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

Analysis of responses to a consultation on a proposal from the Mental Welfare Commission for Scotland

Final report

Dawn Griesbach and Jennifer Waterton
Griesbach & Associates and Jennifer Waterton Consultancy

11 March 2022

Table of contents

Executive summary

1. Between 7 December 2021 and 15 February 2022, a public consultation was carried out on behalf of the Mental Welfare Commission for Scotland (the Commission) by independent researchers, Dawn Griesbach (Griesbach & Associates) and Jennifer Waterton (Jennifer Waterton Consultancy). The purpose of the consultation was to invite views on the Commission's proposal for a new system for investigating the deaths of all people who, at the time of their death, were subject to an order under mental health legislation in Scotland.

2. The consultation document contained four main sections providing (i) details of the background to the consultation, (ii) an overview and description of the revised process, (iii) a proposal for better involving families and carers in the investigation of deaths, and (iv) other matters for consideration, including the values and principles underpinning the proposal; the potential impacts on equality groups and children and young people; human rights; and the potential financial and administrative impacts.

3. The consultation contained a combination of closed (tick-box) and open questions – there were 11 questions in total. Respondents could submit their views online, through SmartSurvey, or by email.

4. In addition, three engagement events were held during the consultation period for (i) families and carers of people with mental health conditions and (ii) people working in health and social care services. The purpose of the events was to allow participants to discuss the proposals, and to encourage them to submit written responses.

Description of the responses and respondents (Chapter 2)

5. The analysis was based on 42 responses received from 22 organisations and 20 individuals. Four of the 20 individual respondents identified themselves as a family member or carer of a person who died whilst being treated under mental health legislation in Scotland. Organisational responses were submitted by NHS organisations, regulatory and professional bodies, third sector organisations, and health and social care partnerships.

6. In addition, 16 individuals attended the engagement events including two individuals with a family member who died whilst in compulsory care.

The Commission's role in investigating deaths (Chapter 3)

7. Respondents were asked if they agreed that the Commission should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases. There were mixed views on this question with just over half answering 'yes', a third answering 'no' and a sixth answering 'not sure'. Organisations were more likely than individuals to say 'yes'.

8. There were three main perspectives:

- The first group of respondents expressed relatively unqualified support for the Commission's proposed role. Some in this group highlighted difficulties which would

need to be addressed, but these were not expressed as significant or especially challenging to overcome. This small group comprised around a sixth of respondents.

- The second, much larger group of respondents identified a range of difficulties or raised significant concerns and caveats. This group included those who supported the proposed role of the Commission in principle, those who offered qualified support for the role, and those who were unsure. Many in this group wanted clarification of the Commission's proposals before they could offer full support. This group comprised just over half of respondents.
- The third group – which comprised a third of respondents – did not support the Commission's proposal.

9. Whilst some respondents saw the Commission as 'strategically well placed' to take on this role, others did not see the Commission as sufficiently independent. A variety of concerns and potential difficulties with the proposal were highlighted. Concerns were voiced, predominantly by organisations, about (i) the language in the consultation document – specifically its use of the term 'investigation' (which implies a legal process aimed at apportioning blame) rather than 'review' (a learning / improvement process), (ii) the potential for the new process to cause confusion in relation to other existing processes for investigating deaths, and (iii) the lack of attention in the consultation document to the welfare and capacity of staff. In addition, there were concerns, predominantly among individuals and third sector organisations, about the (perceived) lack of independence of the Commission, and the lack of independence in the proposed review process itself.

10. Respondents expressed a range of views about which deaths should be investigated. Whilst some were content that **all** deaths which occur during compulsory care and treatment should be investigated, as required by Article 2 of the ECHR, others argued for the focus to be on specific types of deaths. The latter group emphasised the importance of proportionality in determining which deaths will be investigated.

Annual report, guidance and standards (Chapter 4)

11. Respondents were asked if they agreed that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations. There was general support for this proposal with three-quarters of respondents answering 'yes'. Organisations were more likely than individuals to agree.

12. Respondents offered suggestions regarding (i) the purpose – and added value – of the annual report, (ii) its coverage, content and style, (iii) publication and dissemination of the report, and (iv) the role of the Commission in monitoring any recommendations or learning based on findings in the report.

13. Respondents were asked if they agreed that the Commission should develop guidance and standards for use by local services when undertaking investigations. Overall, a large majority of respondents agreed. The overall pattern of views was similar among organisations and individuals.

14. There was a common view that any standards or guidance in this area should have the effect of promoting consistency in investigations and reporting. Respondents noted, however, that standards and guidance for reviewing deaths during care / treatment already exist; it was therefore suggested that any standards and guidance developed by the Commission should dovetail with these. Some respondents also offered suggestions about (i) the content of the standards and guidance and (ii) the process of developing them.

15. Some respondents (mainly individuals) expressed concerns about the implementation of standards and guidance. This group thought systems would need to be put in place to ensure that services adopt and comply with any standards and guidance produced.

The revised process (Chapter 5)

16. Respondents were asked if they had any comments on the Commission's proposed six-stage process for investigating deaths during compulsory treatment. This was an open question and many of the responses (particularly from organisations) were lengthy and detailed. However, there were several recurring themes:

- There are challenges for services in identifying all deaths which occur during, or shortly after a period of compulsory treatment.
- Proportionality (as mentioned above) was seen to be important in determining which deaths will be investigated.
- Respondents wanted clarification about who would (or should) be involved in the initial review of cases
- There were concerns (mainly among organisations) about the review process (and decision-making) being directed by an external organisation – and concerns also about the lack of independence in the process if local services are responsible for conducting reviews
- The involvement of families throughout the process was seen to be vital
- The timescales for investigations – timescales proposed in the consultation document were longer than current standards
- Concerns about whether and how the findings of investigations will be implemented and monitored.

The role of the Commission Liaison Officer (Chapter 6)

17. Respondents were asked if they thought the proposed new role of a Commission Liaison Officer (CLO) would help to improve the involvement of, and communication with, families and carers during the investigations of deaths. Overall, two-thirds of respondents said 'yes', but nearly a third were 'not sure'. Organisations were more likely than individuals to say 'yes', and individuals were more likely to say 'not sure'.

18. In their comments, respondents discussed (i) the independence of the Commission Liaison Officer, (ii) the possibility for duplication and confusion in relation to the role, (iii) the importance of ensuring that the role had sufficient status and seniority, (iv) the definition and scope of the role, and (v) practical and operational requirements of the role.

Respondents also highlighted the importance of families / carers being involved in the selection of the Commission Liaison Officer.

Values and principles (Chapter 7)

19. The consultation document explained that, in order for the Commission's proposals to be in line with its statutory duty to act in a manner which seeks to protect the welfare of persons who have a mental health condition or learning disability, the revised process must: be independent; deliver local accountability; involve families and carers in a meaningful way; be informed by standards and guidance based on good practice; be characterised by openness, honesty and transparency; and provide clear, accessible and timely reporting.

20. Respondents were asked if they agreed that the revised process for investigating deaths would meet these values and principles. There were mixed views on this question, with half of respondents answering 'yes', a third saying 'not sure' and the rest saying 'no'.

21. Respondents highlighted additional values and principles which should be included or proposed extensions to the values and principles. Some thought the values and principles would not be met because of a (perceived) lack of independence in the revised process, or they raised other caveats and concerns in relation to the values and principles.

Potential impacts of the new process of investigating deaths (Chapter 8)

22. Respondents were asked if they had any comments on the potential impacts of the revised process on those with protected characteristics and on children and young people, and what they thought could be done to minimise any negative impacts.

23. In relation to people with protected characteristics, respondents identified potential negative impacts of the revised process for non-mental health patients and older people. Suggestions for mitigation focused on monitoring and measurement; consultation and engagement; and training.

24. In relation to children and young people, respondents identified potential negative impacts in two situations: (i) where a child dies, and their death requires to be investigated; and (ii) where a child may be the next-of-kin of an individual who died.

25. Respondents were asked if they agreed that the revised process (as set out in the consultation document) was human rights compliant. There were mixed views on this question. Over half thought it was compliant, but a sixth said 'no' and a quarter said 'not sure'. There was a similar pattern of views among organisations and individuals.

26. Respondents pointed out that under Article 2 of the European Convention on Human Rights, there is a procedural requirement to investigate the deaths of all individuals who die when detained by the State. These investigations have certain essential requirements for: (i) independence, (ii) effectiveness, (iii) promptness and reasonable expedition, (iv) public scrutiny, (v) involvement of next-of-kin, and (vi) initiation by the State. Respondents identified specific ways that the Commission's proposal could be improved to be more compliant with Article 2.

27. Finally, respondents were asked if they had any concerns in relation to the potential financial or administrative impacts of the revised process. Some respondents identified no impacts, or they identified potential positive impacts. Those who identified potential negative impacts expressed concerns that the revised process would introduce new layers of bureaucracy, would require increased liaison between organisations, and would need (substantial) additional resource both in terms of clinical and administrative time.

Other comments (Chapter 9)

28. Both organisations and individuals made a range of disparate other comments. One which was common to both groups related to a concern that the Commission's proposal would cover only people who died during compulsory treatment. Respondents who raised this issue thought that the proposal should be extended to a range of other groups, including people who are treated for a mental health condition in hospital on a voluntary basis; those who have asked for treatment and been assessed, but turned away without treatment; and those who have died whilst subject to the legislative provisions of the Adults with Incapacity Act 2000, the Adult Support and Protection Act 2007, or the Social Work (Scotland) Act 1968.

1. Introduction

1.1 This report presents the findings of a public consultation carried out on behalf of the Mental Welfare Commission for Scotland (hereafter 'the Commission'). The consultation invited views on a proposal developed by the Commission for a new system for investigating the deaths of all people who, at the time of their death, were subject to an order under mental health legislation in Scotland. This proposal was developed in response to an action arising from a Scottish Government Review (published in 2018).

1.2 The Commission's proposal relates to all people who have died whilst on a compulsory treatment order in the community or in hospital, or who were compulsorily detained on other orders in hospital for assessment and treatment, including those whose detention in hospital was suspended at the time of their death. For the sake of brevity, these deaths will be referred to in this report as 'deaths during compulsory treatment'. The Commission's proposal did not cover people who were admitted to hospital or treated in the community on a voluntary basis.

1.3 Independent researchers, Dawn Griesbach (Griesbach & Associates) and Jennifer Waterton (Jennifer Waterton Consultancy), were commissioned to carry out the consultation and analyse the responses.

The consultation

1.4 The consultation was published on 7 December 2021 and ran for 10 weeks until 15 February 2022. The consultation document included four main sections which covered (i) the background to the proposal, (ii) an overview and description of the revised process, (iii) proposed arrangements for involving families and carers in the investigation of deaths, and (iv) other matters for consideration. These other matters included the values and principles underpinning the proposal; the potential impacts on equality groups and children and young people; human rights; and the potential financial and administrative impacts.

1.5 The consultation contained a combination of closed (tick-box) and open questions focusing on different aspects of the Commission's proposal. The open questions specifically invited comments about difficulties or concerns, and suggestions for improvement. There were 11 questions in total.

1.6 Respondents submitted their views online, through SmartSurvey, or by email. In addition, three engagement events were held during the consultation period.[1] The purpose of the engagement events was to:

- Briefly outline the proposals
- Allow people to raise any concerns about the proposal
- Encourage people to suggest solutions that would address their concerns
- Invite people to take part in the online consultation.

[1] Initially, only two events were planned. However, a third event was subsequently organised due to over-subscription of the second event.

1.7 The first event was intended for family members or carers of people with a mental health condition or learning disability, or those who provide family / carer support services. The second and third events were for people working in health or social care services.

1.8 All of the events took place online (using Zoom or Microsoft Teams). The events were audio-recorded and a detailed anonymised note of the discussion was typed up afterwards and circulated to participants for comment. The final agreed versions of the notes of these events have been incorporated into the analysis presented in this report. The notes have also been published separately alongside the responses to the consultation.

1.9 Throughout this report, those who took part in the consultation will be referred to as 'respondents'. This term covers **both** those who submitted written responses **and** those who took part in the engagement events. Note, however, that the numbers shown in the tables in the report relate only to those who submitted written responses.

Analysis of the consultation responses

1.10 Frequency analysis was undertaken in relation to all the closed questions in the written consultation responses. The responses to open questions were analysed qualitatively with the aim of identifying the main themes and any areas of agreement or disagreement between respondents – including areas of concern and suggestions for improvement.

1.11 Not all respondents answered every question, and in some cases, respondents made comments in relation to a question without answering the related closed question. In the latter case, if a respondent's reply to the closed question was clearly stated in their written comments, the response to the closed question was imputed. The tables in this report include such imputed responses.

1.12 As with all consultations it is important to bear in mind that the views of those who have responded are not representative of the views of the wider population. Individuals (and organisations) who have a keen interest in a topic – and the capacity to respond – are more likely to participate in a consultation than those who do not. This self-selection means that the views of consultation participants cannot be generalised to the wider population.

1.13 For this reason, the approach to consultation analysis is primarily qualitative in nature. Its main purpose is not to identify how **many** people held particular views, but rather to understand the full range of views expressed.

Structure of the report

1.14 The following chapter provides a description of the consultation responses and respondents. Chapters 3–9 then present the main findings of the consultation, on a question-by-question basis. The report includes three annexes containing (i) a list of the organisational respondents, (ii) a summary of comments relating to the six stages in the proposed new process for investigating deaths during compulsory treatment, and (iii) material relating to comments about increasing compliance with Article 2 of the ECHR.

2. Description of the responses and respondents

2.1 This section provides a brief description of the responses to the consultation and the respondents.

Number of written responses received and included in the analysis

2.2 As noted in Chapter 1, submissions to the consultation could be made online via a SmartSurvey web interface, or by email or post.

2.3 Thirty-five (35) responses were received through the online form and 16 were received by email. Responses submitted via SmartSurvey were downloaded as an Excel file, and the offline responses were entered into this database. Following this, an initial review of the database found that seven of the online responses were entirely blank. These seven responses were removed. Two responses were found to be exact duplicates – one of these had been submitted online and a copy sent by email. One of these responses was removed from the database. Finally, two different responses were received from a single individual who submitted a response online and then sent additional comments by email. These two responses were combined, and the respondent was included only once in the analysis. Thus, **the analysis was based on 42 responses**. Table 2.1 below provides a summary of this process.

Table 2.1: Responses received and responses included in the analysis

Types of responses received / removed	Number of responses
Responses received	
Responses received through SmartSurvey	35
Responses received by email	+16
Total responses received	**51**
Responses removed	
Blank responses	-7
Duplicate responses	-1
Multiple responses combined	-1
Total responses removed	**-9**
Total responses included in the analysis	**42**

Description of respondents to the written consultation

2.4 In total, 22 organisations and 19 individuals took part in the written consultation. In addition, one response was submitted by a group of individuals (Table 2.2). In the tables throughout this report, the latter response has been grouped together with the other responses from individuals.

Table 2.2: Responses received, by respondent type

Respondent type	Number	Percent
Organisations	22	52%
Individuals*	20	48%
Total responses	**42**	**100%**

* Note that one response was submitted by a group of individuals. This has been categorised as an individual respondent – as opposed to an organisational respondent – for the purposes of analysis.

Individual respondents

2.5 Four (4) of the 20 individual respondents identified themselves as a family member or carer of a person who died whilst being treated under mental health legislation in Scotland. It was clear from the responses that some individual respondents also worked in health and social care services.

Organisational respondents

2.6 Responses were submitted by a range of organisation types as shown in Table 2.3 below. NHS organisations comprised the largest group of organisational respondents, followed by regulatory and professional bodies, and third sector organisations. Health and social care partnerships (which included one multi-disciplinary team working across health and social care services) were the fourth main category of organisational respondents. The remaining two respondents comprised one other statutory organisation and a (non-statutory) patients' rights group.

Table 2.3: Organisational responses, by organisation type

Organisation type	Number	Percent
NHS organisations	6	27%
Regulatory and professional bodies	5	23%
Third sector organisations	5	23%
Health and social care partnerships*	4	18%
Other organisations	2	9%
Total organisational responses	**22**	**100%**

* Note that one response in this category was submitted by a multi-disciplinary team working across health and social care services.

2.7 A complete list of the organisational respondents is shown in Annex 1 of this report.

Engagement events

2.8 As mentioned in the previous chapter, three engagement events were held during the consultation period. The events were attended by 16 individuals in total including two individuals who had experience of a family member dying whilst in compulsory care. One participant reported having had experience of a family member who **could** have died – because of the treatment that individual received whilst subject to an order under mental health legislation.

2.9 Of the 16 individuals who attended engagement events, most also submitted a written response to the consultation as an individual, or a response was submitted on behalf of the organisation they represented.

3. The Commission's role in investigating deaths (Q1)

3.1 Section 2 of the consultation document provided an overview of the Commission's proposed new process for investigating deaths during compulsory treatment. This section of the document discussed the role of the Commission in the revised process. It was explained that the Commission would be responsible for initiating, directing and quality assuring the process of investigating all deaths during compulsory treatment. In addition, the Commission would also have a role in synthesising and distilling the learning from these investigations; disseminating the main messages to relevant audiences; ensuring that any follow-up actions from local investigations are implemented; and escalating cases to the Scottish Government and Ministers, as appropriate, where recommendations are not implemented satisfactorily.

3.2 The consultation included a series of questions inviting views on the Commission's role in the proposed new process, and the process itself. This chapter presents an analysis of the responses to the first of these 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?

Question 1b: How could such difficulties be addressed?

3.3 Respondents were asked if they agreed that the Commission should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases. Table 3.1 shows that, overall, just over half of respondents (19 out of 37) answered 'yes' to this question, a third (12 out of 36) answered 'no' and a sixth (6 out of 37) were not sure. Organisations were more likely than individuals to say 'yes'. As the table shows, individual respondents were more likely to say either 'no' or 'not sure' to this question, rather than to agree.

Table 3.1: 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		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	11	61%	5	28%	2	11%	18	100%
Individuals	8	42%	7	37%	4	21%	19	100%
Total	**19**	**51%**	**12**	**32%**	**6**	**16%**	**37**	**100%**

3.4 Respondents were asked if they foresaw any difficulties with this arrangement and if so, how such difficulties could be addressed. Altogether, 19 organisations and 17 individuals provided comments. It should be noted that, of those who answered 'yes' to this question, just four individuals and one organisation identified no difficulties with the proposal. All other respondents who answered 'yes' identified potential difficulties – in some cases, multiple difficulties – or they expressed caveats and significant concerns about the

proposal. Many of these comments echoed the views of respondents who answered ‘no’ or ‘not sure’ to this question.

3.5 There were three main perspectives:

- The first group of respondents expressed relatively unqualified support for the Commission’s proposed role. Some in this group highlighted difficulties which would need to be addressed, but these were not expressed as significant or especially challenging to overcome.
- The second group of respondents identified a range of difficulties or raised significant concerns and caveats. This group included those who supported the proposed role of the Commission in principle (they ticked ‘yes’ at Question 1), those who offered qualified support for the role, and those who were unsure. Many in this group wanted clarification of the Commission’s proposals before they could offer full support.
- The third group of respondents did not support the Commission’s proposed role in initiating, directing and quality assuring the process of investigating deaths during compulsory treatment. These respondents answered ‘no’ at Question 1.

3.6 Respondents’ comments at Question 1 were often lengthy and detailed. The sections below discuss the **main** recurring themes arising in the responses. These focused on (i) perceptions of the Commission and the appropriateness of its proposed role, (ii) the purpose in investigating deaths during compulsory treatment, (iii) the importance of independence and transparency, (iv) the relationship between the proposals and other related processes for investigating deaths, (v) staffing issues, and (vi) views about which deaths should be investigated. Each of these themes is discussed below.

Perceptions of the Commission and the appropriateness of its role

3.7 Question 1 specifically asked respondents for their views about whether the **Commission** should take a leading role in the investigation of deaths. Not all respondents directly addressed the issue of whether the Commission – rather than some other organisation – was best placed to take on this role. Those who did had disparate views – both positive and negative.

3.8 Some respondents, mainly organisations, saw the Commission as ‘strategically well placed’ to have a role in initiating, directing and quality assuring such investigations. These respondents acknowledged that the Commission had the necessary powers to undertake this work, and they saw the Commission’s independence (from the Scottish Government and the NHS) as advantages. Others suggested that the involvement of the Commission would help to bring about a more consistent and coherent investigation system – given its expertise and powers of investigation. However, within this group, there were questions about whether the Commission would (i) have the necessary capacity to take on this role (and if it did not, it was suggested that additional capacity / funding should be made available), and (ii) might need additional statutory powers to take on this role.

3.9 Some individual respondents and some organisations did not think the Commission was the best organisation to have this responsibility. Whilst some in this group (mainly

individuals) simply stated that the Commission was ‘not trusted by service users and their families’, others expressed specific concerns about the Commission’s perceived lack of independence. This group argued that the Commission had a clear conflict of interest because its staff are largely drawn from a variety of disciplines in health and social care services and are therefore immersed in these organisational cultures. This, it was suggested, made it impossible for the Commission to take an independent and objective view of the (local) services which it would be investigating. These respondents also argued (and sometimes offered examples based on their understanding of published Commission reports) that the Commission had been unwilling in the past to challenge poor practices in mental health services, and they thought the Commission was not an organisation that was capable of ‘uncovering the truth’, ‘getting to the root of a problem’, ‘holding services to account’, or ‘challenging them to adhere to professional best practice and human rights standards’.

3.10 There was a further specific concern within this group that the Commission would be unable to be impartial in any investigation which might result in the organisation itself being implicated in wrongdoing – for example, in cases where concerns had previously been raised by relatives or staff, but where the Commission’s failure to investigate at the time may have contributed to the person’s death. One professional / regulatory body also queried whether the Commission would have the necessary independence to be able to quality assure reports in cases where there had been substantial direction and / or investigation by the Commission itself.

3.11 Another organisation also expressed concern about the Commission’s lack of independence. However, this organisation suggested that the lack of independence was related to the Commission’s statutory purpose, which is to protect the welfare of persons who have a mental health condition or learning disability. In other words, this respondent suggested that the Commission could potentially be biased **against** (local) services because of its statutory purpose.

3.12 Given their concerns about the Commission’s perceived lack of independence, some respondents argued that a new, independent investigatory body should be established to investigate deaths during compulsory treatment. There were also suggestions that the justice system (the Crown Office and Procurator Fiscal Service (COPFS)) were better placed to provide the required level of independence. One respondent argued that any body with responsibility for investigating deaths during State custody should have judicial powers (and the willingness to use them) to enforce change and hold individuals and organisations to account. This respondent suggested that this body should itself be under critical scrutiny and should be governed by an equal number of professionals and service users / carers with a proportion of these having experience of the death of a relative in State custody.

3.13 Setting aside concerns about the Commission’s independence, two respondents (one organisation and one individual) gave different reasons for suggesting that the Commission was not the best organisation to have responsibility for initiating, directing and quality assuring the process of investigating deaths. These respondents focused on the Commission’s lack of knowledge and expertise in this area. Specifically, the point was

made that the Commission did not have the necessary clinical expertise, or experience of commissioning or quality assuring reviews of deaths. By contrast, they argued, local health boards have considerable expertise in this area. One respondent suggested that decisions about reviews should be made locally – rather than by an external organisation / group. Another stated that they 'fundamentally disagree that the external initiation and direction of reviews is a progressive step'.

3.14 Organisations proposed various alternative roles for the Commission in the process of investigating deaths during compulsory treatment. For example, one respondent thought the Commission could usefully quality assure and assist with the review process, rather than having the main decision-making role. Another organisational respondent made a more specific suggestion that the Commission could be involved in reviewing SAER recommendations and actions plans and using its independent status to have ongoing dialogue with families about satisfaction with timeframes and level of communication with the investigating authority. The Commission could also work more closely with medical records and other administrative systems to ensure that the notification of death process is improved and to ensure compliance from all areas. There was a view that improvements in reviews of death may be needed, but that giving the Commission the role of initiating and directing was likely to be impractical and unlikely to result in additional learning.

Purpose in investigating deaths during compulsory treatment

3.15 A key concern raised frequently by NHS, HSCP and professional / regulatory organisations was in relation to their perceptions of, or beliefs about, the **purpose** of the proposed new system for investigating deaths during compulsory treatment.

3.16 These organisations were concerned about the language used in the consultation document, which they perceived as representing a shift in the purpose of reviewing deaths. Specifically, they noted that the term 'investigation' was used interchangeably throughout the consultation document with the term 'review'. Those who raised this issue suggested that health and social care staff were likely to have very different understandings of the purpose of a 'review' (which is about learning / improvement) as compared with an 'investigation' (which implies a legal process aimed at apportioning blame). There was a suggestion that 'investigative' processes were less likely to produce learning outcomes, and would, in fact, undermine the learning culture established in many health and social care organisations, which encourages and supports the reporting and review of adverse events.

3.17 These respondents suggested that staff may be less likely to engage freely with an 'investigatory' process – as opposed to a 'review' process – and more likely to seek union representation for an investigation. It was also suggested that the Commission may, in fact, find it difficult to recruit staff to take part in the initial review process, or to act as the review lead, if the main purpose of the exercise was to apportion blame.

3.18 Some respondents saw the potential for unintended outcomes from this perceived shift in aim – including a decrease in staff engagement in the wider adverse event review reporting system.

3.19 Respondents who raised these concerns emphasised the importance of a ‘considered and continual effort’ by the Commission to communicate and consult to address concerns regarding the proposal. This was seen to be vital in order for the new process to be introduced successfully.

3.20 In contrast to these concerns, other respondents discussed the importance of public accountability – as well as learning – and the need for services to be held accountable for deaths which were caused by clinical failures, including the ‘inappropriate’ prescribing of medication. Some respondents (individuals in particular) expressed concerns about services putting up barriers to the investigation process and, as noted above, some saw a possible need for greater statutory powers for the Commission, whilst others thought the Commission would be unable to overcome these barriers.

3.21 A third view was expressed by some organisations: that investigations must be undertaken into the deaths of all individuals who die whilst in State custody – including those who have died whilst being compulsorily detained through mental health legislation – to comply with Article 2 of the European Convention on Human Rights (ECHR). This argument is discussed in more detail in Chapter 8 in relation to the human rights compliance of the Commission’s proposals.

Managing conflicts of interest and ensuring independence

3.22 As discussed above, respondents often expressed concern about the perceived lack of independence of the Commission in initiating, directing and quality assuring the investigation process. However, some respondents – particularly individuals and some third sector organisations – were also concerned about the proposal that local services would conduct the investigations – albeit in some cases, there would be an external chair or the Commission itself may conduct the investigation. This proposal was seen to be a ‘glaring conflict of interest’.

3.23 One organisation stated that ‘the overriding need for independent investigations sits at the heart of improving the structure and quality of the investigation system’ and that ‘too many families report the approach after a death being one of reputation management, and lack of transparency’, notwithstanding the organisational duty of candour.

3.24 Some respondents suggested that this issue could be addressed by giving the Commission ‘complete autonomy in these investigations’, by ‘introducing legally binding protocols’, or by giving the Commission the responsibility for acting as ‘lead investigator’. However, others thought – as discussed above – that the Commission’s involvement itself represented a conflict of interest and lack of independence in the process.

3.25 In contrast to these views, there was a suggestion that, in addition to the need for an investigation to be independent and objective, it was also important that someone local, who knew the deceased person well from a medical perspective, should be represented on the investigation panel to ensure that there was an accurate understanding of case.

Relationship to other related processes for investigating deaths

3.26 A common theme in the responses from organisations and, to some extent, also from individuals was that the Commission's proposals had the potential to duplicate, conflict with, and / or create significant additional work in relation to existing well-established systems and processes for investigating deaths.

3.27 Respondents wanted to know how the Commission's proposals would link to and align with these processes, including the SAER process and the work of SCIREG (Serious Clinical Incident Review Executive Group). Other processes mentioned by respondents included Initial and Serious Case Reviews (conducted by local authorities), investigations by the Care Inspectorate, the responsibilities of the Crown Office and Procurator Fiscal Service (COPFS) for investigating deaths in custody, and the Lord Advocate's role in initiating Fatal Accident Inquiries (FAI). The point was also made that some of the deaths which could fall under the remit of the Commission's new process may also be subject to investigation by the Health and Safety Executive (HSE) as breaches of health and safety legislation. Some deaths might also be investigated by professional bodies where there may be evidence of impaired fitness to practice.

3.28 Organisational respondents (and some individuals) were concerned that the Commission's proposals could result in (what they referred to as) a 'two-tier' system of reviews – that is, reviews of those who died during compulsory care and treatment may be given greater priority and scrutiny than other deaths of patients cared for by NHS services. Respondents argued that this had the potential to create inequality and cause confusion among staff and bereaved families.

3.29 Some respondents wanted further information about what would be done to avoid families and staff being subjected to two (or more) separate investigatory processes. These respondents emphasised the importance of families and staff being asked to give their accounts only once and having to repeat their accounts again and again for different investigatory processes – which could be very distressing.

3.30 Respondents who raised these concerns emphasised the importance of the Commission working with other relevant bodies to ensure alignment and a joined-up approach between agencies where there is the potential for overlap in roles and responsibilities. Ideally, this group thought that, where an investigation into a death in care is required, there should be **one** standardised process for this, and that this same process should also cover those who die during compulsory treatment under mental health legislation.

3.31 Note, however, that these views were in contrast to those who argued that, under Article 2 of the ECHR, the investigations of deaths which occur during compulsory mental health treatment **must** operate to a higher standard than those which occur in other (non-compulsory) health and social care settings. (See the discussion regarding Question 9 on human rights in Chapter 8.)

Staffing issues

3.32 Respondents made a number of points, and raised a variety of concerns, relating to staff involved in the care of individuals who have died during compulsory treatment. In general, these comments were raised by organisations. Again, concerns were expressed about the tone of the consultation document which, some organisations suggested, implied that staff have malign motives and that they cannot be trusted to provide appropriate care. Respondents who highlighted these concerns made three main points.

3.33 First, supporting staff during the review process was seen to be critical. It was noted that staff can often be distressed and traumatised in the aftermath of a death in the same way that families can. Some respondents expressed concern at the lack of discussion in the consultation document about staff welfare during the process of investigating deaths.

3.34 Second, the lack of capacity within services was seen to be a significant issue – some areas were finding it difficult to recruit clinical staff to undertake reviews due to work pressures. As noted above, some respondents also suggested that if the process is perceived as 'purely punitive', staff are likely to refuse to participate.

3.35 Finally, it was suggested that efforts must be made to ensure staff are fully involved in – and consulted about – any reviews which take place so that this is not perceived as something being done 'to' them. Staff – as well as families and carers – must be involved in investigations in a meaningful way.

Which deaths should be investigated?

3.36 The final main theme which arose in response to Question 1 was in relation to which deaths should be investigated. Respondents had different views about this. Whilst some were content that **all** deaths which occur during compulsory care and treatment should be investigated, as required by Article 2 of the ECHR, others argued for the focus to be on specific types of deaths, for example:

- All self-inflicted in-patient mental health deaths
- Deaths involving the use of force / restraint
- All deaths of children
- All other unnatural or premature deaths.

3.37 There was a suggestion that any death by suicide or accident should have a detailed review with an independent chair.

3.38 Some respondents suggested that the process should **not** include:

- Most deaths which occur in Old-Age Psychiatry Services
- People who die of natural causes (there was a separate suggestion that natural, or expected, deaths and sudden and, potentially, unexpected deaths due to physical health conditions may be subject to a low-level investigation)

- Deaths where the families have no concerns about the circumstances.

3.39 However, there was also a counter-argument that many ‘so-called natural deaths’ were unexpected and preventable – for example, they may have been caused or exacerbated by medication or deficiencies in care. Some respondents argued that the views of families should always be an important factor in determining the scale of investigation required in relation to deaths from natural causes.

3.40 Some respondents emphasised the need for ‘proportionality’ in determining which deaths are investigated and the level of investigation required. Chapter 5 of this report discusses this issue in further detail.

3.41 At the same time, some respondents also queried why the process would not involve those who had been voluntarily admitted to an acute mental health ward, or those who had **asked** to be admitted but were refused before their deaths.

4. Annual report, guidance and standards

4.1 Section 2 of the consultation document stated that, in the proposed new process for investigating deaths during compulsory treatment, the Commission would produce an annual report to summarise the findings of the investigations; and disseminate the main messages to relevant audiences.

4.2 In addition, the consultation document explained that – early in 2022 – the Commission will develop guidance and standards for local services in relation to the new process of investigating deaths. The guidance would cover such issues as (i) ensuring that the level of review is proportionate to the circumstances of the person's death, (ii) involving a range of other (non-NHS) organisations in the investigation, (iii) advising on steps to maximise independence in the local investigative process, (iv) good practice in relation to the commissioning of external expert reviews, (v) putting in place arrangement to ensure that family concerns and questions are responded to and (vi) following up on how learning and recommendations are implemented.

4.3 The consultation included two questions – regarding the production and dissemination of an annual report and the development of guidance and standards. This chapter covers respondents' views in relation to both these questions.

Question 2: Do you agree that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations as described in paragraph 30 above? [Yes / No / Not sure]

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

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]

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

Question 3b: How could such difficulties be addressed?

Commission's role in producing an annual report (Q2)

4.4 Question 2 asked respondents if they agreed that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations. Table 4.1 shows that, overall, three-quarters of respondents (29 out of 38) answered 'yes', 4 out of 38 answered 'no' and 5 out of 38 answered 'not sure'. Organisations were more likely than individuals to agree (17 out of 19 as compared with 12 out of 19). Nearly a quarter of individuals answered 'not sure' in response to this question.

Table 4.1: Do you agree that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations?

	Yes		No		Not sure		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	17	89%	2	11%	–	0%	19	100%
Individuals	12	63%	2	11%	5	26%	19	100%
Total	**29**	**76%**	**4**	**11%**	**5**	**13%**	**38**	**100%**

4.5 Respondents were asked if they could foresee any difficulties with the suggestion that the Commission should be responsible for producing and disseminating an annual report as described in the consultation document – and if so, how those difficulties could be overcome. Altogether, 19 organisations and 9 individuals offered comments.

4.6 Twenty-three (23) respondents – 10 organisations and 13 individuals – who provided a response to the closed question at Question 2 (i.e. almost two-thirds of all respondents) either said explicitly that they could not foresee any difficulties or they simply left the comments fields for this question blank.

4.7 Those respondents who offered comments sometimes prefaced their comments with a general statement to the effect that their responses should be understood and interpreted in relation to the views they had set out earlier, in Question 1.

4.8 In their comments at Question 2, respondents discussed:

- The purpose – and 'added value' – of the annual report
- The coverage, content and style of the annual report and its relation to the local reports
- The publication and dissemination of the annual report
- The role of the Commission in monitoring the implementation of any recommendations and / or learning based on findings in the annual report.

4.9 Each of these aspects are discussed in further detail below.

Purpose and 'added value' of annual report

4.10 There was a range of views in relation to the purpose and 'added value' of the annual report. In general, respondents thought it was appropriate for the report to take a quality improvement approach, and to focus on drawing out the lessons learned. NHS organisations and HSCPs in particular emphasised that the report should not 'take a league table approach' or 'pitch Health Boards against each other'. However, respondents who did not think the Commission should have a role in producing an annual report – especially individuals – focused on accountability and public scrutiny in specific cases, and were sceptical that an annual report could fulfil that function.

4.11 It was noted that other reports which were produced on a regular cycle (e.g. the reports from Healthcare Improvement Scotland, and the National Confidential Inquiry reports) already provided comprehensive feedback on a subset of the cases which would be covered by the proposed annual report. Therefore, the proposed report's 'added value' was seen to be limited. Moreover, one individual noted that the numbers were likely to be too small to be meaningful in terms of drawing out generalised lessons.

Coverage, content and style of annual report

4.12 Respondents wanted confirmation that the annual report was not a substitute for publishing the outcomes of individual local investigations.

4.13 It was suggested that the annual report should be easy to read, with a 'strong narrative' and should include a clear summary of the key messages. One specific request (from two respondents) was that the reports should contain comprehensive information about the protected characteristics of the individuals who had died; this information was currently thought to be inadequate and of poor quality.

4.14 Two other specific suggestions were made:

- The annual report should include information based on the feedback of families on the investigation process.
- The recommendations should not be limited to those that the NHS and other services agree with.

Publication and dissemination of annual report

4.15 The comments relating to publication and dissemination focused on three main issues:

- There should be a presumption in favour of publishing as full an account as possible (especially in cases where an investigation involved an independent chair). However, respondents did recognise that there were potential issues in relation to the sensitivity of the material and the importance of preserving confidentiality (or anonymity) in relation to specific cases.
- Any urgent implications from individual investigations should be published as soon as possible and not held back until the annual report was produced.
- The annual report needs greater 'visibility' than such reports would ordinarily have. The suggestion was made that the report should be published in Parliament, perhaps through a parliamentary health committee. This would, it was argued, aid debate and public accountability. Other suggestions were simply that it should be 'disseminated widely'. The use of the Significant Clinical Incident Review Executive Group (SCIREG) was also mentioned as a relevant forum for discussing the report.

Monitoring the implementation of recommendations / learning from the annual report

4.16 Respondents thought that the Commission should monitor the implementation of recommendations / learning from the annual report. One individual respondent suggested this could involve the Commission undertaking random checks on individual local services. A regulatory body wished to have further information on how any concerns would be escalated if learning or recommendations were not implemented.

Commission's role in developing guidance and standards (Q3)

4.17 Question 3 asked respondents if they agreed that the Commission should develop guidance and standards for use by local services when they are undertaking investigations into deaths during compulsory treatment. Table 4.2 shows that, overall, a large majority of respondents agreed (31 out of 38). Six (6) of the 38 respondents said 'no' and 1 said 'not sure'. The overall pattern of views was similar among organisations and individuals.

Table 4.2: Q3 – Do you agree that the Commission should develop guidance and standards for use by local services?

	Yes		No		Not sure		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	16	84%	3	16%	–	0%	19	100%
Individuals	15	79%	3	16%	1	5%	19	100%
Total	**31**	**82%**	**6**	**16%**	**1**	**3%**	**38**	**100%**

4.18 Respondents were asked if they foresaw any difficulties with the proposal that the Commission develops guidance and standards – and if so, to suggest ways such difficulties could be addressed. Altogether, 19 organisations and 13 individuals offered comments. These raised a range of issues and did not necessarily highlight potential difficulties, or potential solutions to address those difficulties.

4.19 The main points focused on:

- The purpose of developing standards and guidance
- The fact that standards and guidance already exist in this area
- The difficulties of enforcing adherence to standards and guidance
- The content of any standards and guidance
- The process of developing any standards and guidance.

4.20 Each of these aspects is discussed below, followed by a small number of other issues raised by one or two respondents.

4.21 Note that respondents who agreed that the Commission should develop guidance and standards often raised caveats or concerns that were similar to (or the same as) the reasons given by respondents who did **not** agree, or who were unsure.

The purpose of developing standards and guidance

4.22 There was a common view that any standards or guidance in this area should have the effect of promoting consistency in investigations and reporting. The point was made that the current lack of guidance about what an investigation should cover and what a report should include, as well as the inability to appeal in cases of poor or inadequate investigations, has the effect of undermining public confidence in the effectiveness of the investigation process.

Standards and guidance already exist in this area

4.23 A recurring view among organisations was that standards and guidance already exist in relation to reviewing deaths which occur during care / treatment. Respondents pointed to standards / guidance produced by Healthcare Improvement Scotland (HIS), separate guidance produced by HIS for reviewing the deaths of children and young people, and guidance produced by the Royal College of Psychiatrists for reviewing the deaths of patients who are or have recently been in mental health care / treatment services. Some also highlighted existing guidance for responding to complaints.

4.24 Respondents suggested that any guidance and standards developed by the Commission should 'dovetail' with, reflect, and make reference to existing guidance and standards, rather than duplicating or creating alternative standards and guidance. The Commission will also need to clarify how the proposed standards and guidance will interact with other standards and guidance and how information will be shared between systems already established for the investigation of deaths. However, one respondent suggested that the Commission's guidance should be consistent with the existing SAER process – **so long as** this does not undermine the purpose and human rights framework of the Commission's proposed process.

4.25 Organisations and individuals who were not in favour of the Commission developing standards and guidance for investigations generally did so because, they argued, clear guidance and standards are already available. This group did not agree that additional standards / guidance would be needed for reviewing a (comparatively) small number of deaths, and they suggested that a separate set of standards and guidance would simply lead to confusion and further inconsistency.

4.26 One organisation in this group acknowledged that there have been concerns about the robustness and quality of Adverse Event Reviews (AERs) but thought that the appropriate way of addressing this was to improve the quality assurance of AERs (particularly Level 1 AERs), rather than developing a new and different process. Another suggested that – rather than producing new standards and guidance – the Commission's role could instead involve reviewing the reports produced using existing standards and guidance.

Difficulties in ensuring that services adhere to standards and guidance

4.27 Individual respondents who supported the Commission's role in developing standards and guidance often raised concerns about their implementation. This group suggested that systems would need to be put in place to ensure that services are adopting and complying with any standards and guidance produced. The point was also made that interpretations of guidance may vary from one area to another, and it was suggested that examples of best practice and training should be provided to promote consistency.

4.28 Occasionally, organisations who supported the Commission's role in developing standards and guidance also thought there may be difficulties in ensuring that any such standards and guidance are adopted. This group highlighted potential barriers in organisational cultures (which do not welcome interference or oversight from outsiders), inconsistencies in approaches and practices, a diversity of policies, and the complexity of the NHS processes and procedures.

4.29 There was a suggestion that there may be a need for further statutory powers for the Commission – and the introduction of a legal obligation on other bodies to have due regard to any Commission guidance.

4.30 Some individual respondents focused on the role of the Commission, specifically, and questioned whether the Commission was the best organisation to develop standards and guidance in this area. There was a view (as discussed in Chapter 3) that the Commission

had a conflict of interest, and that its normal way of working, through announced visits, had so far (in the view of the respondents) had little effect on services in adopting best practice.

The content of standards and guidance

4.31 Some organisations who agreed the Commission should have a role in developing standards and guidance nevertheless thought that there may be difficulties in specifying the detail of what local services must provide and how it should be done. There was also a suggestion that it may be difficult to decide what should be standards and what should be guidance.

4.32 Occasionally, respondents made specific suggestions about the (types of) standards that would be needed. For example, they should:

- Be achievable for local services
- Make it possible to assess the quality of local investigations
- Take a more quality improvement approach, instead of a 'pass-fail' approach (in some situations, or in relation to some processes).

4.33 Respondents wanted any guidance to provide information about how a good investigation should be conducted and what should be contained in investigation reports. There was a view that the guidance should set out clearly how local services are expected to meet the agreed standards. Some respondents made specific suggestions about what the guidance should contain, including:

- How to maximise independence in the local investigative process – this is important to ensure human rights compliance (Article 2 ECHR and the Human Rights Act 1998)
- The parameters of the investigation and how the role of the Commission will interact with that of local services
- The expert skills required to carry out a quality investigation – there was a view that this role should not be an 'add-on' to the jobs of clinicians but that a separate resource was needed to develop the necessary skills
- What should be done in cases where local governance processes may be inhibiting the review of death process
- The importance of family / friends of the deceased being able to give sufficient input to a process where there may have been failures by services.

4.34 There was also a suggestion that a 'template' for reports should be provided, and that the guidance should ensure that family and friends of people who died during treatment / care are informed about the type of review process being carried out and why – and what steps they can take if they are unhappy about the approach being taken.

The process of developing standards and guidance

4.35 Organisational respondents emphasised the importance of any standards and guidance in this area being developed through consultation / engagement with local

services (including NHS, local authority, and third sector services), professional bodies, service users, and bereaved families and carers. There was also a suggestion that the Review Implementation Group from Scottish Government's 2018 review should be given the opportunity to comment on any draft standards / guidance.

4.36 One respondent who was unsure about whether the Commission should have a role in developing standards and guidance suggested that the Commission may not be best placed to develop standards and guidance in situations where critical investigations must take place and services must be held to account. It was suggested that, in such cases, the police or COPFS may be in a better position to provide guidance. It was also suggested by one respondent that the Scottish Human Rights Commission should be invited to contribute the human rights and values aspect of the guidance.

Other issues

4.37 A small number of other points were made in response to this question – usually by just one or two respondents – as follows:

- There is a need to consider, specifically, the role of independent advocacy services in any investigations of death. As independent advocacy services have a duty to be 'loyal' to the people they support, it may not always be appropriate for independent advocates to be involved in investigations into the deaths of those individuals if those investigations could potentially compromise the independence of, or create conflicts of interest for, the independent advocacy organisation.
- There was a view that the same standards and guidance should apply across all deaths in state custody in all settings (police, prison, hospital, or community).
- The Commission should put in place procedures that enable monitoring of the effectiveness of the review and reporting processes. These procedures should include gathering family and carer experiences and views in relation to the perceived objectivity and independence of investigations.

5. The revised process (Q4)

5.1 The consultation document provided a brief description of the proposed six stages of the revised process for investigating deaths of people during compulsory treatment. Respondents were asked if they had any comments on this process.

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?

5.2 Question 4 contained three open questions, and 19 organisations and 11 individuals provided comments at one or more parts of the question. The responses – particularly those from professional and regulatory bodies, and some third sector organisations – were often detailed and lengthy. The analysis presented here is unable to fully reflect the level of detail in the responses but focuses on a discussion of the main themes arising in the responses. Annex 2 of this report provides a short summary of points made in relation to each of the six stages.

5.3 There were seven main themes in the comments made at Question 4. These related to (i) the initial notification of deaths, (ii) the proportionality of the proposed new process, (iii) who should be involved in the initial review of cases, (iv) local involvement (and decision-making) in investigations, (v) the involvement of families in the process, (vi) the timescales for investigations, and (vii) issues relating to reporting and monitoring. Each of these is discussed briefly below. Note that respondents also often discussed issues relating to resourcing. However, these comments are covered in Chapter 8, together with the views expressed at Question 10 about the potential financial and administrative impacts of the proposals. In addition to these specific topics, respondents also occasionally made general comments about the process. These are discussed first.

General comments

5.4 Some respondents thought that the process as set out in the consultation document would ensure an independent, multidisciplinary approach to the consideration of the circumstances of an individual's death; and that it would help to establish a national unified system for investigating these deaths. This, in turn, it was suggested, would have a positive impact on the safety of people who receive care and treatment under mental health legislation.

5.5 However, others suggested that the Commission needed to engage further with partners on the details of the practical delivery of the process. Some respondents (both organisations and individuals) commented that insufficient information had been provided in the consultation document to enable an assessment of the proposals or a considered view to be offered on how the process would work in practice. Some organisations thought the lack of detail made it difficult to know what impact the proposals were likely to have on services.

5.6 There was also a view that it would have been helpful to have had information about the progress being made against the other actions / recommendations from the 2018 Scottish Government Review, since these (and action 3 in particular) could have further implications for any new process introduced to review deaths during compulsory treatment.[2]

Initial notification of deaths

5.7 There is a legal requirement for NHS boards to notify the Commission if an individual dies whilst being treated compulsorily for a mental health condition. However, the consultation document explained that, over the past six years, an average of around 7% of deaths per year were not reported. The point was made in the consultation document that in order for the new system be effective, the notification process will need to be improved.

5.8 Some organisations addressed this point in their responses to Question 4. This group highlighted the difficulties that can arise for services in certain circumstances in relation to identifying the relevant deaths. For example, a health board may not know about the death of a person who had recently been treated under a mental health order if, for example, the person had been discharged from the mental health service and subsequently died of causes relating to a sudden or chronic physical illness. The mental health service may only find out about this death much later. Similarly, because of systems in place to protect patient anonymity, if a person recently detained under the mental health act dies in the care of non-mental health acute services or primary care services, these services would not necessarily know about the other service contacts the person had at (or immediately prior to) their death.

5.9 The point was also made that it is not always clear **who** exactly has the responsibility to notify the Commission of a death. For example, in the case of the death of a person with a mental health condition recently detained for a crime, it is not clear whether the health service or procurator fiscal is responsible for notifying the Commission of the death.

5.10 Respondents suggested that providing additional resources to address the problems of the under-reporting of deaths may not be sufficient. Instead, there may be a need to develop new reporting and tracking systems to enable all relevant deaths to be identified and automatically notified to the Commission. One respondent noted that, in the case of unexpected deaths, Police Scotland would be involved and able to notify local services through a local notification process. It was suggested that a similar process could be developed for cases of 'expected' deaths.

The proportionality of the proposed new process

5.11 The issue of the 'proportionality' of the process was a very common theme in the responses from organisational respondents, with respondents repeatedly emphasising its importance.

[2] Action 3 from the Review was as follows: The Scottish Government will begin an options appraisal in conjunction with partner organisations, to determine an appropriate process of review for the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder. This will support delivery of action 10 in the Scottish Government's 'Suicide Prevention Action Plan' to review every death by suicide and ensure the importance of clarity, alignment and integration of review and investigation processes for maximum impact.

5.12 Some organisations wanted clarification about how decisions would be made (at stage 2) about which deaths would require further investigation following the initial review undertaken by the team assembled by the Commission, and how the level of review will be determined. It was suggested that the Commission will need to develop a reliable basis for taking these decisions. (Some offered suggestions about ways of developing the current ND1 form to assist with this process.)

5.13 Some respondents felt they had insufficient information about whether the proposed new process would (or would not) lead to a significant increase in the number of reviews being carried out. This, therefore, made it difficult to assess the likely impact of the proposals on services. There was a specific request for information about (i) how many deaths are **currently** being investigated (the consultation paper reports only on how many deaths are notified each year), (ii) how many **more** investigations are likely to take place under the proposed new process, and (iii) what is the likely level of those investigations. One respondent commented that there may be a problem with the under-reporting of deaths by health boards, but 'this is a different issue to whether deaths are being appropriately investigated'. It was suggested that if there **is** a problem with the under-investigation of deaths, then the Commission has not yet identified the extent of this problem – which creates the risk of a disproportionate response being taken.

5.14 Respondents also wanted to know how the proposed new process was likely to impact on different groups of clinicians. The point was made that it could have a disproportionate impact on large health boards and on certain services (for example Old Age Psychiatry).

5.15 As discussed in relation to Question 1 (see Chapter 3) respondents sometimes called for a distinction to be made between unexpected deaths (which would require investigation) and expected deaths (the example was given of a patient with a terminal cancer diagnosis and palliative care involvement who was detained in a mental health setting due to dementia and challenging behaviours). It was also suggested that, in relation to natural / expected deaths, the views of families should be considered in determining the level of review required – and that in cases where families do not have concerns, a mechanism should be put in place for a more rapid review process.

Who should be involved in the initial review of cases

5.16 The consultation document explained that the initial review of the circumstances surrounding the death (at stage 2) would be undertaken by 'a team assembled by the Commission for this purpose' and that this team would include psychiatric, social work and nursing expertise, as well as administrative and analytical support, and a Commission Liaison Officer.

5.17 Concerns about the need for a 'proportionate' approach led some organisational respondents to comment on or ask questions about who would, or should, be involved in making decisions about the level of review required. These respondents expressed a range of views on this issue, including that:

- There should be a ‘partnership approach’ – involving relevant local services – in deciding whether an investigation is needed and the terms of reference for any investigation.
- Any team assembled by the Commission for the initial review of the death should have the ability to consider the patient’s physical condition, as well as their mental health condition. This was seen to be important because people with long-term mental health conditions can have their physical health issues downgraded or overlooked in acute mental health settings, where the focus tends to be on psychiatric treatment delivered by specialists who are not necessarily qualified to assess / diagnose other medical issues.
- Police Scotland should be involved in all initial reviews of death and in setting the terms of reference for any reviews – to prevent the possibility of two parallel investigations being initiated.
- The use of clinical experts (such as a learning disability expert) was welcomed. The point was made that this is sometimes lacking in existing review processes.
- The inclusion of nursing expertise in the initial review team was welcomed. However, it was thought that this expertise should also be included in any subsequent review team, to ensure that those involved in the investigation have faith that those investigating understand their professional practice and the requirements of professional regulation and matters such as staffing levels.

5.18 However, there was an alternative view that the involvement of a ‘team’ may not always be necessary at the initial review stage. For example, where an ND1 form discloses no apparent need for further investigation, a single responsible person could be given the responsibility of deciding that no further investigation is required.

5.19 It was common for respondents of all types to say that families should have a significant say in deciding whether a death is investigated, and what the terms of reference for the investigation should be.

5.20 Some individual respondents queried the proposal to include psychiatry, social work and nursing disciplines in the initial review of death – seeing this as biased. This group called for the initial team assembled by the Commission to instead (or in addition) include legal involvement and / or involvement from a representative of the family (which may be a solicitor). Respondents who had these views thought that legal representation for the families should be provided at no cost to them.

Local involvement (and decision-making) in investigations

5.21 Organisations expressed a range of concerns and raised a number of questions about the review process itself (stage 3).

5.22 First, there was concern that the proposals implied that decision-making was potentially being taken away from local teams for one (small) group of patients. There was a question about what the process would be for conflict resolution if the Commission decides on a level of review that the local service thinks is not appropriate. One respondent

argued that reviews ‘should be decided upon and undertaken as locally as possible’, given that knowledge of local systems would be necessary, and a more local review was likely to result in better engagement of staff. Respondents specifically asked for information about how frontline clinical staff would be meaningfully engaged in the process under the Commission’s proposals.

5.23 There was also a request for clarity about when it would **not** be appropriate for local services to conduct the investigation.

5.24 Individual respondents often had different perspectives to organisations on this issue, and in general were more concerned that any review team was independent of the local service in which the death occurred. As previously noted in Chapter 3, there was a view among this group that any review team comprising individuals from medical and social work disciplines would be unable to be impartial in cases where there may be evidence of negligence.

5.25 A related point was made by one organisation that psychiatric specialisms are small, and that any psychiatrists involved in reviews of death or the services being reviewed are likely to know each other. This could compromise the perception of impartiality in the process; it was suggested that a ‘disclosure of interest’ system may need to be established as part of this process.

The involvement of families in the process

5.26 As noted above, respondents frequently highlighted the need to involve families (who wish to be involved) at all stages of the process: from the development of the review brief through to the creation and implementation of the action plan. Families were seen to have a vital role to play; respondents thought that good quality investigations with meaningful family engagement would help to identify changes that need to be made in services to prevent future deaths. A range of points were raised – mainly by organisations – including that:

- The views of families should always be an important factor in determining the scale of investigation required where the death has been attributed to natural causes.
- The ND1 form should be amended to give the part dealing with relatives a separate heading and questions designed to encourage more discussion with families (i.e. replace the question ‘Have the circumstances been discussed…?’ with a more open question requiring the detail of the discussion with families to be recorded). However, the timing of this discussion needs careful consideration. Relatives of the deceased should not feel rushed. In certain cases, it may be appropriate to leave the completion of this part of the form to the Commission Liaison Officer.
- There needs to be an awareness of the possibility of conflicts within families – and that different members of the family may want (or not want) an investigation, or they may want different things from an investigation.
- Repeat questioning and interviewing of families over a prolonged period should be avoided. Short timescales need to be set for completion of the process (from

beginning to end). At the same time, the need to adhere to a timely process should never be used as an excuse to exclude family involvement.

- In complex investigations (which may have longer timescales, and different processes involved), family members should be kept informed at all times.
- The involvement of families in the process should be a joint responsibility of the Commission and the local investigating bodies.

5.27 One organisation noted that efforts to involve families in the process are positive – however, there also needs to be a recognition that will be resource intensive. (See Chapter 6 and the discussion of the role of Commission Liaison Officer for further details.)

The timescales for investigations

5.28 Another recurring theme in the comments of organisations was in relation to the timescales for reviews. Several organisations noted that current standards for undertaking reviews were 3 months to completion. There were suggestions that a timeframe of 3-6 months for a 'reasonably straightforward' review, set out in the consultation document, was too long – and was likely to feel too long to families. Timescales of this length could also result in clinicians facing multiple processes going on simultaneously which, it was suggested, would be very stressful.

5.29 Respondents wanted further details about the timescales for each stage of the process (including the initial review at stage 2). They commented that delays in the process may arise in relation to information sharing, and they suggested that the Commission should be able to have direct access to local records, rather than having to ask others to provide them.

5.30 They also pointed out that other potential delays to the process – for example, for post-mortems – do not seem to have been taken into account.

5.31 Individuals and some organisations emphasised that any delays in an investigation should be clearly, concisely and promptly communicated to families, carers and staff.

Issues relating to reporting and monitoring

5.32 Organisations and individuals made a range of points concerning the processes of reporting the findings of an investigation and then monitoring the extent to which recommendations are followed through by the service(s) concerned.

5.33 It was noted that there was a gap in the proposed process (as set out in the consultation document) in relation to ensuring that any learning from a review in one service is widely disseminated to enable learning in services elsewhere in Scotland. It was suggested that systems would need to be put in place to share learning. Respondents emphasised that the dissemination of key findings and recommendations from reviews should be undertaken promptly and not be delayed for inclusion in an 'annual report'.

5.34 One individual respondent commented on the importance of the Commission having a role in quality assuring the actions plans which arise from reviews. This respondent thought

that action plans ‘need to be widely visible with clear actions, timescales, outputs and impacts’. It was suggested that guidance and training may need to be given to investigating teams on how to produce meaningful action plans.

5.35 Both organisations and individuals raised concerns or identified potential difficulties with the reporting stage as described in the consultation document. In particular, respondents wanted to know:

- What the purpose was for the Commission’s team to prepare a **separate** report following completion of the review (at stage 5)? It was suggested that this would potentially add further delays to the process. Respondents were concerned that this proposal implied that the family and staff involved in the incident would not receive the original report of the investigation. This group thought this would simply lead to concerns about transparency and freedom of information requests for the original report.
- What would happen if the findings and conclusions of a Commission-led review under stages 3 or 5 differ fundamentally from the initial findings and conclusions of the local investigating body? It needs to be made explicit whose findings and conclusions would take primacy and what route of appeal or redress there would be if a family member, carer or member of staff disagrees with any the Commission’s findings or conclusions.
- How exactly will the Commission assess the reliability and robustness of a local investigation if all it sees is a report at the end of the process? Will it conduct an ‘audit’ of the report?

5.36 Respondents commented that there was a gap in the Commission’s proposed process in relation to the enforceability of any recommendations made. Respondents thought the Commission would need to independently monitor action plans and check on progress to ensure that learning is implemented. However, it was also suggested that further consideration would need to be given to situations in which services may fail to respond to direct or indirect recommendations. The Commission should have the power to challenge organisations when progress is slow, and it will need to consider whether additional statutory powers may be needed to make recommendations enforceable.

6. The role of the Commission Liaison Officer (Q5)

6.1 The consultation document described the Commission's proposal to develop a new role of the 'Commission Liaison Officer'. The consultation explained that it was intended that the new role would improve the involvement of, and communication with, families and carers during the investigation process. The main aspects of the new role were described in the consultation paper and included: providing continuity of contact for families and carers throughout the investigation; keeping families and carers fully informed of the progress of the investigation; explaining any legal requirements and processes; and ensuring the questions of families and carers were addressed.

6.2 Question 5 in the consultation asked respondents if they thought the proposed new role of a Commission Liaison Officer (CLO) would help to improve the involvement of, and communication with, families and carers during the investigations of deaths. Table 6.1 shows that, overall two-thirds of respondents (24 out of 37) said 'yes'. Just 2 out of 37 said 'no', but nearly a third (11 out of 37) said 'not sure'. Organisations were more likely than individuals to say 'yes', and individuals were more likely to say 'not sure'.

Table 6.1: Do you think that the role of CLO will help to improve the involvement of, and communication with, families and carers during investigations of deaths?

	Yes		No		Not sure		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	13	72%	1	6%	4	22%	18	100%
Individuals	11	58%	1	5%	7	37%	19	100%
Total	**24**	**65%**	**2**	**5%**	**11**	**30%**	**37**	**100%**

6.3 Respondents were asked if they had any concerns with this type of arrangement – and if so, to suggest ways such concerns could be addressed. Altogether, 17 organisations and 12 individuals offered comments. These raised a range of issues and did not necessarily focus (solely) on the potential concerns, or potential solutions to address those concerns.

6.4 The main points raised by respondents covered:

- The independence of the Commission Liaison Officer
- The possibility for duplication, overlap and confusion
- Status and seniority of the role
- Definition and scope of the role
- Practical and operational requirements of the role
- Family involvement in selecting the Commission Liaison Officer.

6.5 Each of these aspects is discussed below, followed by a small number of other issues raised by one or two respondents.

6.6 Note that respondents who thought the role of CLO would improve the involvement of, and communication with, families and carers often raised caveats or concerns that were similar to (or the same as) the reasons given by respondents who did **not** agree, or who were unsure.

The independence of the Commission Liaison Officer

6.7 The independence of the CLO was seen as vital, if the needs of families were to be properly addressed. However, several respondents (both individuals and organisations) did not think that the CLO would be able to offer independent support and advice to families and carers. The reasons for this perceived lack of independence have already been discussed in the analysis of Question 1. It was noted that the Commission itself would have oversight of the investigation process and that the organisation has statutory duties under the Mental Health Act. Therefore, these respondents argued, any individual employed by the Commission could not be said to be fully independent.

6.8 Some organisations and individuals suggested that families should be supported by a fully independent body – perhaps an equivalent body to INQUEST which operates in this capacity in England and Wales – whilst another respondent suggested that this role could potentially be provided via established support services.

6.9 In contrast to the above views, two individuals specifically highlighted the impartiality of the CLO as a benefit.

The possibility for duplication, overlap and confusion

6.10 The possibility for duplication, overlap and confusion in relation to the proposed new role was the issue most commonly raised by both organisational and individual respondents. Respondents explained that:

- This role currently already exists in relation to Adverse Event Review (AER) / Serious Adverse Event Review (SAER) processes. The responsibilities attached to this role are very similar to those described for the Commission's CLO role.
- There are also other liaison roles within the investigatory process (the police family liaison role was specifically mentioned, as was the 'governance facilitator role') which at least partly overlap with or duplicate the proposed new role.
- There is potential for the CLO role to be 'at odds with' local processes, to cause confusion for families and carers, and to have harmful effects by requiring families and carers to repeat their stories and relive their negative experiences.

6.11 Respondents – both those who agreed and those who disagreed with the proposal – offered some suggestions for how any difficulties of this nature could be resolved. Specifically, they suggested that (i) clearly defined roles and responsibilities should be developed, along with agreed structures of liaison between any involved agencies, (ii) information sharing agreements should be drawn up between agencies, and (iii) clear communication needs to be in place across all involved agencies and organisations. There

was a suggestion that a Standard Operating Procedure (SOP) would be required to bring clarity to the arrangements.

The status and seniority of the role

6.12 Both individual and organisational respondents queried whether the CLO would have sufficient status and seniority to support families effectively and to influence the work of the review team.

6.13 These kinds of comments were usually linked to reflections about the composition of the review team / investigatory panel. Respondents noted that the review team was mainly comprised of senior professionals, clinical experts, and other high-status individuals. It was therefore queried whether the CLO would have sufficient power, influence and status to advocate effectively for the families and to challenge the review team if required.

Definition and scope of the role

6.14 Respondents provided comments in relation to both the coverage of the role and the job description, and in relation to the expertise, knowledge and personal qualities of individuals who would be able to fill these roles.

6.15 As far as the **coverage of the role was concerned**, respondents for the most part supported the focus on family liaison, and they emphasised the importance of the CLO role in relation to transparency and communication. However, some also noted that there were potential omissions from and difficulties with the role as described in the consultation document:

- Professional and regulatory bodies, third sector respondents, and some individuals explained that families need to know their legal rights and may require access to legal expertise and support. This would be necessary to ensure that families were empowered with the knowledge, advice and information about the investigation process to enable them to participate fully. Some thought that independent advocacy services may be able to assist with this; however, others said that they would prefer to have formal legal representation. There was a view that non-means-tested legal aid should be provided for this purpose.
- Families don't just need a point of contact, but active support. They need to be treated as an important source of information about loved ones. The CLO would have to either provide that active support themselves or signpost the family to relevant organisations and services.
- It was not clear what role the CLO would play in engaging secondary victims (e.g. the family of a perpetrator, clinical staff who were providing care). This needed to be clarified.
- The CLO role should be identified as a specialist role. This would require specific training and support to be put in place for the welfare of the CLO. CLO would need robust supervision.

- Based on their experience of investigations two respondents (one organisation and one individual) said that the new role might create a barrier to family participation in investigations. It was said that families dislike increasing the 'distance' from the (local) clinical team, and the CLO role may be seen as defensive or evasive or as providing an unhelpful 'buffer' in relation to family participation in the review process.

6.16 A small number of respondents (both organisations and individuals) thought that the CLO was useful as an administrative role only. This administrative role was an important function but would not address the wider issues that families would have in participating with the review.

6.17 As far as the **knowledge, expertise and personal qualities** required for the role was concerned, respondents noted that:

- The CLO should be highly experienced, senior, and well paid, with excellent communication skills. However, one individual noted that it was not clear from the information provided what discipline the CLO would be drawn from and how experienced they would need to be.
- The CLO would need to have a detailed understanding of (all) local services. This would be vital if they were going to be able to provide proper support.
- The CLO should be honest, compassionate, and sensitive.

Practical and operational requirements of the role

6.18 Respondents – both individuals and organisations – made a range of comments and concrete suggestions about the CLO role, and how it might work in practice. These suggestions sometimes arose from questions which respondents had about the nature and scope of the role. In particular:

- The role needs significant resources if it is to be effective. One organisation said it is difficult to see how one person could support 120 families each year. (This indicated that this respondent assumed that a single individual would undertake the CLO role.) Moreover, a second organisation noted that if the CLO was overseeing many different reviews, they may not have the detailed knowledge required to provide full and timely updates to the family. By contrast, other respondents suggested that there could be several – or even many – individuals performing the CLO role for different investigations.
- It was noted that if a review takes a long time, the CLO role may need to be undertaken by more than one person. This would need to be managed carefully as continuity from the families' perspective would be important.
- A single point of contact based in Edinburgh may be perceived as geographically remote from the local investigation. This means that attention to the practical and operational arrangements will need to be considered. Will the CLO travel to offer face-to-face meetings? If not, thought will have to be given to how families will be offered support to participate in meetings by Zoom.

Family involvement in selecting the Commission Liaison Officer

6.19 A range of respondents (mainly individuals) suggested that the families should take the lead in defining the role of the CLO and moreover, that they should be able to select their own CLO. This was mentioned specifically in the context of discussions around advocacy, and access to legal advice.

6.20 These respondents suggested that families could select an individual from an 'approved list', or (possibly) through an established advocacy service.

Other issues

6.21 The one organisational respondent who answered 'no' to the closed question explained that they thought the CLO role should be part of the local review process rather than located in / with the Commission.

6.22 It was noted by another organisation that Healthcare Improvement Scotland and NHS Education for Scotland are developing guidance following recent research to support (patient and) family engagement during SAERs which may be relevant in defining the nature and scope of the CLO role, and in addressing questions about the knowledge, expertise and personal qualities required. Reference was also made to the National Hub Guidance for reviewing deaths of children and young people in Scotland and which includes guidance on engaging with families and carers.

6.23 A range of other issues were raised by one or two respondents including:

- Consideration should be given to developing a Charter – similar to the Family Liaison Charter – for the CLO role
- A CLO is not a substitute for good caring liaison with families in the immediate aftermath of a death.
- Some organisations noted that, in relation to existing processes for reviewing deaths, every effort is made to contact relatives. However, they often decline to be involved, or do not respond. It is unclear if the Commission would have more success in engaging relatives.
- Rather than a specific CLO for each review, the Commission could offer an advice service for families who wish it and talk them through review processes in general. The Commission could also assess if additional support is needed on a case-by-case basis in discussion with families and the clinical team.

7. Values and principles (Q6)

7.1 The consultation document explained that, in order for the Commission's proposals to be in line with its statutory duty to act in a manner which seeks to protect the welfare of persons who have a mental health condition or learning disability, the revised process must:

- Be independent
- Deliver local accountability
- Involve families and carers in a meaningful way
- Be informed by standards and guidance based on good practice
- Be characterised by openness, honesty and transparency
- Provide clear, accessible and timely reporting.

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? [Yes / No / Not sure]

Question 6a: Please explain your answer.

7.2 Question 6 asked respondents if they agreed that the revised process for investigating deaths would meet the values and principles set out in the consultation paper. Table 7.1 below shows that, overall, half of respondents (17 out of 34) thought it would. Five (5) out of 34 thought it would not, and just over a third of respondents (12 out of 34) were not sure. Organisations were more likely than individuals to answer 'yes' to this question, whereas individuals were more likely to answer 'not sure' or 'no'.

Table 7.1: Do you agree that the revised process will meet the values and principles set out in the consultation paper?

	Yes		No		Not sure		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	10	59%	2	12%	5	29%	17	100%
Individuals	7	41%	3	18%	7	41%	17	100%
Total	**17**	**50%**	**5**	**15%**	**12**	**35%**	**34**	**100%**

7.3 Respondents were asked to explain their answer. Altogether, 16 organisations and 11 individuals offered comments. Of these, 7 respondents (4 organisations and 3 individuals) simply reiterated their support for the proposals and affirmed that these values and principles would be achieved through the revised process. In addition, three organisational respondents affirmed that the application of the revised process (and the underpinning values and principles) should improve the consistency of the approach to investigations, allow benchmarking, and support continuous improvement.

7.4 The comments offered by the other respondents offered qualifications, caveats, and sometimes disagreement as to whether these values and principles would be achieved. To some degree, these comments simply repeated views respondents had expressed earlier in the consultation.

7.5 The main issues raised by respondents included:

- Additional values and principles which should be included
- Doubts about the independence of the revised process
- Other caveats and concerns about the values and principles.

7.6 Each of these aspects is discussed further below, followed by a small number of other issues raised by one or two respondents.

Values and principles which should be included

7.7 Respondents made a range of suggestions for (i) extending the coverage of the values and principles already set out, and (ii) adding in new values and / or principles.

7.8 Three organisational respondents asked that the third principle (to 'involve families and carers in a meaningful way') should be extended to include 'staff' – and in one case to also include 'panel members'. Respondents commented that it was not clear why 'staff' had not been included in this principle, and that the omission could be interpreted as taking the starting point for the investigation as an assumption of staff fault or guilt.

7.9 Other values mentioned by respondents for inclusion were 'proportionality' (discussed in more detail in the analysis of Question 4), 'balance' (which was explained as 'balancing the interests of all so that no-one's interests are unfairly prioritised') and 'realism' (which was raised by an individual who identified as a clinician and who emphasised the importance of being realistic about what could be achieved within the constraints of the existing system and resources).

Doubts about the independence of the revised process

7.10 Doubts about the independence of the Commission's revised process were raised by both organisations and individuals. These issues have been discussed in detail in the analysis of Question 1 and Question 4 and are not repeated here.

Caveats and concerns about the values and principles

7.11 Other doubts about the values and principles raised by a range of respondents covered:

- The values and principles themselves were appropriate and should support a more meaningful process. However, there was scepticism about whether these values and principles could or would actually be achieved in practice.
- Two organisations commented that local accountability may already be being achieved under the current local investigation process. A third organisation explained that the local process currently in place has more ambitious timescales for completion of investigations – thus the introduction of this revised process could actually **decrease** local accountability by slowing down the response times.

Other issues

7.12 One organisational respondent reiterated their opposition to the revised process overall, stating that it ‘entrenches a culture of blame’. Another organisational respondent said there was insufficient information contained in the consultation paper to answer the question about values and principles. Finally, two respondents (one organisation and one individual) said it would be important to regularly review and independently audit whether these values and principles were being achieved in practice.

8. Potential impacts of the new process of investigating deaths

8.1 Section 4 of the consultation paper explained that the revised process will be subject to an Equality Impact Assessment (EQIA). This would help to determine any potential impacts the process could have on individuals with protected characteristics and how any impacts could be mitigated.[3]

8.2 The consultation included two questions, inviting views on the potential impacts of the revised process on (i) those with protected characteristics, and (ii) children and young people. Two further questions covered the extent to which the revised process was human rights compliant (Q9) and what respondents thought could be done to minimise any negative financial or administrative impacts of the revised process (Q10).

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.

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

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

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

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

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.

Potential impacts on equality groups (Q7)

8.3 Respondents were asked if they had any comments on the potential impacts of the revised process on those with protected characteristics, and what they thought could be done to minimise any negative impacts. This was an open question, and 17 organisations and 6 individuals offered comments.

8.4 Six organisations and 3 individuals simply stated that – if the EQIA was implemented fully – the needs of all those with protected characteristics would be addressed, and there would therefore be no adverse impacts. By contrast, one individual respondent stated that the revised process was discriminatory as it was 'not in keeping with national arrangements with HIS'. However, it was not clear from the comment exactly how a departure from national arrangements would lead to impacts on people with protected characteristics.

[3] Protected characteristics are defined by the Equality Act 2010 and comprise age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

8.5 The other (13) respondents (i) discussed the background and context for considering any potential impacts on those with protected characteristics, (ii) identified some potential negative consequences of the revised process on those with protected characteristics, and (iii) made suggestions for ways in which any potential harms could be mitigated.

8.6 Each of these aspects is discussed below.

Background and context

8.7 Respondents who discussed the background and context for considering the potential impacts of those with protected characteristics made the following points:

- The 2021 Mental Welfare Commission report found unacceptable differences in the application of the Mental Health Act by ethnicity. This report described the negative perceptions of diverse ethnic groups in mental health settings and argued that services are not always good at engaging with these groups.
- There is a lack of access to gender-specific and trauma-informed therapeutic services and treatments; this has impacts on girls and women who have experienced domestic violence and abuse.
- There is currently a lack of consistent and comprehensive statistical data about the protected characteristics (age, gender, race, and disability were specifically mentioned) of individuals detained under the Mental Health Act.

Potential negative consequences on those with protected characteristics.

8.8 It was suggested by one organisation that if **more** time was devoted to investigating deaths under mental health legislation, then **less** time would be available to investigate the deaths of those with protected characteristics among non-mental health patients (the so-called 'two-tier' problem, as described earlier in Chapter 3, see paragraph 3.28).

8.9 Two respondents (one organisation, and one individual) explained their divergent views of the impacts of the revised process on elderly patients as follows:

- It was not appropriate to limit the revised process to those cared for under the Mental Health Act. In particular, older adults are more likely to be subject to the Adults With Incapacity Act, and these individuals (who are covered by the 2010 Equality Act) should also be covered under any revised process.
- There is a risk that – if the revised process is seen to pose an excessive clinical or administrative burden on staff – some clinical settings (a general hospital geriatric medicine ward was mentioned) might avoid using the Mental Health Act. This would mean that elderly patients (or those with dementia) would be at risk of losing the protections currently available to them under the Act.

Suggestions for mitigation

8.10 Respondents made a range of general comments about the importance of supporting those with protected characteristics, and one respondent emphasised that managing any

potential (negative) impacts for those with protected characteristics was an obligation, not a choice.

8.11 There were three main suggestions for the mitigation of any harmful impacts. The first related to monitoring and measurement, the second to consultation and engagement, and the third to training. These suggestions were made both by organisations (including all organisation types) and by individuals. Each of these is described briefly below.

8.12 Respondents emphasised that it would be vital to monitor the impacts of the revised process on those with protected characteristics and to collect comprehensive statistical data. This would allow the Commission to assess the equality implications of its work as required by the Public Sector Equality Duty (PSED).

8.13 As far as consultation and engagement was concerned, the comments focused on the importance of early engagement with families to establish any particular requirements, and consultation with organisations who had expertise in working with specific groups (e.g. those with expertise in communication strategies for particular groups, those who could advise on approaches to digital inclusion, etc.).

8.14 The availability of well trained and highly skilled staff lay at the heart of the approach to mitigation. It was suggested that all staff involved in the investigation process (including the CLO) should be provided with training in the 'promotion of anti-discriminatory, trauma-informed, culturally competent practice'. Staff would also have to ensure that families were made aware early on (in their induction) of the complaints process which would allow them to report concerns about the treatment of those with protected characteristics at any time.

Impacts on children and young people (Q8)

8.15 Respondents were asked if they had any comments on the potential impacts of the revised process on children and young people, and what they thought could be done to minimise any negative impacts. This was an open question, and 10 organisations and 5 individuals offered comments.

8.16 Four respondents (3 individuals and one NHS organisation) thought there would be no adverse impacts and / or that the treatment of children and young people under the revised process would be an improvement on the current situation.

8.17 Two organisations simply pointed to their previous response (at Question 7).

8.18 The additional substantive points raised at Q8 covered two situations: (i) where a child dies and their death requires to be investigated, and (ii) where a child may be the next-of-kin of an individual who died during compulsory treatment.

- Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, co-hosts the National Hub for Reviewing and Learning from the Deaths of Young People. The National Hub implemented a new approach for reviewing and learning from these deaths on 1 October 2021. It is possible, therefore, that some deaths occurring during treatment under mental health legislation will meet the criteria for the National Hub process. Respondents stated that it is important that the Commission's process is fully

joined up and aligned with the National Hub process, and that there is a single, fit for purpose, investigation in each case.

- Any member of the investigation team who interacts with a child or young person who has been affected by one of these deaths will be required to show great sensitivity and skill. They may require additional training to mitigate any possibility of further trauma being inflicted on the child or young person as a consequence of the investigative process. The CLO is likely to play a particularly important role in these cases and they may require additional training and support. If this expertise is not available within the existing team, then access to external experts will be required.
- A child or young person affected by the death of an individual during compulsory treatment will require access to appropriate advocacy, bereavement support, and mental health care.

8.19 Finally, one individual respondent questioned why 'voluntary patients' were to be excluded from these investigations. They said that, without including these cases, it would not be possible to apply proper scrutiny in these cases or to learn lessons about the treatment and care of children and young people.

8.20 As in Question 7 (above), respondents said that it would be important to conduct ongoing monitoring and review of any cases involving children and young people.

Human rights compliance (Q9)

8.21 Question 9 asked respondents whether they agreed that the revised process (as set out in the consultation document) was human rights compliant. Table 8.1 shows that 21 out of 36 thought it was. However, a sixth (6 out of 36) thought it was not, and a quarter (9 out of 36) were not sure. There was a similar pattern of views among organisations and individuals on this question.

Table 8.1: Q9 – Do you agree that the revised process for investigating deaths during compulsory treatment is human rights compliant?

	Yes		No		Not sure		Total	
Respondent type	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Organisations	10	59%	3	18%	4	24%	17	100%
Individuals	11	58%	3	16%	5	26%	19	100%
Total	**21**	**58%**	**6**	**17%**	**9**	**25%**	**36**	**100%**

8.22 A follow-up question invited views about what could be done to ensure that the new process fully complies with human rights standards. Twenty-one (21) respondents – 16 organisations and 5 individuals – provided comments. Among those who commented were 7 organisations and 3 individuals who answered 'yes' to the initial closed part of the question. These respondents made very brief suggestions.

8.23 By contrast, the comments from those who answered 'no' or 'not sure' to the initial closed question – and comments from one third sector respondent who did not answer the closed question – were longer and more detailed. Thus, the focus in the discussion below is

mainly on the views of respondents who had concerns about the extent to which the proposed new process was compliant with human rights standards and / or who made detailed suggestions of how human rights compliance could be improved.

8.24 The sections below look at the main areas for which respondents offered suggestions about how the proposed process could align better with international human rights standards. The response from the Scottish Commission on Human Rights was a key response in relation to this question, and the first two sub-sections below summarise the main issues raised in this response – covering (i) the human rights framework, and (ii) ways of improving compliance of the Commission's proposals with the human rights framework. Other respondents often addressed the same or similar issues, albeit in less detail. The final sub-section briefly covers a range of other points made by respondents in their comments at Question 9.

The Human Rights framework

8.25 Article 2 of the European Convention on Human Rights (ECHR) provides that 'everyone's right to life shall be protected by law'. This right includes positive obligations to protect individuals from real threats to life. These positive obligations include a procedural element requiring effective investigation of deaths to ensure the protection of life.

8.26 The procedural obligation to conduct an effective investigation has particular weight in situations where there is the possibility that the State may have caused or contributed to the death. There is also a particular obligation on the State to provide explanations for deaths in custody or detention, in recognition of the fact that people in these situations are in a vulnerable position and the authorities are under a duty to protect them.

8.27 The purpose of an 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 any deaths occurring under their responsibility. Flexibility as to the form of investigation is allowed. However, there are certain essential (minimum) requirements of these investigations:

- **Independence:** The investigation must be carried out by a body with both institutional or hierarchical independence, and also practical independence from those involved in the events
- **Effectiveness:** The investigation must be capable of leading to a determination as to whether or not a behaviour or failure to act was justified, and (if not) to identify and punish those responsible
- **Promptness and reasonable expedition**
- **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
- **Involvement of next-of-kin:** The victim's next-of-kin must be involved to the extent necessary to safeguard their legitimate interests.
- **Initiation 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.

8.28 Some respondents expressed concerns that the current proposal is **not** Article 2 compliant, as the investigation would not be independent, would not appear to allow for effective participation by families, and would be lacking in public scrutiny.

Ways of improving compliance with the human rights framework

8.29 Reference was made to the Independent Review of the Response to Deaths in Prison Custody, which reported in November 2021.[4] It was suggested that the recommendations of this review would be relevant to the Commission's proposals for investigating deaths during compulsory treatment.

8.30 It was recommended that a separate, fully independent investigation should be undertaken into each death which occurs in mental health detention. If the Commission is acting in the role of the independent body, this would require the Commission to carry out the investigation itself. It was recognised that this would involve a more significant role for the Commission as primary investigator than the proposals appeared to suggest.

8.31 An independent investigation should be carried out in **all** deaths, including those relating to 'natural causes' since human rights concerns may arise even in these cases. A system administered by the Commission could take a proportionate response, and this would involve the Commission (as the independent investigator) concluding that a death was from natural causes and that a less far-reaching review is necessary.

8.32 The most thorough of reviews should be carried out by the Commission in all deaths which are self-inflicted or involve the use of force, and those which give rise to concerns about ill treatment, medication and / or medical failings.

8.33 Local reviews and Serious Adverse Event Reviews (SAERs) should ensure independence (through oversight by the Commission), the involvement of family members and adequate public scrutiny. Guidance should provide clear information on what families can formally influence and how they can participate, as well as how to ensure adequate public scrutiny throughout the review and through the publication of the findings.

8.34 There was a comment (from a regulatory / professional body) that specific reference to the Human Rights Framework for Adults in Detention published by the Equality and Human Rights Commission in 2015 would be helpful, together with a detailed analysis of how the proposal meets the requirements set out under the 'State's Obligation to Investigate'. It was suggested further review of the extent to which the proposals are human rights compliant should be undertaken again once they are fully formulated.

8.35 Annex 3 contains a brief summary of the (assessed) current Article 2 compliance of the Commission's proposals and recommendations for improving compliance.

Other issues raised by respondents

8.36 Some NHS respondents suggested that the proposals are not human rights compliant because no consideration had been given to the human rights of clinical and managerial

[4] This review was chaired by Wendy Sinclair-Gieben (Her Majesty's Chief Inspector of Prisons for Scotland), Professor Nancy Loucks (Families Outside) and Judith Robertson (Scottish Human Rights Commission).

staff, or the strain that staff and services may face when under scrutiny. Some of these also questioned whether a proposal for a **different** investigation process for the deaths of those detained under mental health legislation – as compared with the deaths of those who are not detained – would be human rights compliant (because there would be greater scrutiny applied in relation to the former as compared to the latter).

8.37 Some respondents pointed out that work is currently underway nationally to incorporate the ECHR and the UNCRPD into Scot's Law, and therefore, any new system for investigating deaths in compulsory treatment should align with this work.

Financial or administrative impacts for local services (Q10)

8.38 Respondents were asked whether they had any concerns in relation to any financial or administrative impacts the revised process may have, especially for local services, and to explain what they thought could be done to minimise any negative impacts. This was an open question, and 15 organisations and 14 individuals offered comments.

8.39 Respondents offered two distinct perspectives in response to this question as follows:

- One group of eleven (11) respondents was not concerned about the potential financial and administrative impacts of the revised process.
- One group of twelve (12) respondents thought there would be negative financial and administrative impacts of the revised process.

8.40 Both these groups included a range of individual and organisational respondents. The remaining (6) respondents did not directly address the question in their responses or had mixed views.

8.41 The issues raised by the two main groups were different. They are discussed in turn below. The section concludes with a discussion of respondents' ideas in relation to minimising any negative impacts.

Views of those who were not concerned about the potential financial and administrative impacts

8.42 Eleven (11) of those offering comments were not concerned about the potential financial and administrative impacts. These respondents thought that:

- There would (or could) be cost savings due to increased efficiency and streamlining (this included a comment to the effect that there **could be savings** if a single independent body (not the Commission) was established to develop and implement a standardised system for investigating deaths).
- Any financial or administrative impacts would be minimal.
- There might be a short-term cost but in the long term there would be cost savings.
- The current system for investigating deaths needed to be improved and any costs incurred were necessary and would be worth it.

Views of those who were concerned about the potential financial and administrative impacts

8.43 Twelve (12) respondents thought there would be negative financial and administrative impacts. These respondents thought that the revised process would introduce new layers of bureaucracy, would require increased liaison between organisations, and would need (substantial) additional resource both in terms of clinical and administrative time. It was not thought that these extra demands could be accommodated within existing funding arrangements.

8.44 These respondents emphasised that the systems for investigating deaths were already under strain, that current funding was inadequate, and that it was challenging to meet the existing requirements and timetables. The situation had been exacerbated by the COVID-19 pandemic, and there was concern that the 'willing resource' which currently existed may decrease as those undertaking the reviews feel under ever greater pressure.

8.45 The main issue respondents identified was that of staffing capacity, and particularly clinical staff capacity. Organisational respondents (especially those from the NHS and HSCPs) explained that they were not able to recruit staff – either in general, or to these specific roles. It was noted that:

- The burden for undertaking reviews currently falls on a small number of people
- It would be counterproductive to fund extra time for existing clinical staff to participate in (more) reviews as this would have a negative effect on the care given to patients (and ultimately result in more unnecessary deaths).
- There was a particular problem in relation to the clinical capacity within Old Age Psychiatry (as discussed above at Question 7).

8.46 Respondents noted that the more complex reviews took longer and involved more specialist input. They said that these lengthy reviews were particularly difficult to staff.

Ideas for minimising any negative impacts

8.47 A number of ideas for minimising negative impacts were offered by respondents who believed that the revised system would result in negative financial and administrative impacts.

8.48 The main suggestion was that the Commission (or some other central body) should provide any additional resources required, in relation to both administrative and clinical capacity.

8.49 There was a range of other specific suggestions as follows:

- Provide additional training – in a standardised format – for staff involved in reviews
- Fund a new role of 'service / implementation lead' at local level
- Introduce a Service Level Agreement for the CLO role with established service providers

- Minimise unnecessary expenditure on reviews by adopting a principal of ‘proportionality’ – and in particular exclude ‘expected deaths’ from the revised process.

8.50 There were also suggestions that the Commission should (i) supply ‘external specialists’ who will give independent oversight in relation to local reviews, (ii) escalate any concerns about the lack of resources for this work to the Scottish Government, and (iii) undertake a proper workforce planning exercise to identify the resource requirements in relation to the revised process.

8.51 Finally, one organisational respondent suggested an alternative (in their view, less resource intensive) approach which would involve targeting additional resources to local services operating the current system.

9. Other comments (Q11)

9.1 Question 11 asked respondents if they had any other comments. Altogether, 19 respondents (10 organisations and 9 individuals) commented. Most of these reiterated views expressed in response to earlier questions. (In some cases, comments made at Question 11 have been integrated into the discussions of earlier questions in this report.)

9.2 A few respondents raised new or slightly different issues in their comments at Question 11. This chapter provides a listing of these, with the views of organisations presented first, and then the views of individuals.

9.3 **Organisational respondents** made the following points, each of which was made by one respondent:

- There was concern that the way of communicating these changes may cause confusion and has the potential to harm this process from the outset. Improved communication with clinicians will be necessary (including an explanation of why the term 'investigation' rather than 'review' has been used).
- There will need to be a clear information about when these proposed changes will begin – to enable services to prepare.
- The actual delivery of this proposed process will likely lead to unresolved operational issues emerging. Any revised system of investigating deaths will need to be reviewed on a regular basis and changes made following implementation.
- There was concern that no information was included in the consultation document about what was working well in the current system – which could be carried forward with these proposals. The Commission will need to consider what might be lost in the current system by the proposed changes and think about how this might be avoided.
- There was a suggestion that the current Adverse Event Review process was not perfect. However, it was seen to be preferable to put arrangements in place to address concerns about family and carer involvement and lack of independence / externality in the **current** system rather than establish a separate **new** system. Such arrangements would include, for example, ensuring the routine involvement of families and carers (with the aim of co-production of reports) and the use of colleagues from other NHS boards as a 'critical friend' in Adverse Event Reviews.
- There was disappointment from one respondent that it was only **deaths** that are to be investigated. This respondent wanted to see false statements on documents, and ill-treatment of patients investigated too.
- Families and carers should be involved in monitoring and evaluating this new process as it will be untested and its effectiveness will need to be assessed. Families should also sit on an advisory panel to ensure their views feed into the relevant processes as they develop and are reviewed.

9.4 Among **individual respondents**, some shared their personal experiences of shortcomings in the reviews of a close relative's death and their frustration at trying to

ensure that the service involved would learn from its mistakes. Other individuals made the following points:

- If there is no relative to fulfil the 'next-of-kin' role in investigations of deaths, a close friend of the deceased should be able to act in this role instead.
- Medical records should be available for inspection by next-of-kin in cases of death during compulsory treatment.
- The Commission and COPFS need to take seriously the offences of ill-treatment during detention and the giving of false evidence in investigations. It was suggested that where criminal prosecution might have little prospect of success because of a lack of corroborating evidence, the possibility of professional disciplinary procedures should be considered instead.
- The consultation document does not provide any information about what would happen if clinical negligence is found to have contributed to a death.
- Consideration should be given to setting up a charity similar to INQUEST in Scotland.

9.5 One further concern, raised by both organisations and individuals, was that the Commission's proposal relates only to people who died during compulsory treatment. These respondents argued that:

- Article 2 of the European Convention on Human Rights applies equally to people who are not detained – including in situations where a failure to assess needs, offer help, or even detain may have contributed to the death. The development of the proposed process should not be delayed to address a wider group of deaths; however, further consideration should be given to how this additional group of deaths can be more effectively investigated in the future.
- There should be a requirement to also investigate the deaths of:
    - People treated on a voluntary basis – it was suggested that many of these people are detained *de facto* in that they have agreed to be treated on a voluntary basis under the threat of being sectioned if they refuse or try to leave hospital
    - People who have applied for treatment of a mental health condition and have been assessed, but turned away without treatment, and have died (often by suicide) within a few days
    - People who have died whilst subject to the guardianship of the Chief Social Work Officer under the Adults with Incapacity Act 2000, or while removed without consent by the local authority to a 'place of safety' under the Adult Support & Protection Act 2007, or to a care home or nursing home under Section 13za of the Social Work (Scotland) Act 1968.
- Those who made these points considered it to be incongruous and unacceptable that the deaths individuals in these situations should not be subject to the same level of scrutiny as those which would be covered by the Commission's proposal. Some of these deaths would be subject to a Fatal Accident inquiry, but a Sheriff would not have the powers to ensure that recommendations from an FAI are implemented.

Annex 1: Organisational respondents

The consultation received responses from 22 organisations. These are listed below, by organisation type.

NHS organisations (6)
- Forensic Mental Health Services Managed Care Network
- Healthcare Improvement Scotland
- NHS Ayrshire and Arran
- NHS Borders, Mental Health Services
- NHS Greater Glasgow and Clyde
- NHS Lothian

Regulatory & prof bodies (5)
- General Medical Council
- Law Society of Scotland
- Royal College of Nursing (RCN) Scotland
- Royal College of Psychiatrists in Scotland
- Scottish Public Services Ombudsman

Third sector organisations (5)
- INQUEST Charitable Trust
- Scottish Association for Mental Health (SAMH)
- Scottish Human Rights Commission
- Scottish Independent Advocacy Alliance
- Support in Mind Scotland

Health and social care partnerships (4)
- Clackmannan and Stirling Health and Social Care Partnership
- Grampian System Wide Mental Health & Learning Disabilities Strategic Huddle
- North Lanarkshire Health and Social Care Partnership
- South Lanarkshire Health and Social Care Partnership

Other statutory organisation (1)
- Police Scotland

Other non-statutory organisation (1)
- Psychiatric Rights Scotland

Annex 2: Detailed views on the stages of the process

A brief summary is provided in the table below of key points made at Question 4 regarding each of the six stages of the new process.

Stage 1	• There are difficulties in how these deaths are identified. • The process of identification relies on services being aware of the service user death and reporting this to Commission. However, information about the individual's death, or previous contacts with services, may not be known at all, or not in a timeous way. • It is not always clear **who** exactly within different services has the responsibility to notify the Commission of a death in different circumstances. • There was a suggestion that the ND1 'notification of death' form should be amended to give the section dealing with relatives a separate heading, and that questions should be designed to encourage greater discussion with relatives. However, the timing of these discussions needs to be given careful consideration. [Various specific changes to the form were suggested.] Also, services need to be aware of potential conflicts within families – i.e. that different family members may expect different approaches to an investigation and / or may want different things from an investigation. • There may be benefit in having separate forms for reporting different categories of death. Suicide and accidental death may be thought always to call for independent investigation; reporting the detail of the views of relatives on the form itself may be of less importance in such cases. • Consideration should be given to the possibility of creating an ND1 form which can provide a reliable / robust basis for deciding whether further investigation is needed.
Stage 2	• Clarification is needed on the criteria for determining the level of review to be conducted. • The views of families will be important in determining the scale of investigation required in relation to deaths from natural causes. • There should be a partnership approach in making decisions about the level of review required – local services should be involved in these decisions. • There is a need to distinguish between expected and unexpected deaths – the Commission should develop a process to manage expected deaths that do not require formal investigation. If upon an initial review, the Commission decides that a formal investigation is required for an expected death, this should be requested. It should be possible for services to notify Commission in advance about any individuals who deaths are expected. • The initial review process – i.e. to decide on the nature / need for a full review – has the potential to be overly bureaucratic. This proposal does not take into account the substantial experience and local knowledge that services have in commissioning and quality assuring SAERs. • The involvement of a team in the initial review process may not always be necessary. Where the ND1 discloses no apparent need for further investigation, a single responsible person could have the role of deciding whether further investigation is required. • Reviews should be decided upon and undertaken as locally as possible – some respondents disagree with the proposal of external initiation and direction of reviews. • The initial review process needs a time limit and protected time (and resource) for those involved to undertake this. Guidance will need to cover what is expected. • Psychiatric specialisms are small – the people involved will all know each other. This could compromise the perception of impartiality. A robust 'disclosure of interest' type system may need to be established. • The team assembled by the Commission will also need to have the capacity to consider the patient's physical condition as well as the mental health condition. This is important since people with long term mental health conditions have poorer health outcomes than others and experience more severe health inequalities. A patient's physical health issues can be downgraded, or even overlooked, in acute mental health settings, with the focus tending to be on psychiatric treatment delivered by specialists who are not necessarily qualified to assess /

	diagnose other medical issues. Access for the patient to more mainstream medical services can be limited. • The consultation does not indicate that there will be representation from Police Scotland on the review panel. This could result in the police not being aware of when an agency's negligence has led to a death – and a case being closed without the need for possible criminal investigation being considered. Police Scotland should be involved in setting the initial terms of reference. • The process of compiling information to establish the terms of reference for the investigation could, in itself, put significant demands on services. Respondents emphasised the importance of providing administrative support to local services to deliver this aspect of the work. • How will the terms of reference for the review be set? What reference will be made to existing action plans and previous review findings? • Insufficient detail has been given to explain how the new system will operate. Will the Commission direct only those investigations which would otherwise have been investigated by NHS boards and local authorities? Will it also investigate deaths that might have been subject to an investigation by the Health and Safety Executive and / or COPFS? Will the Commission decide whether an autopsy is needed?
Stage 3	• Timescales for the review process should be shorter and more clearly defined. Some local areas are doing in much shorter timescales. Short timescales are also important for families. • The timeframes of 3-6 months for a 'reasonably straightforward' review runs the risk of clinicians facing multiple processes going on at the same time. This could be particularly stressful. • Potential delays to the process – for example, to conduct post-mortems – do not seem to have been accounted for • There is no definition in the consultation document of a 'reasonably straightforward' review. • How will review teams be selected? What training / skills will be required? Will shadowing be permitted? • Family views and questions need to be included in the review process. • Local services have established procedures for investigating complaints. Thus, guidance will be needed to explain what should happen if a complaint is received – to avoid duplication of processes. • Clarity is needed about the circumstances in which it would be inappropriate for local service to conduct the investigation. • It is difficult to see how the Commission could put together a review team without going through local service management – this will result in duplication of existing processes. • Local frontline clinical representation in the process was seen to be important. • The inclusion of those with nursing expertise in the initial review team (at Stage 2) was welcomed. This expertise should also be included in any investigatory team (at Stage 3). 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. • Some areas may not have sufficient staff or staff with the right expertise to be able to contribute to the investigation process. Further information is needed about how this expertise can be brought in externally. • It is not clear why paragraph 39 in the consultation document states that the investigation may be postponed 'pending a significant case review' – it was suggested that the investigation should **be** the significant case review. • The review should focus on any possible action which might have prevented a death. It should also consider the 'quality' of the death – i.e. whether there was avoidable emotional discomfort for the person or for those (family members / carers / friends) reasonably needing to be sensitively involved before and immediately after the death.

	• It was acknowledged that the Commission cannot investigate every death itself; however, it may need to investigate more often than 'exceptionally' – criteria should be developed to identify cases that may warrant Commission investigation – e.g. deaths involving restraint, victims of homicide, or where the circumstances suggest concerns of a significant failure by the local service. This could be an alternative to an FAI. • In cases where the investigating team receive evidence to suggest impaired fitness to practice on the part of a health or social care professional, the relevant regulatory body must be given that information in a timely manner to enable the regulatory body to investigate these concerns. (Guidance exists to explain thresholds for when regulatory bodies can and cannot open an investigation and the process of conducting that investigation. A charter also exists for patients, relatives and carers which sets out what they can expect when they raise a concern about a doctor.) • Investigating teams should be aware of GMC guidance on the professional standards expected of all doctors registered in the UK. (Similar guidance is probably available from other regulatory bodies.) • Guidance is needed on who the reviewing team can approach with problems and questions – possibly best if they approach the Commission. • 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. • It is a glaring and unacceptable conflict of interest for services to be entrusted with the investigation of deaths in their own care, even subject to guidance and review. Especially where the reviewing body has a professional bias and its own conflict of interest. Such investigations cannot be trusted to be independent.
Stage 4	• In relation to the process of reviewing the draft review report, guidance is needed on the exact process for the completion of reviews – who gets to see and comment on the report before it is published? • Review recommendations should be SMART. • Action plans to address recommendations need to be widely visible with clear actions, timescales, outputs and impacts. Guidance and training may need to be given on how to create a meaningful action plan. There will be a need for the commission to independently monitor actions plans and check progress. The Commission should have the power to challenge organisations when progress is slow. • There is a gap in relation to the enforceability of any recommendations made – further consideration needs to be given to situations where services fail to respond to direct or indirect recommendations. • How exactly will the Commission assess the reliability of 'local' investigations if the only thing it sees is a report? Will it conduct an 'audit' of that report?
Stage 5	• There were concerns about the potential for repeat questioning and interviewing of families over a prolonged period. • It is unclear what the purpose is for the Commission to prepare a separate report following completion of the review report. This will potentially introduce further delay to the process. It also implies that the family and staff involved in the incident will not receive the original report of the investigation – which will lead to concerns about transparency and FOI requests for the original report. • There is no explanation of what happens if the findings and conclusions of a Commission 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. • What happens if the findings and conclusions of a Commission review or investigation under stages 3 or 5 differ fundamentally from the findings and conclusions of the investigating body (e.g., a Health Board)? Whose findings and conclusions take primacy? This needs to be made explicit. What routes of appeal or redress will there be if any family member, carer or member of staff disagrees with any findings / conclusions of the Commission's?

Stage 6	• It may be useful for the Commission's purposes to produce an annual report to report on its activities. However, important lessons may be lost or delayed if this report is seen as the main method of communication. • A system needs to be put in place to (rapidly) disseminate lessons / learning at the end of each investigation. • The Commission needs to provide clarity the escalation process. • It is not clear what 'follow(ing) up on recommendations' and 'escalation' under stage 6 actually involves. Currently, there is no obligation, other than a moral obligation, on Scottish Government or any other organisation to act on recommendations made by the Commission. 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 to be clarified and making recommendations enforceable should be considered.

Annex 3: Improving compliance with Article 2 of the ECHR

The table below sets out (i) the key aspects of the human rights framework (Article 2 of the ECHR), (ii) views from the Scottish Human Rights Commission about the extent to the Commission's proposals are currently compliant and (iii) ways of improving compliance.

Aspects of human rights framework	Extent to which the Commission's proposal are compliant	Ways of improving compliance
Independence and effectiveness	The Commission has the necessary institutional and practical independence (from Scottish Ministers, the NHS and NHS boards) and the necessary powers to carry out an effective investigation. Where the investigation is carried out by the Commission itself, it may be possible to satisfy the requirements of independence and effectiveness. However, an after-the-fact review of a review carried out by bodies lacking the necessary independence (as required by Article 2) is not sufficient to remedy a defect in the investigation. In any subsequent investigation by the Commission 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.	The current powers of the Commission may require to be clarified in law to ensure they are comprehensive and directed towards this purpose. All reviews carried out by local services should be chaired by an individual approved by the Commission.
Promptness and reasonable expedition	The proposals to fix timescales for the completion of reviews was seen to be positive.	Any independent investigation should be completed within a matter of months.
Public scrutiny	The preparation of reports shared with families and services and the preparation of an annual report would be an improvement on the current situation	Additional elements of public scrutiny may be necessary, depending on the case. It may be necessary for some hearings to be held in public.
Involvement of next-of-kin	The proposal for a Commission Liaison Officer provides a significant opportunity to increase involvement of next-of-kin, but further support may be required.	It is important to clarify, in both local reviews and Commission investigations, what specific role or rights family members will have to be involved in the process – e.g. in terms of influencing the terms or reference, submitting questions, having access to documents, etc. Recommendations include: (i) giving families the opportunity to raise questions about the death with relevant senior managers and to receive responses; (ii) inviting families to comment on proposed recommendations and changes resulting from the investigation; and (iii) having access to free and immediate non-means-tested Legal Aid funding for specialist representation to allow for their participation in legal processes.