-patients where there has been or may have been a breach of the duty to protect their lives, the state is under an obligation to conduct an investigation into the death. The Article 2 procedural obligation includes:

- ensuring that the full facts are brought to light;
- that culpable and discreditable conduct is exposed and brought to public notice, and those responsible are identified and brought to account;
- that suspicion of deliberate wrongdoing (if unjustified) is allayed;
- identifying and rectifying dangerous practices and procedures;
- ensuring that lessons are learned that may save the lives of others;
- safeguarding the lives of the public and reducing the risk of future breaches of Article 2.

The investigation into deaths that engage the right to life must meet minimum standards, including:

- the investigation must be independent;
- the investigation must be effective;
- the next of kin must be involved to an appropriate extent;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the state must act of its own motion and cannot leave it to the next of kin to take conduct of any part of the investigation.

The lack of any public scrutiny of deaths of people in mental health settings and under the care and control of the state is a matter of serious concern and

one that begs questions about adherence to human rights standards and domestic and international case law.

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

- The mandatory referral of all deaths of mental health patients that are violent, unnatural, or natural cause deaths which arise from an arguable breach of Article 2 or where the cause of death is unknown to a fatal accident inquiry process.

- To ensure independent investigations into unnatural deaths – these would include self-inflicted deaths, deaths following the use of force and those which give rise to concerns about ill treatment/medication and medical failings.

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

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

- Whilst greater independent investigations may have resource implications as would legal aid funding for bereaved families if these reforms were to lead to safer practice and fewer deaths it would be a price worth paying. It also addresses the current inequality of arms that exists between bereaved families and state agencies, the latter of which presently benefits from unfettered access to public funding for legal representation.

- No monetary value can or should be placed on a human life. However, what would minimise financial impact would be if these reforms were to lead to safer practice, better preventative measures, and therefore fewer deaths. This in turn would result in fewer investigations, civil actions, and related costs for Trusts. It would also minimise the likelihood of retraumatising families with better quality effective investigations, an end to the defensiveness and closed cultures, and a process in which they have been involved and that have provided scrutiny, an acknowledgment of failings or changes to be made. Investigations can be traumatising and result in individuals requiring mental health or other support services.

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

- INQUEST work with families when the worst imaginable thing has occurred. Many of these deaths can be avoided but the absence of a framework or coordinated response among public bodies to ensure that investigation, inquiry, review, or inquest outcomes feed into concrete implementation of learning and demonstrable action is a significant failure of accountability that must be addressed.

- The lack of any national system for independent monitoring and oversight is allowing dangerous systems and institutions to go unnoticed and unchecked. INQUEST

believes that a national oversight mechanism that can audit, monitor, and follow up on progress on recommendations after state related deaths could play a vital role in filling the accountability gap that exists. This must be supported by an independent investigation process that complies with Article 2.

- Regardless of the type of investigation process adopted in Scotland moving forward there should be a requirement that families and carers are involved in monitoring and evaluating this new process as it will be untested and its effectiveness needs to be tested by families, patient's groups etc. Families should also sit on an advisory panel to ensure their views feed into processes as they develop and are reviewed.

- **It is clear from our work in Scotland that the Fatal Accident Inquiry process is in need of urgent review and fundamental reform.**

- **Ultimately this is about human rights. It us about the accountability of the State and its institutions.** We are all committed to an NHS that does its best to protect those in its care. It is about all of us and how we would want to be treated after a death or patient harm, for our loved ones lives to be valued. It's about what happens to any one of us or our family members. Families have a vital role to play and good quality investigations with meaningful family engagement that can point to any changes needed to prevent future deaths and then result in those changes being implemented is of benefit to us all and to the public interest. Ultimately, they can save lives.

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.