Investigating Deaths Occurring during Compulsory Care and Treatment under Mental Health Legislation in Scotland

The Mental Welfare Commission for Scotland Proposals

Final report to the Scottish Government

March 2022

deaths in detention reviews

mental welfare commission for scotland

Contents

1 Acknowledgments

This review was led by the Death In Detention and Homicide Review (DIDHR) Project team at the Mental Welfare Commission for Scotland (the Commission). Together we are grateful to the individuals, agencies and staff who have been able to discuss these issues with us so far to help us begin to formulate a way forward.

Our thanks in particular to families who contributed to this work.

A number of other people also contributed their expertise. We would also like to acknowledge Seona Hamilton, Public Health Librarian, NHS Heath Scotland Knowledge Services who led the initial rapid literature search and Rebecca Dodd, Alexandria research, who undertook the jurisdictions review.

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We also acknowledge the impact of COVID-19 on the activities and timescales for this development project. There were multiple changes in personnel and roles throughout the pandemic, both at the Commission and within all partner agencies.

The curtailment of opportunities for face-to-face contact impacted especially on opportunities to interact with families, notably our intention to hold a Listening Day for bereaved families, twice arranged and cancelled. The data-linking exercise with PHS was also delayed as the Public Benefit and Privacy Panel focussed on more pressing research needs related to COVID-19.

However, despite the difficulties we all faced, we are pleased that we were able to engage and progress as planned.

2 Language and terminology

2.1 Abbreviations

CHI	Community Health Index
CIPOLD	Confidential Inquiry into Premature Deaths of People with Learning Disabilities
CLO	Commission Liaison Officer
COPFS	Crown Office and Procurator Fiscal Service
COVID-19	Coronavirus Disease 2019
CPSA	Criminal Procedure (Scotland) Act 1995
CQC	Care Quality Commission
DIDR	Deaths in detention review
DMP	Designated Medical Practitioner
DoC	Duty of Candour
DPIA	Data protection impact assessment
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
eDRIS	The electronic Data Research and Innovation Service
FAI	Fatal Accident Inquiry
GDPR	General Data Protection Regulation
GMC	General Medical council
HIS	Healthcare Improvement Scotland
HRBA	Human Rights-Based Approach
IMP	Information management portal (MWC)
ISD	Information Services Division
IT	Information Technology
LeDeR	Learning Disability Mortality Review
MHTS	Mental Health Tribunal Service

MOU	Memorandum of Understanding
MSP	Member of the Scottish Parliament
MWC	Mental Welfare Commission for Scotland
NHSCR	NHS Central Register
NHS-NSS	National Health Service-National Services Scotland
NRS	National Records Scotland
NSPLG	National Suicide Prevention Leadership Group
PANEL	Participation, Accountability, Non-Discrimination, Empowerment and Legality
PBPP	Public Benefit and Privacy Panel
PF	Procurator Fiscal
RCA	Root Cause Analysis
SAER	Significant/Serious Adverse Event Review
ScotSID	Scottish Suicide Information Database
SEAR	Significant event analysis review
SFIU	Scottish Fatalities Investigation Unit
SIRO	Senior Information Risk Owner
SJR	Structured Judgement review
SMR	Scottish Morbidity Record
SPS	Scottish Prison Service
SSSC	Scottish Social Services Council

2.2 Key Terms

2.2.1 Investigation vs Review

Section 37 of the 2015 Act refers to the arrangements for investigating deaths and therefore to avoid confusion, the term ‘Review’ (capitalised) is used to refer specifically to the Scottish Government Review of the arrangements for investigating deaths of patients being treated for a mental disorder – the report of which was

published in 2018[1]. The term ‘mental disorder’ is used in the Scottish Government Review report to reflect the language used in mental health legislation in Scotland.

The public consultation on the proposals identified that the term review was preferable to investigation and the preferred terminology.

Section 328 of the 2003 Act defines a ‘mental disorder’ as any mental illness; personality disorder; or learning disability, however caused or manifested.

3 Executive Summary

3.1 Summary of Commission Proposals

Throughout our development work we heard of dissatisfaction with existing arrangements and that the Commission should do more.

- We propose the **revised process** as set out in Section 8.
- We propose that the Commission should be responsible for **initiating, directing and quality assuring** the process of investigating deaths during compulsory treatment in all cases.
- We propose that that the Commission should **be responsible for producing and disseminating an annual report on the results of the reviews**, with a focus on the lessons learned. All reviews conducted (whether by local services or by the Commission itself) will be summarised and reported on an anonymised basis (i.e. all reasonable efforts will be made to ensure anonymity of individuals).
- The Commission team **will follow up on recommendations made at a local and national level** and have a clear escalation policy to the Scottish Government when it considers that local services have not complied with recommendations made or there has been an unacceptable response to recommendations made.
- In order to enhance consistency, we propose that the Commission should **develop guidance and standards** for use by local services when

[1] Review of the arrangements for investigating the deaths of patients being treated for mental disorder - gov.scot (www.gov.scot)

undertaking reviews into deaths during compulsory treatment. Local services will include NHS, local authority, Health and Social Care Partnerships, third/independent sector and private sector care providers – all of which may be involved in the review of deaths.

This proposal does not cover people who were admitted to hospital or treated in the community on a voluntary basis.

3.1.1 Values and principles

The Commission believes that in order for its proposals to be in line with its duty (as set out in the 2003 Act) 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

3.1.2 The role of the Commission in the revised process

We propose that, in the revised process, the Commission should be responsible for initiating, directing, and quality assuring the process of reviewing all deaths during compulsory treatment. This will include cases where a person died within one month of having their compulsory treatment or detention order revoked. This will mean that the Commission will take an active role from the outset in every case.

The Commission will also have a role in bringing together and reporting on the learning from these reviews; authoring an annual report to summarise the findings of the reviews; and disseminating the main messages to the relevant audiences including local services, families and carers.

The Commission will also have a role in ensuring that any follow-up actions from local reviews are implemented and in escalating cases to Scottish Government and

Ministers, as appropriate, where recommendations are not implemented satisfactorily.

The rationale for proposing this role for the Commission is that the organisation – as described above– is in a unique position in relation to:

- the powers it has to (i) carry out investigations into an individual's case, (ii) require that any individual's records, including medical records, are presented to it for inspection and (iii) hold an inquiry for the purpose of carrying out an investigation
- its independence.
- its experience in carrying out a range of investigations into deficiencies in care and treatment relating to people with mental ill health and/or learning disability

3.1.3 The development of guidance and standards

To support the revised process, the Commission will develop –by autumn 2022 – guidance and standards for local services. Local services will include NHS, local authority, Health and Social Care Partnerships, independent sector and private sector care providers – all of which may be involved in the reviews of deaths.

The guidance will cover such issues as:

- ensuring that the level of review is proportionate to the circumstances of the person's death;
- involving a range of other (non-NHS) organisations in the reviews;
- advising on steps to maximise independence in the local review process;
- good practice in relation to the commissioning of external expert reviews;
- putting in place arrangements to ensure that family concerns and questions are responded to; and
- following up on how learning and recommendations are implemented.

4 Background & Remit of the Death in Detention Review

4.1 Aims of the Review

People in Scotland may receive care and treatment for a mental health condition or learning disability in a variety of settings – both in the community and in hospital. When a person dies in hospital, there may be a review into their death. This review is usually undertaken by the local service(s).

In certain situations, the Mental Welfare Commission may be involved in the review of deaths of people who have been compulsorily treated or detained in hospital.

The nature and complexity of the review will depend on a number of factors including (i) whether the death was unexpected or unexplained; (ii) staff action, or inaction, which may have contributed to the death; and (iii) organisational policies, procedures or practices which may have contributed to the death.

Section 37 of the Mental Health (Scotland) Act 2015[2] set out a requirement for Scottish Ministers to undertake a Review of the arrangements for investigating deaths of people who were in hospital for the assessment and treatment of a mental health condition or learning disability. The remit of this Review was subsequently extended to also examine the processes for investigating the deaths of people being compulsorily treated in the community.

The aim of the Review was to establish whether the current arrangements for investigating the deaths of people being treated for a mental health condition or learning disability are adequate, and how well local organisations support and engage with the families and carers of people who have died.

4.2 Findings of the Scottish Government Review

The report of the Review was published in 2018. Its main finding was that the deaths of people being treated for a mental health condition or learning disability are currently not being investigated consistently in a way that can be guaranteed to be independent.

[2] Mental Health (Scotland) Act 2015 (legislation.gov.uk)

The Review found that not all deaths are investigated, especially in cases where the deaths have not been recorded as 'unavoidable' or 'unexpected', despite the fact that the people who died may have spent long periods of time subject to orders under the 2003 Act or part VI of the 1995 Act.

The Review also found that there is wide variation in the time taken to carry out investigations – from a few weeks to as much as two years – and that families and carers are often excluded from the process.

The Review recommended that every death where the person was subject to an order under mental health legislation should be subject to a proportionate level of review. The investigation process should be timely, should have a sufficient element of public scrutiny, and should involve families, staff and carers.

Several actions arose from the Review – the first of which was that[3]:

'The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended).'

'This process should take account of the effectiveness of any investigation carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.'

[3] The proposals set out in this paper specifically address action 1 from the Review. However, the proposals also touch on (some of the) other Review actions and may contribute to broader developments in a positive way.

4.3 Why was the Mental Welfare Commission asked to take on this task?

The Commission was established by the Mental Health (Scotland) Act 1960, with changes made to its constitution and functions by the 2003 Act and the Public Services Reform (Scotland) Act 2010. It is accountable to Scottish Ministers but carries out its work and produces reports independently from Scottish Government.

In carrying out its functions, the Commission is required by section 4(2A) of the 2003 Act to act in a manner which seeks to protect the welfare of persons who have a mental health condition or learning disability. It has extensive powers to carry out investigations and make recommendations into an individual's case. These powers apply to people detained in hospital and to those who are in the community. The Commission can inquire into and make recommendations relating to any individual's case, including in circumstances where a person may be, or may have been, subject or exposed to ill-treatment, neglect or some other deficiency in care or treatment. Investigations can be carried out while the individual is alive and also following death.

4.4 Specific Powers of the 2003 Act

- **Section 1** of the 2003 Act sets out the general principles according to which people performing functions under the Act must discharge those functions. Subsection 6 extends this to giving regard to the importance of the provision of appropriate services to the person, including continuing care, where the person is no longer subject to the certificate or order.
- **Section 11** of the 2003 Act gives the Commission power to investigate a person's case and to make recommendations in cases where a person has been unlawfully or improperly detained or may be or have been subject to ill-treatment or other deficiency in care or treatment.
- **Section 12** of the 2003 Act gives the Commission the power to hold an inquiry for the purpose of carrying out an investigation. The chair of such an inquiry has the power to require people to attend to give evidence, administer oaths and examine witnesses under oath. Inquiry proceedings are equivalent to court proceedings and refusal to attend or give evidence at an inquiry is a criminal offence.

- **Section 16** of the 2003 Act gives the Commission the power to require that any individual's records, including medical records, be presented to it for inspection.

4.5 Remit of the Review

The Commission was asked to develop a revised process for investigating deaths during compulsory care and treatment under mental health legislation in Scotland. As set out in the 2018 Scottish Government Review, the revised process should:

- Take account of any investigation carried out by other agencies
- Reflect the powers of the Commission
- Include appropriate elements of public scrutiny
- Involve families, carers and staff
- Have clear timescales for investigation, reporting and publication.

In addition, the design and testing of the new system should involve and be informed by the views of carers, families and staff with direct experience of existing systems.

The Commission's work to develop the systems for reviewing these deaths will culminate in a process for implementation of the revised system.

4.6 Scope of the Review

The scope did not include people who were receiving care and treatment for mental disorder on an informal basis.

Children can be detained under the MH Act, there is no lower age limit so the death of a child was within the scope of the review.

Future work would include working with the National Hub for Deaths of Children and Young People[4], to ensure input to any under 26 year olds with a care history.

[4] National Hub for Reviewing and Learning from the Deaths of Children and Young People (healthcareimprovementscotland.org)

4.7 Policy in Other Areas

A thematic report following an independent review of the response to deaths in prison custody in Scotland was published in 2021[5].

The review made a number of recommendations, including that an independent body should carry out an investigation into every death in prison custody. This is intended to complement the current inquiry processes, including Fatal Accident Inquires. All of the review's recommendations have been accepted in principle by the Scottish Government.

The Key Recommendation from that review was:

'In particular, we are recommending that a separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS'.

5 Current Situation in Scotland

5.1 Policies and Processes Following a Death

The s37 Review noted the multiplicity of agencies and processes that can be involved in the review of deaths of people in mental health care.

In our work and from our engagement with families and pilot work with Boards we know that in some cases deaths are not reviewed to any extent, while others will have a review similar to the Royal College of Psychiatrists Care Review tool for mortality reviews[6] and others will be investigated in line with NHS boards' adverse event review processes. Multiagency learning reviews may also be undertaken as part of child or adult protection processes.

Healthcare Improvement Scotland's (HIS) national framework for learning from adverse events supports a consistent national approach to the identification, reporting and review of adverse events, and allows best practice to be actively

[5] Death in custody review - gov.scot (www.gov.scot)
[6] Care Review Tool for Mental Health Trusts| Royal College of Psychiatrists (rcpsych.ac.uk)

promoted across Scotland[7]. Health boards may choose to share the results of any adverse event review with others, including the Crown Office and Procurator Fiscal Service (COPFS), and the Commission. The national framework's focus is on sharing any learning that could inform service improvement and organisations' adverse event management processes to improve the quality of care delivered.

The Lord Advocate has the responsibility for investigating deaths that require further explanation. The Procurator Fiscal, acting on behalf of the Lord Advocate, receives reports of deaths in certain circumstances. Within COPFS, the Scottish Fatalities Investigation Unit (SFIU) is a specialist unit responsible for investigating sudden, suspicious, accidental and unexplained deaths.

The role of COPFS in relation to the deaths of people under mental health detention is set out in a joint letter from the Scottish Government's Chief Medical Officer and the Crown Agent and Chief Executive of COPFS. The letter was issued to health boards in November 2015 requiring medical practitioners to report to the Procurator Fiscal, any death of a person subject to an order under either the 2003 Act or part VI of the 1995 Act (whether in hospital or in the community)[8].

The letter states that there may 'be a small number of cases where some further investigation is required into the circumstances of the death. This will enable discretionary Fatal Accident Inquiries (FAI) as appropriate, as in any reported death.' It goes on to say that

'The change has been introduced to ensure that these deaths are given the appropriate level of scrutiny in accordance with Article 2 of the European Convention on Human Rights.'

Where a death is a result of an unintended or unexpected incident during the provision of care and treatment and not related to the course of the condition for which the person was being treated, healthcare (and other) providers are required to follow the Duty of Candour procedure[9].

[7] https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx
[8] https://www.sehd.scot.nhs.uk/cmo/CMO(2015)20.pdf
[9] Organisational duty of candour: guidance - gov.scot (www.gov.scot)

It is important to note that a Fatal Accident Inquiry (FAI) is always held when a death occurs in police custody or prison[10]; this is not the case for deaths that happen when someone is under mental health detention in Scotland.

There have been criticisms of the FAI and adverse event review processes in relation to deaths in prison due to often-lengthy delays, limited involvement and participation of family members, a lack of follow up on recommendations made and national learning from these individual events[11].

Deaths of people being treated for mental disorder in Scotland are not always routinely reviewed or formally investigated. A small number lead to further detailed investigation by the Commission which progress to an FAI. Most deaths of people subject to mental health detention at the time of their death are not currently being reviewed locally or investigated consistently in a way that can be said to be independent.

5.2 Families and Carers Involvement

It was acknowledged in the Scottish Government Review that families and carers offer a perspective on the circumstances surrounding a person's death that others do not have. The Review report emphasised the importance of ensuring that in future, all investigations relating to the death of a person during compulsory treatment should involve families and carers in a meaningful way. This is currently not consistently the case[12].

The Review explained that the key reason why families and carers wished to be involved in the investigations was so that lessons could be learned, and others could be protected in the future.

[10] Fatal Accident Inquiries: review - gov.scot (www.gov.scot)
[11] Betsy Barkas, Linda Allan, Stuart Allan, Sarah Armstrong and Deborah Kinnear (2021) Nothing to see here? 15 years of FAI determinations for deaths in custody. https://www.sccjr.ac.uk/projects/deaths-in-custody-15-years/

[12] A survey of family members and carers conducted for the Review received 42 responses. Approximately half of the respondents to this survey had a family member or friend who had died whilst being treated compulsorily under the 2003 Act. The survey findings showed that just under half of respondents (48%) said they were not kept informed about the progress of the investigation, more than one-quarter (29%) were not offered a meeting with anyone as part of the investigation process.

The Review suggested that one specific element to assist with improving the involvement of families and carers would be to create a ‘single point of contact’ for them in relation to all investigations/reviews.

In our conversations with bereaved families (Phase One) we found that families wish investigation processes to be more accessible to families; to be reassured of the review process objectivity and independence; and that a proper and effective investigation of their relative’s death had been carried out. Whilst we heard of good practice and positive experiences with staff we also heard where there was still room for improvement. For example lack of sensitivity, not enough time and space to ‘tell their story’ and really pass on what they knew about the deceased, lack of clarification of expectations about process, what is and is not included, timescales and decision making, errors and use of poor language in reports, lack of signposting to emotional or bereavement support.

Our examination of Commission case records and cases highlighted by families themselves illustrate the lack of opportunity for families to input their experience and concerns at the time of an ‘expected’ or even ‘sudden or unexpected death’ due to physical ill health as families were not invited to any form of review process.

We learned that local services generally intend to be open, transparent and honest with families during reviews of deaths during compulsory treatment, as set out in the organisational duty of candour. Local policies and associated written materials for families support this aim. However, local services identified a range of barriers to full involvement of families in local review processes. These include a lack of dedicated resource to liaise with families, a lack of administrative time for recording minutes, and gaps in training and support for staff dealing with difficult emotional issues.

5.3 The Commission Liaison Officer

We propose that the Commission develops a new role of a Commission Liaison Officer. The purpose of the role will be to help improve the involvement of, and communication with, families and carers during reviews of deaths. The Commission Liaison Officer will be involved in the initial review of any death which occurs during compulsory care and treatment. The role will involve:

- Providing continuity of contact with the family and carer(s) from the outset of the review through to its completion
- Keeping the family and carer(s) fully informed about the progress of the review
- Ensuring that any questions, points or contributions which the family and carer(s) wish to ask or make are communicated – and responded to – in a timely fashion
- Signposting family and carer(s) to appropriate support services (e.g. bereavement counselling)
- Take account of impact/diversity requirements

The post will require the holder to display sensitivity, compassion, respect, empathy at all times, and to take account of any special communication requirements that family members or carers may have.

In addition the Commission Liaison Officer role will work to:

- Develop and promote standards for good practice in engaging with families.
- Network across Scotland with boards and other agencies to ensure that barriers to family participation in local reviews are addressed
- Ensure learning from individual reviews about family involvement is fed into national level learning reports and actions

Current experience in NHS England exemplifies good practice and highlights the importance of availability and continuity of this liaison role to families[13] [14]. We propose dual deployment, with the proposed Commission Liaison Officer role(s) working across both deaths occurring during compulsory care and treatment and also across investigations of homicides where the perpetrator has a mental disorder.

[13] https://www.makingfamiliescount.org.uk/2021/06/21/webinar2/

[14] Healthcare Safety Investigation Branch (September 2020) National Learning Report. Giving families a voice: HSIB's approach to patient and family engagement during investigations Independent report by the Healthcare Safety Investigation Branch I2020/007 https://www.hsib.org.uk/investigations-and-reports/giving-families-a-voice/

6 Findings

6.1 Key Findings

The key findings from our engagements with individuals, health boards and partner organisations concerned the following key areas:

- Notification of deaths
- Current system/situation in Scotland (Policies and processes following a death)
- Independence
- Human rights
- Availability of personnel/admin
- Guidance and Standards
- Training
- Family involvement in investigations

7 Developing our Proposals

7.1 Phase One (November 2019 to March 2021)

We adopted a human rights-based approach, using PANEL principles (Participation, Accountability, Non-discrimination, and Legality) to inform our development work.

Our work had regard to the relevant human rights provisions in domestic and international law.

We explored existing systems of review in Scotland and other UK and international jurisdictions to identify best practice approaches. We commissioned an initial rapid literature review via NHS Heath Scotland Knowledge Services. Further literature reviewed across four jurisdictions (Rep of Ireland, Canada, Australia and New Zealand) was then undertaken by Rebecca Dodd, Alexandria research. We have drawn from this work throughout the development work (Appendix 1)

We engaged within the Commission to design new processes, and identify the resources required for implementation of a new system.

We established external engagement processes for families and carers with experience of current systems of review.

We established external engagement processes for staff in NHS Boards and Health and Social Care Partnerships, including closer working with 4 pilot areas.

We liaised with other Scottish Government reviews of relevance including the commitment to review all suicides, the implementation of additional recommendations from the s37 review and the current review of the Mental Health Act.

We liaised with Healthcare Improvement Scotland (HIS), which has developed a national adverse events framework to support a consistent national approach to the identification, reporting and review of adverse events (including suicides whilst in care) and to allow best practice to be promoted across Scotland

We liaised with the Crown Office and Procurator Fiscal Service (COPFS), which receives reports of deaths in certain circumstances, and has a role in investigating sudden, suspicious, accidental and unexplained deaths

We engaged with many other key informants e.g., Death Certification Review Service, s37 Review Implementation Group, Police Scotland, NHES , Prisons Review, Inquest and Hundred Families,

We implemented internal tests of change for devising a new system.

We initiated test reviews of a small number of deaths.

During the process of scrutinising the completeness and accuracy of notifications, we found that there is variation in practice across Scotland. We conducted an exercise via Public Health Scotland, to link our data with that of National Records Scotland register of deaths and the Scottish Suicide Information Database towards ensuring a complete data set of all deaths under an order and understanding of causes of death. We are aware that the National Confidential Inquiry into Suicides and Safety in Mental Health (NCISH) (May 2021) Annual report for 2021 reported that in the decade up to 2018, 32% of inpatient suicides in Scotland were of people detained under the Act, an average of 14 deaths per year. Three percent of suicides

were of people detained on community based compulsory treatment orders, an average of 6 deaths per year.

From our examination of this data, we know that 6.7% of deaths of people under detention are not routinely notified to the Commission. (See Appendix 2)

7.2 Phase Two (March 2021 to March 2022)

In this phase, proposals for a new process were developed and these were put out to public consultation in December 2021 for eight weeks.

Work commenced and is ongoing on two reviews of deaths using the proposed new process.

8 Proposals

8.1 Revised Process

The stages of the proposed revised process are set out below. It should be noted that, unlike the situation at present, the revised process proposed requires that all deaths during (and shortly following) compulsory care and treatment are reviewed.

This proposal will not remove the right for families and others to request a Fatal Accident Inquiry but aims to provide an independent level of review that is compliant with human rights legislation and principles and designed to put families at the heart of the process.

Stage 1

The Commission will be notified by local services of the death of a person who was subject to the 2003 Act at the time of their death or who died within a month of being subject to the Act.

Stage 2

An initial review of the circumstances surrounding the death will be undertaken by a Commission team set up for this purpose. The team will include medical, social work and nursing expertise, administrative and analytical support, and a Commission

Liaison Officer (CLO). (The role of the Commission Liaison Officer is described in more detail in Section 5.3)

The Commission will also ensure that the team involves specialist expertise where this is required and not available within the Commission. For example, where the death involves a person with a learning disability, the team would include an individual professional who has specialist expertise in this area.

Stage 3

Based on this initial review, the Commission will liaise with the relevant local services about the level of review that should be conducted and will agree the terms of reference for the review and the timescale for completion.

The timescales will depend on the circumstances of the individual case.

This may range from 3–6 months for the local service, to 6–12 months or more for a Significant Adverse Event Review (SAER) involving a range of agencies and disciplines. (Further details about the timescales for reviews will be set out in the guidance and standards, which the Commission will develop in early 2022)

Note that at this stage the Commission may advise the local service(s) that the review should be chaired by an individual agreed by the Commission.

Exceptionally, at this stage, the Commission may undertake an investigation. The Commission will take this step if it considers it is inappropriate (for whatever reason) for the local service(s) to carry out the review.

There is another possibility at this stage, namely, where the death is subject to an ongoing criminal investigation, the Commission will discuss with the Crown Office and Procurator Fiscal Service (COPFS) the type of review which is required; in certain cases, this review may need to be postponed until any criminal investigation or significant case review has concluded.

Stage 4

Following completion of the review by the local service(s), the Commission's team will assess whether (i) the agreed terms of reference for the review have been met and (ii) the actions identified for follow up by the local service(s) are being satisfactorily progressed.

The Commission's team will discuss specific timescales to follow up on any actions arising from the review.

Stage 5

A range of possible options may then be pursued at this stage as follows:

- If the team at the Commission are satisfied both with the review and with the follow up actions by the local service(s), then the team will prepare a report to be shared with families and the service(s).
- If the team at the Commission is not satisfied that the local review complied with the terms of reference which had been set, then the Commission may undertake its own further proportionate level of review, which could involve requesting case files, interviewing staff and other key individuals and publishing findings – either as part of an annual report, or as a separate stand-alone report.

Stage 6

The Commission will produce an annual report, with a focus on the lessons learned. All reviews conducted (whether by local services or by the Commission itself) will be summarised and reported on an anonymised basis (i.e. all efforts will be made to ensure no details will be included which would allow for the identification of individuals).

The Commission team will follow up on recommendations made at a local and national level and have a clear escalation policy to the Scottish Government when it considers that local services have not complied with recommendations made or there has been an unacceptable response to recommendations made.

The Commission will produce good practice guidance that will cover such issues as:

1. ensuring that the level of review is proportionate to the circumstances of the person's death;
2. involving a range of other (non-NHS) organisations in the review;
3. advising on steps to maximise independence in the local review process;
4. good practice in relation to the commissioning of external expert reviews;

5. putting in place arrangements to ensure that family concerns and questions are responded to;
6. following up on how learning and recommendations are implemented.

The Commission are aware of the sensitivity of staff involved in an incident and will need to demonstrate sensitivity towards staff involved in these incidents[15]. The guidance should also refer and signpost practitioners to support.

9 Commission Powers to Investigate

9.1 Legal basis for the Commission's role in proposed process

The Commission's Deaths in Detention Review Project, arises from the Action Point at page 24 of the Scottish Government's S37 Review of the arrangements for investigating the deaths of patients being treated for mental disorder.

At paragraph 41-43 of the Report, the Scottish Government sets out its understanding of the relevant functions and powers of the Commission:

"41. The Commission, in carrying out its functions, is required by section 4(2A) of the 2003 Act to '…act in a manner which seeks to protect the welfare of persons who have a mental disorder'.

Section 11 of the 2003 Act gives the Commission the power to carry out an investigation as it considers appropriate into a patient's case and to make such recommendations as it considers appropriate.

It has extensive powers to carry out such investigations and make recommendations into a patient's case. These powers apply to people detained in hospital and also to those who are in the community. The Commission can inquire into and make recommendations relating to any patient's case, including in circumstances where a patient may be, or may have been, subject or exposed to ill-treatment, neglect or some other deficiency in care or treatment. Investigations can be carried out while the person is alive and also following death.

[15] What is compassionate leadership? | The King's Fund (kingsfund.org.uk)

9.2 Discharging Functions (within proposed process with reference to current statutory powers)

Section 16 of the 2003 Act gives the Commission the power to require that any patient records, including medical records, are presented to it for inspection.

Under section 12 of the 2003 Act, the Commission can hold an inquiry for the purpose of carrying out an investigation. The chair of such an inquiry has the power to require people to attend to give evidence; administer oaths and examine witnesses under oath. Inquiry proceedings have the privilege of court proceedings and refusal to attend or give evidence at an inquiry is a criminal offence.

The Commission has extensive powers in relation to a “patient” meaning a person who has, or appears to have, a mental disorder as defined in sections 328 and 329 of that Act.

The nature and scope of the duty in section 17 affords the Commission all facilities to enable the Commission to discharge the Commission's functions under the 2003 Act.

The power in section 16 to require the production of records for examination is in connection with any of the Commission’s functions in the 2003 Act or the Adults with Incapacity (Scotland) 2000 Act[16]. The duty to afford all facilities under section 17 is to enable the Commission to discharge the Commission's functions under the 2003 Act only.

In terms of paragraph 2 to Schedule 1 of the 2003 Act the Commission may do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of its functions.

A “patient” does not require to be a person admitted to hospital. If the records are held by authorities listed in s.17, the Commission can request copies.

Medical or “other records” Includes care and social work records. Medical or other records of a patient cover all records of all types including documents, videos, messages, records on mobile devices, scans, notes, test results, care and social work records, records created for criminal justice processes about a patient, (being a

[16] Adults with Incapacity (Scotland) Act 2000 (legislation.gov.uk)

person who has or who appears to have a mental disorder,) and includes records which contain significant information about offences.

The Commission can make the formal requirement in terms of section 16 to produce those records for inspection to each and every one of the persons listed at section 17(2)(a) of the 2003 Act. If making the formal requirement, the Commission has to refer to the statutory function or functions in connection with which they are making the section 16 requirement.

The Commission can make the section 16 requirement not only to the persons listed in section 17(2) (a) (being the persons who are to afford “all facilities”) but to any person holding the records of a patient.

The Commission can request access to records about a patient that are not health or social care records, for example records of the authority’s own investigations or reports. The purpose for which the person is holding the records does not matter if section 16 applies.

In respect of section 17, all relevant bodies must do what is necessary to help the Commission carry out its duties, including Scottish Ministers, police forces, care services, and prisons and young offenders’ institutions.

There is no definition of “other records” within the 2003 Act or any guidance as to its interpretation within the explanatory notes. Therefore, this is likely to extend to care and social work records provided they are relevant for the discharge of the Commission’s functions.

9.3 The Legal Definition of Records and Patient for the purposes of the proposed process with reference to the Commissions existing powers

The definition of patient within the Act appears to only relate to living persons. However, the role of the Commission in investigating deaths in care is well-established. The powers to require production of records for inspection appears to only relate to living persons because of the definition of patient within the MHCTSA 2003. That issue is not expressly addressed in the legislation.

This view was reached because the definition of a patient in section 329 of the 2003 Act as a person who has, or appears to have, a mental disorder could not, on the

face of it, apply to a deceased person who had a mental disorder as that is not a person who has, or appears to have, a mental disorder. That would mean that where “functions” in the 2003 Act, as mentioned in sections 16 and 17, related to a patient, it could not relate to a deceased patient.

That view is, on the face of it, fortified, by the terms of section 11 of the 2003 Act.

The verbs are all in the present tense except where the past tense “have” is specifically used and even there the circumstances appear to relate to a living patient who may have been, subject, or exposed, to (i) ill-treatment; (ii) neglect; or (iii) some other deficiency in care or treatment, or because of the mental disorder, the patient’s property may have suffered, loss or damage; or (ii) may have been, at risk of suffering loss or damage.

That view is supported by other sources. For example the Report on the Review of the arrangements for investigating the deaths of patients being treated for mental disorder published by Scottish Government in December 2018 states at paragraph 41: “Investigations can be carried out while the person is alive and also following death.” That statement could have been made because section 11 expressly provides that the patient may have been, subject, or exposed, to (i) ill-treatment; (ii) neglect; or (iii) some other deficiency in care or treatment, and a deceased patient may be thought to be included as a patient who may have been so subjected or exposed.

Having regard to all these factors and on seeking legal advice, in the event of a dispute about whether the functions mentioned in sections 16 and 17 apply to deceased patients the Commission will argue, for the above reasons that they do.

Given the statutory objectives in the 2003 Act to protect people who have or appear to have a mental disorder, the Commission can argue it was Parliament’s intention to include within the scope of the section 16 and 17 provisions, patients who had and appeared to have had a mental disorder but are deceased.

9.4 Criminal Procedure (Scotland) Act 1995

Regarding the Commission's powers and duties as set out in sections 16, 17 and any other relevant sections: these powers apply in an equivalent way for patients who are subject to orders under part IV of this Act as for patients under 2003 Act.

The duties and powers to make orders and remits in Part VI of the 1995 Act all apply to persons who are, may be, or appear to be suffering from mental disorder, so will be persons who fall into the definition of "patients" for the purposes of the 2003 Act as they fall within the definition at section 329.

Accordingly, the Commission's powers and duties as set out in sections 16, 17 and any other relevant sections apply to persons who are subject to orders under Part VI of the 1995 Act because those persons are "patients" under the 2003 Act.

In respect of section 17, all relevant bodies must do what is necessary to help the Commission carry out its duties, including Scottish Ministers, police forces, care services, and prisons and young offenders' institutions.

9.5 Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016

It is to be noted that there is a potential overlap, of which the Commission is mindful, between an investigation by the Commission and the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

The Commission can give consideration to (and discuss with COPFS) whether to carry out any investigation and when, if there is to be or has been an FAI or any of the other proceedings set out in section 3(2) of the 2016 Act and if the Commission is satisfied that the circumstances of the death have been sufficiently established during the course of an FAI or such proceedings.

A protocol will be established so that the timing of any investigation by the Commission does not interfere with or prejudice any investigation by the police or any other reporting agency under the direction of COPFS. There is learning for the Commission from the terms of the COPFS Family Liaison Charter in terms of section 8 of the 2016 Act and we make reference below to section 11 of the 2016 Act which makes provision for the persons who may participate in an FAI.

The Commission will be subject to judicial review if it acts unlawfully in carrying out its activities including in relation to the investigation of mental health homicides by acting unlawfully, irrationally or unfairly. Illegality can arise where the Commission fails to do what the common law or enacted law, including the 2003 Act and the Human Rights Act 1998 require, or where it exceeds its powers, or where it makes an error of law.

It may be necessary for the Commission to instruct its own experts or assessors, or to have certain experts or assessors sit with it when considering aspects of a case out with areas of expertise.

9.5.1 Summary

It is clear that the Commission is afforded a wide discretion in the exercise of its powers in relation to the receipt of ‘facilities’ from third parties and in the inspection of documentation in the hands of third parties, provided that the use of those powers is sufficiently linked to a core function of the Commission.

In respect of the powers under section 16 of the Act specifically, the Commission is also afforded a wide discretion as to whom those powers may be exercised against.

In any circumstance where the Commission seeks to obtain information from a third party using those powers or any other powers at its disposal, consideration will require to be given to various other legal obligations including those arising under the common law duty of confidentiality, data protection law and the human rights regime.

The current independent review of mental health and incapacity legislation in Scotland will allow the Commission to ensure that further duties, powers and functions are updated to reflect changes in practice across Scotland.

10 Duty of Candour and Relevance to Deaths in Detention Proposed Process

10.1 Organisational Duty of Candour

Duty of Candour (DoC) regulations came into effect from 1 April 2018. The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act)[17]

The Duty of Candour Procedure (Scotland) Regulations 2018[18] set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm.

Organisational DoC guidance[19] focuses on the implementation of the legal duty of candour procedure for health, care or social work services. Organisations are required to be open and honest when something goes wrong that is not related to the course of the condition for which the person is receiving care.

The Scottish Government has made available Organisational Duty of Candour in Scotland leaflets[20] for organisations to distribute to the patient, service user or person acting on their behalf (and in easy read formats).

The organisational DoC procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death, to apologise and to meaningfully involve them in a review of what happened.

When the review is complete, the organisation, in its capacity as 'responsible person' should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) – the 'relevant person', what those actions are and when they will

[17] Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (legislation.gov.uk)
[18] Scottish Statutory Instrument 2018 No 57 National Health service Social Care Social Work The Duty of Candour Procedure (Scotland) Regulations 2018 https://www.legislation.gov.uk/ssi/2018/57/made/data.pdf
[19] https://www.gov.scot/publications/organisational-duty-candour-guidance/
[20] Duty of candour leaflets and easy read versions https://www.gov.scot/publications/duty-of-candour-leaflets/

happen. They must also publish a publicly accessible annual report on how they implemented DoC procedure for adverse events which resulted in harm.

Organisational DoC reflects Professional Duty of Candour, whereby individual healthcare professionals were already obligated to be open and honest with patients when things went wrong, culminating in the publication of a professional duty of candour[21] in 2014.

10.2 Duty of Candour – Relevance to Deaths in detention

It is only a sub-set of deaths under detention which might trigger a Duty of Candour response. The duty of candour procedure must be followed as soon as possible after an organisation providing health, care or social work services receives confirmation that, in the opinion of an independent health professional, a person has experienced an unintended or unexpected incident which appears to have resulted in harm or death. The death or harm should not be related to the natural course of the illness or underlying condition for which the person is receiving treatment or care. The family representative of a person who has died in detention is the 'relevant person' to whom the board or care and treatment service provider must respond.

The learning outcomes of any investigative review must be included in anonymised format in the annual DoC report published by the Board.

In our Phase 1 work we found that not all Boards' annual DoC reports break down events by speciality, and numbers by speciality may be small (e.g. one board reported just one mental health related DoC event in 2019/20). Given the small numbers, it may not be feasible for individual Boards to report on deaths in detention DoC events annually. Our view is that these should be collated and reported on nationally on an annual basis and the Commission will follow up on this further.

[21] NMC/GMC (June 2015, updated June 2019) Openness and honesty when things go wrong: the professional duty of candour https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand pdf-61540594.pdf

11 Human Rights Considerations

11.1 Relevant Human Rights Principles

The revised process for reviewing deaths during compulsory treatment will take a human rights-based approach – that is, every effort will be made to put the human rights of families and carers at the centre of the process. Human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life. They can never be taken away, although in certain circumstances, they can sometimes be restricted. These basic rights are based on shared values like dignity, fairness, equality, respect and independence, and they are protected by law.

The PANEL principles[22] have guided the development of the Commission's proposals. The PANEL principles require that consideration is given to Participation, Accountability, Non-discrimination and equality, Empowerment and Legality.

Consideration has also been given, specifically, to Articles 2, 3 and 14 of the European Convention on Human Rights[23], which provide for the right to life (Article 2), the right to freedom from torture and inhuman or degrading treatment (Article 3), and the protection from discrimination in respect to these rights (Article 14). Article 14 is closely related to the Convention on the Rights of Persons with Disabilities[24] which requires that there should be no discrimination in how laws, policies and procedures affect people with disabilities as compared with other people. (See Appendix 3)

11.2 The Right to Life

The right to life identified in Article 2 ECHR is one of the ECHR's most fundamental provisions. Article 10 CRPD also identifies the right to life[25].

[22] https://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf
[23] https://www.echr.coe.int/documents/convention_eng.pdf
[24] https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx
[25] Article 10 CRPD states 'States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.'

Article 2 ECHR comprises two substantive obligations being:

- the general obligation to protect by law the right to life; and
- the prohibition of intentional deprivation of life (subject to some exceptions)
- and, a procedural obligation to carry out an effective investigation into alleged breaches of its substantive limb.

This positive obligation to protect life requires the State to take appropriate steps to safeguard the lives of those within its jurisdiction and there are two aspects to this:

1. the duty to provide a regulatory framework; and
2. the obligation to take preventive operational measures.

11.3 Effective and Independent Investigation into Deaths

In terms of the procedural obligation to ensure an effective and independent investigation into deaths, there have been some further European Court of Human Rights rulings reinforcing or further developing the jurisprudence and direction around Article 2 ECHR requirements for investigations into deaths.

In the context of healthcare, the Court has reinforced and reiterated that Article 2 requires:

1. The establishment of an effective and independent judicial system which can provide civil and, where appropriate, criminal remedies[26] and, where state agents or members of a profession are involved, disciplinary measures[27].
2. The nature and form of the investigation is in individual state's discretion[28] and that when assessing the adequacy and effectiveness of this provision the whole legal framework rather than single elements of it must be considered[29].
3. The Court has also ruled that where there is a lack of clarity as to whether or not the cause of death or harm was unintentional then the authorities must conduct an initial investigation to establish this[30]. Once a lack of intentionality has been established then a civil remedy is usually sufficient, and a criminal

[26] *Cevrioglu v Turkey* (69546/12) [2016] ECHR 808, para 54; *Lopes de Sousa Fernandes v Portugal* (56080/13) [2017] ECHR 1174, paras 137, 214-215.
[27] *Zinatullin v Russia* (10551/10) [2020] ECHR 77, para 32.
[28] *Cevrioglu v Turkey*, paras 53 and 55; *Fernandes v Portugal*, para 216.
[29] *Valeriy Fuklev v Ukraine* (6318/03), judgment 16 April 2014, para 67.
[30] *Tunc and Tunc v Turkey* (24014/05) [2013] ECHR 793, para 133; *Tanse v Romania* (41720/13) [2019] ECHR 491, paras 160-164.

remedy will only be required in exceptional circumstances[31], for example in the context of the victim having been denied healthcare[32]. This could conceivably therefore apply to both care and treatment for mental illness and physical health conditions.

4. Where a patient is in the care of medical professionals, the investigation must have independence from those implicated, including those who are providing expert evidence[33].
5. Relevant proceedings must be completed timeously given the importance of the outcome to patient safety[34].
6. Where medical negligence as a cause of death has been unintentional then it is acceptable for the state's procedural obligation to become operational at the stage when the deceased's relatives commence proceedings[35].Note that this is quite different to situations where death occurred as a result of the use of lethal force by state agents or an accident.
7. In terms of the investigatory proceedings themselves, excessively lengthy proceedings (for example, those lasting for many years),[36] medical evidence which is not impartial[37]and expert opinions without reasons[38] may constitute violations of the procedural duty of Article 2 ECHR. A legal system which prevents the deceased's next of kin from claiming or receiving recompense will also constitute a violation[39].

[31] *Tanse v Romania*, para 163; *Zinatullin v Russia*, para 55; *Cevrioglu v Turkey*, para 54; *Fernandes v Portugal*, para 215.
[32] *Asiye Genc v Turkey* (24109/07) [2015] ECHR 78, para 73. This case involved a failure to provide appropriate care and treatment for a premature baby.
[33] *Bajic v Croatia* (41108/10) judgment 13 February 213, paras 90 and 95; *Fernandes v Portugal*, para 217.
[34] *Cavit Tinarlioglu v Turkey* (3648/04) [2016] ECHR 140, para 115; *Fergec v Croatia* (68516/41) [2017] ECHR 435, para 38; *Bilbija and Blazevic v Croatia* (62870/13) [2016] ECHr 70, para 107; *Fernandes v Portugal*, para *219. See also the earlier ruling of Oyal v Turkey (4864/05) [2010] ECHR 369, para 761.*
[35] *Fernandes v Portugal*, para 220.
[36] *Bilbija and Blazevic v Croatia*, paras 105-107.
[37] *Bilbija and Blazevic v Croatia*, paras 98-102.
[38] Noting an earlier case *Lazar v Romania* (32146/05) judgment 16 February 2010, paras 81-85.
[39] *Sarishvili-Bolkvadze v Georgia* (58240/08) [2018] ECHR 628, paras 90-98.

12 Notification of Deaths

12.1 Reporting to COPFS

Scottish Government, Chief Medical Officer, and COPFS issued updated guidance on Reporting Deaths to the Procurator Fiscal in 2015[40] [41] for the attention of the medical profession in Scotland. This highlighted the addition of 'Deaths while subject to compulsory treatment under mental health Legislation' to the categories of death due in whole or part to natural causes to be reported to the Procurator Fiscal, using Form eF5 as described in COPFS Guidance for Medical Practitioners 2015[42]:

(f) Deaths while subject to compulsory treatment under mental health legislation

Any death of a person who was, at the time of death:

- detained or liable to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995; or
- subject to a community based compulsory treatment order or compulsion order under the above provisions.

12.2 Understanding Notification of Deaths

In order to understand how notification of deaths under detention was being handled at service level we spoke with four Boards who agreed to share their expertise and experience.

We aimed to clarify how sudden or expected natural cause deaths under detention might be captured at boards and what actions might follow. We asked about deaths in hospital or community (e.g. from end stage dementia, or sudden cardiac event).

We were informed that in practice detention orders could be revoked for people at end of life/palliative care pathway (e.g. Old Age Psychiatry, confirmed via eDRIS exercise)

[40] CMO Letterhead.dot (scot.nhs.uk)
[41] REPORTING DEATHS TO THE PROCURATOR FISCAL (copfs.gov.uk)
[42] COPFS (2015) REPORTING DEATHS TO THE PROCURATOR FISCAL (copfs.gov.uk)

Natural expected deaths are excluded from National Adverse Events Framework and Notification processes[43].

Board staff were clear as to how to report adverse incidents locally and collect data (on to Datix[44] or equivalent system), and that systems were robust. The notification of suicides of people under mental health legislation was clear and robust.

Statements from different boards about the recording and notification of natural cause deaths were sometimes contradictory.

- **Email from HB**: "We look at every death of patients known to our service, or who have been in contact with our services over the previous 12 months, in the same way".
- **Adverse Event Group**: "We do not necessarily review deaths by natural causes"

Generally board representatives were surprised to find that the project about Deaths in Detention also concerned natural cause deaths which might occur in general hospitals or community services. There was a sense that staff had not been asked to notify natural cause deaths to the Commission, this would not be on their radar as "it would not be thought of as an adverse incident".

In general such natural-cause deaths would be low rated and not progress through the local scrutiny system. There was a lack of confidence in being able to extract lists or data about numbers of such natural cause deaths.

There was some uncertainty if deaths of people on community CCTO were added to the local Datix system[45]. Uncertainty was also expressed as to who has the locus to notify if an individual was from another Board area and died by suicide in a local emergency department.

In the main, Boards/Regions had robust and mature systems in place to respond to significant incidents with clear delineation of their scope and limits, and senior

[43] Learning from adverse events through reporting and review - A national framework for Scotland: December 2019 (healthcareimprovementscotland.org)
[44] Datix is an application widely used by staff including clinicians in more than 80% of the National Health Service (NHS) to **report clinical incidents**. The system can even be used by paramedics, air ambulances and water companies The system can be used to manage incident reporting, risk registers, complaints, claims, requests for information, safety alerts and CQC standards in the UK.

management and governance support. Some of the limits identified included, having different IT systems onto which deaths are reported; service responsibility delineations; and difficulty in identifying if the PF had been notified.

12.3 Using Datix for Monitoring Purposes

Datix is an application widely used by staff including clinicians in more than 80% of the NHS to report clinical incidents. The system can even be used by paramedics, air ambulances and water companies. The system can be used to manage incident reporting, risk registers, complaints, claims, requests for information, safety alerts and CQC standards in the UK.

Whilst one Board had developed a bespoke use of Datix to capture quality and monitoring information – other boards used separate spreadsheets to pull out specific lists and monitor progress in the review of Level 1 and 2 incidents (as defined by HIS). Reporting on deaths by suicide could involve cross-checking several sources of information.

12.4 Notification Documents

Some Boards had their own formatted letters for reporting suicides or attempted suicides to local management and the Commission. One Board had embedded into its documentation for the notification of all significant events within the Mental Health and Learning Disabilities department a check list of indications for notifying the Commission.

12.5 Reporting to Procurator Fiscal

There was some lack of clarity about the requirement to notify all deaths in detention to the Procurator Fiscal and whether this was being done, reflected in comments such as “guidance definitely circulated a year ago, think people familiar with it”. “Sudden unexplained deaths might be reported but not the understanding re; ‘anyone detained’ embedded with all psychiatrists”. “Not clear how co-morbid deaths would be reported to PF”. “Acute services may not know of requirement or not see it as their job to report the death of a detained patient transferred to acute”.

“Sometimes no post mortem for LD”. “Not clear how natural cause deaths would be reported to PF”.

Several Boards described active working relationships with the local PF service and valued the communication systems they had in place.

12.6 Reporting to HIS and the Commission

Boards described a number of issues;

- Confusion remains as to where boards should report suicides. Boards used to report to the Commission then it changed to reporting to HIS around 2008/09 and now they are being asked to report to the Commission again.
- Notifications to HIS and the Commission are made for all Level 1 Reviews – but might be made via a number of people e.g. Clinical Governance manager at the board or at HSCP
- For natural cause deaths, even if discussed at local adverse events group– information may not be sent to the Commission
- Some feeling that it would be easier if all notifications to HIS and Commission came through one designated person at the board
- There are resource implications in ensuring that notifications to the Commission happen
- Board notifies Commission (practitioner) if a review is to be carried out. Once review completed any documentation is sent to Commission, but there is no active involvement of the Commission practitioner.

12.7 Considerations for a New System

The existing requirement for mandatory reporting to PF, HIS and the Commission should be clear on all relevant assessment, recording and monitoring forms at board level and guidance provided.

The existing requirement for mandatory reporting separately to all three of PF, HIS and the Commission for some deaths is needlessly resource intensive and places an administrative burden on Boards.

A central notifications system across all three bodies would reduce the drain on resources and potentially improve reporting and the potential for learning from reviews of deaths in detention (and other significant reportable deaths in mental health care).

12.8 Establishing a Baseline Data Set

The 2003 Act requires that when a person with a mental health condition or learning disability comes to the end of a period of compulsory treatment or detention in hospital, healthcare providers must notify the Commission – including in cases where detention has ended as a result of the person's death. In 2021, the Commission worked with Public Health Scotland to identify all deaths during compulsory treatment: over five years from 2015/16 to 2019/20. There have been an average of 126 such deaths per year.

Following further examination of this information, the Commission found that on average, around 6.7% of deaths per year are not reported to the Commission (Appendix 2).

Based on a sample of 364 individuals whose deaths were notified to the Commission, the cause of death was reported as follows:

- Natural cause or 'expected' death (41%)
- Sudden or unexpected death (due to physical health causes) (33%)
- Suicide (8%)
- 'Other' causes, including accidents (2%)
- 'Unascertained' (as stated on death certificate) (1%)
- No information on cause of death provided to the Commission (16%).

In order for any new system to be effective, the notification process will require to be improved so that key information on all relevant deaths is reported to the Commission.

The Commission has already implemented a revised version of the ND1 'Notification of Death' form for use by Boards[46].We intend to develop this further with stakeholders.

We propose that the Commission continues to work with partner agencies (health boards, COPFS, HIS) to ensure that all relevant deaths are notified to the Commission.

The development phase, via the PHS data-linking exercise has provided a baseline set of data for deaths in detention and exploratory data for deaths of people occurring up to one month after their detention was ended (Appendix 2). We will continue to use this data to improve the process of notification of deaths and, within 12 months will evaluate the utility of repeating the data linking exercise and the ongoing inclusion of deaths up to a month after detention ceased. A summary of the data-linkage work[47] was published on the Public Benefit Privacy Panel for Health and Social Care website.

[46] A revised version of the ND1 'Notification of Death' Form is now available.
[47] End-of-Project-Reporting-summaries-1.pdf (scot.nhs.uk)

13 Independent Review of the Response to Deaths in Prison Custody - November 2021

13.1 Key recommendation

This review makes a number of important recommendations for improving processes following a death in prison custody. The main recommendation, however, relates to the need for an independent body to conduct a speedy review of every death in custody.

This is intended to complement the current inquiry processes, including Fatal Accident Inquires. All of the review's recommendations have been accepted in principle by the Scottish Government. The Key Recommendation was:

'In particular, we are recommending that a separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.'

13.2 Where this recommendation differs from the Commission's proposals

This is proposing a **new** independent body carries out all investigations of deaths in prisons.

The Commission's proposal is that the Commission be responsible for **initiating, directing and quality assuring** the process of investigating deaths during compulsory treatment in all cases and would move directly to its own investigation in certain cases only. E.g. when the death of mental health patients that are violent, unnatural, or natural cause deaths which arise from an arguable breach of Article 2 or where the cause of death is unknown. Exceptionally, at this stage, the Commission may undertake an investigation.

Feedback from our development phase was that rather than a third party body taking over complete control of any review process, for an effective improvement model in health and social care, services needed to be involved in and take accountability at an early stage.

13.3 Prison death proposals

- The independent investigation should be instigated as soon as possible after the death and completed within a matter of months.
    - ***The Commission's proposal meets this***

- The investigation process must involve the families or Next of Kin of those who have died in prison custody.
    - ***The Commission's proposal meets this***

- The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR.
    - ***The Commission's proposal meets this***

- All investigations must result in a written outcome.
    - ***The Commission's proposal meets this***

- In determining the process of investigation and the intensity of review required, the independent investigatory body must have regard to applicable human rights standards, including those set out in the online Appendices.
    - ***The Commission's proposal meets this***

- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant institutions requiring the completion, retention and production of relevant information in their possession.
    - ***The Commission's proposal meets this. The Commission already has powers in place.***

- The independent investigatory body must be required to produce and publish reports analysing data on deaths in custody, identifying trends and systemic issues, making recommendations and promoting good practice.
    - ***The Commission's proposal meets this***

- The independent investigatory body should also be tasked, in statute, with the duty to monitor and report on the implementation of its recommendations. The views of bereaved families or Next of Kin should be taken into account in this process.
    - ***The Commission's proposal meets this, not in current statute but proposal has clear escalation policy to SG if noncompliance with recommendations. Opportunity for current review of mental health legislation to add in additional Commission powers and functions to include a level of accountability directly to the Scottish Parliament, including a power to make a report to Parliament where the Commission determine there is a serious failure by a public body to follow a recommendation by the Commission.***

- Families or next of kin of those who have died in custody should have access to full non-means-tested legal aid funding for specialist representation throughout the processes of investigation following a death in custody, including at the FAI
    - ***The Commission agree that for any case that proceeds to FAI, the above should apply***

14 Consideration of Equality Groups

14.1 Equality Impact Assessments

The Commission's DIDHR work was subject to an Equality Impact Assessment (EQIA) in 2020 and updated in 2022. If the Commission's proposals are accepted a further EQIA will be completed.

An EQIA helps to determine any potential impacts the process could have on individuals with protected characteristics and how any impacts could be mitigated. The protected characteristics, defined in the Equality Act 2010, are: age; disability;

gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

14.2 Children & Young People

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.

The child or young person will require access to appropriate advocacy, bereavement, and mental health support.

14.3 Other Equalities Groups

The consultation on proposals asked specific questions about equalities groups'. These responses will be incorporated into a new EQIA but broadly included:

A range of general comments about the importance of supporting those with protected characteristics.

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.

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).

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 relation to specific groups (e.g. those with expertise in communication strategies for particular groups, those who could advise on approaches to digital inclusion etc.).

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.

Further information is included in the Consultation analysis report and will be used to inform future work on addressing the needs of equalities groups.

15 National Consultation and Analysis

15.1 Overview

A public consultation on proposals and analysis of responses was commissioned and carried out by Dawn Griesbach & Associates and Jennifer Waterton Consultancy. The consultation was published on 7 December 2021 and ran for 11 weeks until 15 February 2022.

Respondents submitted their views online, through SmartSurvey, or by email. In addition, three engagement events were held during the consultation period. 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 intended for people working in health or social care services. All of the events took place online (using Zoom or Microsoft Teams).

15.2 Aims of the Consultation

The aim of this public consultation was to seek views on the Commission's proposals for a new system of investigating the deaths of people who, at the time of their death, were subject to compulsory treatment under mental health legislation in Scotland.

The consultation contained 11 questions that invited comment – including concerns and suggestions for improvement – on different aspects of the proposals.

The consultation ran from 7 December 2021 to 15 February 2022.

15.3 Consultation responses

15.3.1 Key Individual Questions

The tables below represent the overall responses to key individual questions asked.

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%**

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%**

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%**

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%**

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%**

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%**

15.4 Key Outcomes & Responses

15.4.1 Independent investigation

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.

Comments included…

It undermines family and public confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its own staff and systems. The introduction of oversight by the MWC does not remedy this

problem, not least because the MWC will not in fact be undertaking the investigations and they cannot be seen to be sufficiently independent in any event, for the reasons set out below.

When undertaken by the organisation that was responsible for caring for the deceased, it is common for investigations to be treated as an 'internal' process with an inward focus without sufficient sense or priority being given to the outward facing responsibilities of the Trust in terms of the family, the need for public accountability and the preventative role of the investigation in the context of national learning.

Families describe their sense that the overriding priority for Trusts in the investigation is one of damage limitation and deflecting criticisms. Despite a 'Duty of Candour' intended to introduce and strengthen the need for openness, this sits at odds with the continued experience of a closed investigation and a perceived lack of transparency.

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

''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 staff, or the strain that staff and services may face when under scrutiny.''

The Commission's response

We believe that other key considerations need to be balanced with the argument that 'independence' in reviews surpasses all other rights and principles.

There will be occasions when the Commission will move directly to its own investigation if it considers it is inappropriate for the local service(s) to carry out the investigation.

We do not believe that Commission staff are immersed in the organisational culture and with colleagues working in the NHS making an independent objective view very difficult. Reviews of deaths in mental health detention require specialist experience of and expertise in mental health. Commission staff are well placed to understand this but also have experience in challenging staff and effecting change and improvement and investigation that leads to practicable recommendations.

We believe some degree of 'alignment' to services can be positive e.g. an understanding of the trauma on staff as well as others. There is some very good work in place and HIS and NES have influenced patient safety.

We say more about DoC in our report, with intention to tie in with it more tightly than is currently the case for Board level reviews (based on our review of cases).

Further information on why we believe the proposals are article 2 compliant can be viewed in Appendix 4.

15.4.2 Informal patient - detained patient

Concerns were raised that the proposals are not human rights compliant as investigation of the deaths of non-detained patients are not included. Whether a proposal for a different investigation process for the deaths of those detained under mental health legislation – compared with the deaths of those who are not detained – would be human rights compliant was questioned, (because there would be a greater scrutiny applied in relation to the former as compared to the latter).

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

'This proposal could result in a two tier system whereby the deaths of detained patients will receive a higher degree of scrutiny than those of informal patients; possibly at the expense of the rights of families of informal patients given limited service resources and a requirement to focus on deaths of detained patients over others.'

The Commission's response

We do not disagree in principal with the comments above. However, following the s37 Review, the Commission was asked to consider proposals in relation to those detained under the Act. Informal patients were not within the remit or scope of the review.

As part of the wider s37 action plan, the Scottish Government committed to 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 was to 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.

The deaths of some informal patients will currently fall within the category of meeting SAER level 1 or local mortality review. There is already a requirement for services to review deaths that fall into this category.

We have proposed that, at least initially, we will look at the deaths of people who died up to a month after their detention ended; as 1 month after 'discharge ' is a recognised period of increased risk for suicide.

This is a way to ensure we do not rigidly exclude all voluntary patients, and any learning – either from collection of data or review of some cases in more detail – will be fed back to wider system learning including patient safety.

The commission is keen to increase its wider investigatory functions to ensure an increased level of scrutiny to particular categories of deaths of informal patients particularly

- Inpatient death by suicide
- Premature deaths of people with a learning disability in hospital/residential care
- Deaths involving the use of force/restraint
- Deaths where there are significant human rights concerns regarding the individual's care, treatment and support (the Commission has developed a human rights screening tool)

- Cases where a number of deaths have occurred, or a pattern has been identified to allow the identification of wider system issues and thematic review.

We will liaise further with COPFS in relation to determining certain categories of deaths in mental health detention having priority consideration of an FAI, to include

- Death by suicide of any inpatient
- Any death occurring during or after physical restraint or during a period of seclusion

15.4.3 FAIs, death in mental health detention review and review of a death in prison custody

Concern was raised that deaths of those in mental health detention would not receive the same independent scrutiny as those in police or prison custody. At present, all deaths in prison and police custody in Scotland result in a mandatory FAI and we heard from some that there should be the same mandatory referral to a fatal accident inquiry process for deaths in mental health detention.

The Commission's response

We believe a mandatory FAI is unnecessary and disproportionate in many cases of mental health detention.

There have been criticisms of the FAI processes in relation to lengthy delays, limited involvement and participation of family members, a lack of follow up on recommendations made and dissemination of important national learning from these individual events.We agree that the FAI process should be improved but the body with responsibility to do that has taken that on board.

The Commission can give consideration to (and discuss with COPFS) whether to carry out an investigation and when, if there is to be or has been an FAI or any of the other proceedings and if the Commission is satisfied that the circumstances of the death have been sufficiently established during the course of an FAI or such

proceedings. Within COPFS, the Scottish Fatalities Investigation Unit (SFIU) is a specialist unit responsible for investigating sudden, suspicious, accidental and unexplained deaths.
A protocol will be established so that the timing of any investigation by the Commission does not interfere with or prejudice any investigation by the police or any other reporting agency under the direction of COPFS.

15.4.4 Duplication- confusion with HIS/SAER system

We heard 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.

The Commission's response

We will work closely with others to prevent duplication/confusion. A central notifications system would reduce the drain on resources and potentially improve reporting and the potential for learning from reviews of deaths in detention.

In partnership with Boards, HIS and COPFS, the Commission will develop a national quality assurance framework to drive up the quality of reviews of deaths of people under detention and a national set of publicly reportable measures that reflect best practice in the investigations of deaths in detention.

15.4.5 Staff wellbeing and an increasing workload for services

We heard concerns relating to staff who were involved in the care and treatment of those who had died and the tone of the consultation document which, some organisations suggested, implied that staff cannot be trusted to provide appropriate levels of review.

Supporting staff during the review process was seen to be critical; staff can often be distressed and traumatised in the aftermath of a death in the same way that families can. 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.

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 and respondents also suggested that if the process is perceived as 'purely punitive', staff may refuse to participate.

Others suggested that the Commission needed to engage further with partners on the details of the practical delivery of the process. Some 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.

The Commission's response

We agree that further detail is required and this will be addressed.

The scope of the Commission's work was not primarily about the needs of staff however we support HIS and professional bodies on an approach which puts systems learning at the centre.[48]

We acknowledge there is tension between a human rights PANEL approach which underscores 'blame', versus the learning culture approach of HIS and NHS Scotland which moves away from individual error and 'root cause'.

We acknowledge that investment is required to ensure adequate staffing resource is available within services to carry out reviews.

15.4.6 Power to enforce

Some respondents commented that there was a gap in the Commission's proposed process in relation to the enforceability of any recommendations made. Respondents agreed 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 recommendations. Some thought the

[48] NHS England » A just culture guide

Commission should have the power to challenge organisations when progress is slow, and it will need to consider whether additional powers in law may be needed to make recommendations enforceable.

The Commission's response

As part of the process of following up on recommendations made, the Commission will have a clear pathway to escalate unresolved concerns to Scottish Government.

This will also be considered in the Commission's ongoing discussions with the Scott review and whether increased powers to enforce change are indicated to consider a level of accountability directly to the Scottish Parliament, including a power to make a report to Parliament where the Commission determine there is a serious failure by a public body to follow a recommendation by the Commission.

15.5 Summary of Options

We have summarised several options for a proposed new system of reviews on deaths in mental health detention in Scotland (Appendix 5). In light of the extensive work carried out and presented in this report, we believe the MWC proposal best meet the values and principles of an effective review process.

This would require additional funding to be in place for the MWC and would be implemented incrementally over a three year period as outlined in the business plan submitted to Scottish Government.

16 References

16.1 Key references

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Scottish Government (2018). Review of the arrangements for investigating the deaths of patients being treated for mental disorder.

The Knowledge Network (2021). Adverse Events. NHS Education for Scotland. Sharing learning - Adverse Events (scot.nhs.uk)

17 Appendix 1 - Other Jurisdictions

17.1 Findings

An initial preliminary search was conducted for the Commission by NHS Health Scotland Knowledge Services to inform the commissioning of a literature review. A search to consider the question “What can Scotland learn from other jurisdictions about reviewing deaths in mental health settings? (Including natural, unnatural, sudden or unexplained deaths)” was then undertaken by an external consultant.

Much of the literature search processes identified material concerning deaths in custody (police or prisons), particularly suicides in custody.

A key 2015 academic review found that patients with severe mental health issues live on average 10 years less than the general population and that 67% of deaths are attributable to natural causes, whereas the remaining deaths are by unnatural causes, including suicide.

The DIDR literature review found several lessons that Scotland can learn:

- The need for a country-wide register for deaths in mental health detention
- Mental health deaths in detention can be natural, unnatural or unascertained
- In terms of natural deaths, poor physical health conditions including cardiovascular illness, lung disease, cancer and diabetes can be significantly associated with increased deaths in mental health settings
- The application of psychiatric drugs, sometimes in combinations which increase risk needs to be considered
- The role of illegal substances as well as tobacco and alcohol need to be taken into account
- Scotland’s changing demographics need to be considered - there is some evidence that BAME individuals suffer poorer outcomes
- The literature search found five jurisdictions pointed to best practice overall: England and Wales; Ontario, Canada; Victoria, Australia; New Zealand and Ireland (Some material also from the Netherlands but little grey literature as focussed on English language search)

17.2 NHS England

The Patient Safety Incident Response Framework (PSIRF) will replace the NHS England Revised Serious Incident Framework 2015 (SIF) from Spring 2022. It is currently being trialled by early adopters.

The current NHS England definition excludes natural cause deaths.

Independent investigations should be managed locally by the care commissioner. Local management and ownership of Serious Incidents is of fundamental importance to ensuring appropriate and timely action.

Independent investigations are required where the integrity of the internal investigation and its findings are likely to be challenged or where it will be difficult for an organisation to conduct a proportionate and objective investigation internally due to the size of organisation or the individuals or number of organisations involved.

An independent investigation can be used as a means of assessing whether a provider's account of an incident has been fairly presented to give credit to the findings and assurance that lessons will be learnt to prevent recurrence, or it can be used to obtain an objective assessment of the nature and causes of an incident irrespective of whether or not any investigative work has been or is to be undertaken by the service provider.

An independent investigation would be considered for the following circumstances:

A serious incident where the organisation is unable to conduct an effective, objective, timely and proportionate investigation. This is particularly relevant to incidents where the obligation on the authorities to account for the treatment of an individual is particularly stringent including:

Deaths (and near deaths resulting in severe harm) of those detained under the Mental Health Act (1983) and, in certain circumstances, the deaths of informal psychiatric in-patients53 where;

- the cause of death is unknown; and/or
    - Where there is reason to believe the death may have been avoidable or unexpected .This includes suicide and self-inflicted death.

- Where the commissioner(s) or provider(s) or the patient/family feel that the nature of the potential causes of an incident warrant independent scrutiny in order to ensure lessons are identified and acted upon in a robust, open and transparent manner54.
- Where incidents represent a significant systemic failure leading to wide-spread public concern and independent investigation is required to ensure public confidence in the findings.
- Where it is necessary to examine the role of the wider commissioning system or configuration of services (involving multi-agencies/organisations) in the causation of a serious incident or multiple serious incidents.

Not all incidents being investigated under this guidance will trigger a duty for the investigation to be Article 2 compliant. The duty does not, for example, arise in every case where someone dies in hospital. On the other hand, it will almost always arise where there is an unexpected death in custody.

It is important to note that any duty to carry out an Article 2 compliant investigation covers the whole span of investigations following death or incident, and not simply an investigation under this guidance in isolation.

Normally, the coroner's inquest will ensure Article 2 compliance either on its own or with an investigation carried out under this guidance and/or civil or criminal proceedings. An investigation under this guidance may contribute towards to the coroner's inquest as part of the State's overall response to its Article 2 obligations.

17.3 Law and Resolving the Principal Important Controversial Legal Questions

The Commission may have to consider principal important controversial questions of law. Ordinarily, such controversies can be resolved by allowing the parties to the legal controversies to make written submissions. The Commission can instruct its own legal experts, or have certain legal experts sit with it when hearing submissions on the legal controversies. The Commission can confer with its legal advisers in private but, if that advice bears upon a controversy of interest to a party, that advice

received by the Commission should be shared with that party who should be given the opportunity to comment. As with factual controversies, where fairness requires it will be necessary for the Commission to hold an oral hearing.

17.4 Standard of Proof

The Commission will be producing an investigation report which will need to have adequate and proper reasons for its findings, decisions and recommendations which identify the controversial questions of fact and law that arose and how the Commission went about resolving these fairly. Accordingly the report must leave the informed reader in no real and substantial doubt as to what the reasons for their findings, decisions and recommendations were and what material considerations were taken into account in reaching these.

18 Appendix 2 – Data

18.1 Establishing a baseline data set

At the outset of the deaths in detention reviews project, we sought to identify what we knew about the numbers of deaths in detention and where any gaps lay.

Two earlier exercises had been conducted:

The MWC Death in Detention monitoring report (2014)49 noted: In the year 2012-13, 78 deaths of individuals subject to compulsory treatment were notified to us. During this period, a total of 6721 individuals were, at some point, subject to compulsory treatment. It had not been possible to provide a detailed breakdown of the data at the time.

The s37 Review report (p13) included the below table provided by the Commission which indicated that the Commission received around 100 notifications per year of persons who died whilst subject to an order.

[49] https://www.mwcscot.org.uk/sites/default/files/2019-06/death_in_detention_final.pdf

Table (i) — Deaths of people subject to orders for treatment of mental disorder*				
	2014-15	2015-16	2016-17	2017-18
2003 Act	86	94	91	93
Part VI, 1995 Act	5	4	10	7
TOTAL	**91**	**98**	**101**	**100**

*source: Mental Welfare Commission for Scotland

The DIDR project undertook a data exploration and coding exercise in order to understand the profile of deaths under an order, and the quality of material received at the Commission about such deaths. We took an initial download from the Commission's Information Management Portal (IMP) for the period 01/04/2014 to download at 10/12/2019, and conducted two separate exercises using this data.

An initial audit was conducted of the 23 deaths of persons with learning disabilities which occurred across the years. (Appendix 2).

The full IMP download coding exercise, required scrutiny of individual cases in order to establish the date of death, confirm detention status, and whether the Commission had information on cause of death.

We focussed on more recent cases notified to the Commission (for three years data, 2016/17, 2017/18, 2018/19 and half of 2019/20; a total of 364 deaths) and published our outline findings in the consultation document (December 2021)

During this coding exercise we also looked at a number of other issues to inform our understanding of external notification processes, internal processes and data recording, and the quality of information received. This included: how the Commission was informed of the death (had the appropriate Revocation form been completed timeously and accurately, had the death pro-forma been issued or returned); was it a Duty of Candour event; had the Procurator Fiscal been informed or a post-mortem been completed or an FAI been initiated; was there police involvement; had the Commission been involved in the case or a DMP opinion; had an SAER been initiated, completed and the completed report returned to the Commission. We also sought to note particular characteristics and circumstances of the deceased, to help to understand whether an individual's needs and rights had

been met and if there was an involved family member or other advocate at time of death.

This ambitious coding exercise exposed weaknesses in data recording and communication both internally and externally. Although, given the inconsistency in data available we were not able to report quantitatively from this exercise, it drew attention to the importance of consistency of approach in notification of deaths in a new system.

The audit work informed the identification and selection of cases for the Test of Change Phase One ECHR Sample of cases. The sample was selected from the last three years data of the IMP download for the four pilot boards. In total some 34 cases were discussed in detail within the DIDR project team, from which 16 were used to assess how existing tools and a human rights framework for investigation could be applied.

18.2 Public Benefit and Privacy Panel (PBPP) - Data linking application and exercise via Public Health Scotland.

From the outset it was clear the Commission is not informed of all deaths in detention, however we did not know the nature of the shortfall. Deaths occurring in the month post detention were also of interest. NCISH research highlights the period immediately post-discharge from hospital in relation to suicides as a time of increased risk. Our audit work also indicated that orders may cease in final ‘months’ for persons receiving palliative care. In order to ensure that the Commission is aware of all deaths, and to identify deaths one month post detention a data linking exercise was essential.

The original eDRIS (electronic Data Research and Innovation Service previously of ISD, now of Public Health Scotland) application was submitted 17 March 2020. The first data from the Commission to PHS was transferred 11/05/21 to allow the process of matching via the CHI number with NRS deaths data.The SMR data sets were received 11/01/22 and work is ongoing in relation to SMR25/SDMD data sets.

This exercise will enable us to more fully report on all deaths in detention in Scotland and shape recommendations about how such deaths are reported on in the future.

We asked for data relating to deaths occurring 1st Jan 2015 to 30 Apr 2020 as this would allow us to obtain a reasonable number of types of cases which occur infrequently (e.g. deaths of persons with learning disabilities under detention, cases from smaller health boards). Extension to 30 Apr 2020 allowed us to pick up deaths occurring one month after detention ceasing at 31 March i.e. end of financial year.

The main objective of the data-linking exercise is to audit our data in order to;

- Clarify what we do not know about. What categories are being missed. Any particular location, services which are not notifying?
- Identify what improvements to data collection/transfer might be required
- Explore the usefulness of extending the routine collection of data to include people who die in the 4 weeks period after their detention ended
- Describe cause of death and clarify characteristics of sub-groups (e.g. prematurely ended detentions, sudden unexpected deaths which were suicide attempts/overdoes)
- Describe key demographics of people who die in detention (age range, ethnicity, Health Board of treatment)
- Explore access to healthcare in the 12-13 months before death
- Allow us to make statements about numbers and categories with more confidence
- Evaluate whether moving to a regular data linking exercise might be beneficial

The data sources

- The Commission's original IMP download was refreshed to include deaths up to 30/04/2020 and also deaths occurring one month post detention.

The PHS data sources:

- SMR00: Outpatient attendance
- SMR01: Inpatients
- SMR04: Mental Health Inpatients
- SMR25: Drugs misuse
- NRS Deaths
- ScotSID (Scottish Suicide Information Database)

Initial findings

- The data-linking work is in progress. Initial findings indicate over five years (from 2015-16 to 2019-20), there have been an average of 126 deaths subject to an order per year and 104 such deaths within a month of the order ceasing per year.

(Provisional data at 14/02/22)	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**Total**
On order at death						
Criminal Procedure Scotland Act (CPSA)	*	11	7	9	*	36
Compulsory Treatment Order (CTO)[x]	84	87	98	104	93	466
Emergency Detention Certificate (EDC)	*	*	*	*	*	12
Short Term Detention Certificate (STDC)	22	12	24	30	28	116
Total	**111**	**111**	**133**	**148**	**127**	**630**
On order-one month pre death						
Criminal Procedure Scotland Act (CPSA)		*	*			*
Compulsory Treatment Order (CTO)[x]	29	37	44	43	46	199
Emergency Detention Certificate (EDC)	10	19	12	14	20	75
Short Term Detention Certificate (STDC)	28	39	53	60	62	242
Total	**67**	**97**	**111**	**117**	**128**	**520**
Grand Total	178	208	244	265	255	1150

- Figure suppressed where <=5
- **X** - Includes Community Compulsory Treatment Order

(Provisional data at 14/02/22)	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**Total**
On order at death						
18-24	*	*		6		9
25-44	15	19	18	21	16	89
45-64	31	26	40	43	41	181
65-84	44	52	61	61	54	272
85+	19	13	14	17	16	79
Total	111	111	133	148	127	630
On order-one month pre death						
18-24	*	*			*	*
25-44	*	8	10	6	*	32
45-64	14	15	22	25	16	92
65-84	38	50	59	56	78	281
85+	10	23	20	30	28	111
Total	67	97	111	117	128	520
Grand Total	178	208	244	265	255	1150

- Figure suppressed where <=5

From all initial data-linking and audit work to date we have found evidence of: not being notified of all deaths in detention (through data-linking with NRS deaths,

shortfall was found to be 6.7%), not fully following up on a notification of a death in detention, deaths within 4 week of detention being lifted/ending; deaths while on AWI both notified and not notified to the Commission.

19 Appendix 3 - Learning Disability

19.1 Audit of 23 Learning Disability Cases

The initial Phase 1 sample of cases on IMP identified 23 deaths of persons with learning disability from a variety of NHS and private provider settings. Working only from information held by the Commission, an audit of these cases was undertaken applying a framework based on the human rights requirements for the right to life, Article 2 ECHR. The aims were;

1. To test out a first draft Human Rights Framework tool and assess if obligations to protect life and to investigate 'non-natural'[50]deaths were met
2. To note any learning and advise on improvements to relevant internal (Commission) processes and a future system of review of deaths in detention of people with LD

The tool proved effective for collating information from individual IMP records, testing of assumptions, and testing if relevant evidence was actually available to the Commission.

The EHRC Human Rights Framework first draft tool has these sections:

Circumstances at time of death;

A. Obligation to protect life
B. Obligation to investigate non-natural deaths – providers
C. Obligation to investigate non-natural deaths – the Commission

[50] An unnatural death results from an external cause, typically including homicides, suicides, accidents, medical errors, alcohol intoxications and drug overdoses.

19.2 Findings

19.2.1 Obligation to Protect Life

Physical health care provision was evident, but it was usually not possible to be sure that it had been 'timely and appropriate' on the basis of the available information. It was also common for it to be 'unknown' as to whether mental health care was timely and appropriate. However, in more than one third of cases it was possible to conclude that care and treatment had been appropriate for the person as a person with learning disability.

It was usually 'unknown' whether in the course of their treatment the person had access to appropriate social support, regular family contact or had received advice in an appropriate format on how to access treatment and support (however this information will be contained in NHS files, not accessed by the Commission in this audit).

19.2.2 Obligation to Investigate Non-natural Deaths – Providers

The Commission lacked evidence of whether local providers had informed the Procurator Fiscal, or actions taken such as a post mortem. There were few investigations into care and treatment of individuals and none were independent, prompt or quick. Results were not open to public scrutiny and it was rare for next of kin to be involved.

Using a system of 'counting' a proxy measure of concerns was obtained for each case. Although not formally validated, the 'count' mechanism aligned well with Commission practitioners' professional judgements and decisions to take cases to MWC 'Investigations Group'.

19.2.3 Obligation to Investigate Non-natural Deaths – the Commission

Gaps in the Commission investigation processes were identified. The Commission's 'death pro-forma' was sent out for two thirds of the cases. However the form in use at the time was insufficient to gather required EHRC data, was often poorly or partially completed, and follow up from the Commission was inconsistent.

Summary findings from the review of casework data on IMP;

Of the 23 deaths in detention of people with LD;

- seven had been referred to the Procurator Fiscal, 11 had not been referred, and in 5 cases it was unclear
- four deaths were followed by an adequate internal investigation by a local provider
- three had internal investigations by a local provider which were considered 'limited or inadequate'
- sixteen of the 23 deaths had no review or investigation
- in 4 cases the cause of death was listed as 'unknown' (on the Commission's system)
- there had been calls made to the Commission in a third of cases – and on further exploration of case materials available there were concerns in relation to 16 of the 23 deaths.
- around one third of people had no known advocate at the time of death and usually, there was no known action by advocates around the time of death.

19.3 Conclusions

- The human rights framework could be feasibly applied as a means of informing the development of revised processes for ensuring deaths are reviewed adequately in line with legislation
- The approach identified three cases which had already gone to Commission investigations group but also additional cases which warranted further review. The approach raised questions and issues which had not been asked at the time of death.
- With further adjustment the excel-based draft tool could be used in monitoring and potentially reveal patterns of concern across small numbers of cases over time and support decision-making in individual cases as to potential further investigation.
- Thematic analysis across cases could aid learning and identify best practice across different provider types.

- A significant proportion of deaths were insufficiently investigated internally by local providers and very few were subject to externality
- The existing arrangements did not convince that individual rights in relation to the obligation to review or investigate deaths in detention of people with LD were being met
- The study identified improvement areas for the Commission with regards to review and investigation processes for adverse events.

20 Appendix 4 – Independent Investigation Response

20.1 Further response to independence of investigation

Article 2 requires:	MWC proposal
The establishing of an effective and independent judicial system which can provide civil and, where appropriate, criminal remedies and, where state agents or members of a profession are involved, disciplinary measures.	• Route to FAI would remain • Route to criminal proceedings would remain. • Referral to appropriate regulatory bodies either by employer or MWC
The nature and form of the investigation is in individual state's discretion and that when assessing the adequacy and effectiveness of this provision the whole legal framework rather than single elements of it must be considered.	• As above
The Court has also ruled that where there is a lack of clarity as to whether or not the cause of death or harm was unintentional then the authorities must conduct an initial investigation to establish this. This could conceivably therefore apply to both care and treatment for mental illness and physical health conditions.	• MWC will liaise with COPFS • Once a lack of intentionality has been established then a civil remedy is usually sufficient, and a criminal remedy will only be required in exceptional circumstances, for example in the context of the victim having been denied healthcare.
Where a patient is in the care of medical professionals, the investigation must have both formal and de facto independence from those implicated, including those who are providing expert evidence.	• MWC is an independent body. • MWC has independence and proven experience in carrying out investigations of this type and are clear about potential conflicts of interest.
Relevant proceedings must be completed timeously given the importance of the outcome to patient safety.	• Clear timelines will be in place and subject to MWC internal audit. • Proposed process has early engagement and clarity of responsibility to reduce unnecessary duplication
A legal system which prevents the deceased's next of kin from claiming or receiving recompense will also constitute a violation.	• Financial recompense is out with the scope of the MWC proposals but exists through other routes
In terms of the investigatory proceedings themselves, excessively lengthy proceedings (for example, those lasting for many years) medical evidence which is not impartial and expert opinions without reasons may constitute violations of the procedural duty of Article 2 ECHR.	• Clear standards on timelines will be in place and subject to internal MWC audit

The Article 2 procedural obligation includes:	The Commission's Proposal
Ensuring that the full facts are brought to light;	• liaison with families to agree terms of reference • level of review proportionate to the circumstances • published reports
That culpable and discreditable conduct is exposed and brought to public notice, and those responsible are identified and brought to account;	• Publication of reports- individual and annual report • Referral to appropriate regulatory bodies either by employer or MWC
That suspicion of deliberate wrongdoing (if unjustified) is allayed;	• Publication of reports- individual and annual report

Identifying and rectifying dangerous practices and procedures;	• MWC well placed to
	  ○ disseminate national learning through a variety of methods
	  ○ Make and follow up on local and national recommendations
	• Memorandum of understanding in place with all key organisations e.g.HSE/HIS
	• MWC is a member of Sharing Intelligence for Health and Social Care Group

Ensuring that lessons are learned that may save the lives of others;	• Able to follow up recommendations through its visits programme and established experts in development of good practice guidance
Safeguarding the lives of the public and reducing the risk of future breaches of Article 2.	• As above
The investigation into deaths that engage the right to life must meet minimum standards, including:	**The Commission's Proposal**
The investigation must be independent;	• MWC is an independent body
The investigation must be effective;	• Would be subject to review – MWC governance structures and audit.
The next of kin must be involved to an appropriate extent;	• Proposals for CLO and family engagement throughout process
The investigation must be reasonably prompt;	• Timescales as above ,clear standards on timelines will be in place and subject to internal MWC audit
There must be a sufficient element of public scrutiny;	• Publication of reports- individual and annual report
The state must act of its own motion and cannot leave it to the next of kin to take conduct of any part of the investigation.	• Proposals for CLO and family engagement throughout process

21 Appendix 5 – Options for a new process

PRINCIPLES OF EFFECTIVE INVESTIGATION(page 9)						
Option	**Independent review**	**Family & Carer involvement in a meaningful way**	**Be informed by standards and guidance based on best practice**	**Be characterised by openness, honesty and transparency**	**Provide clear, accessible and timely reporting**	**Local accountability and Learning**
Status Quo Do nothing	• Does not meet article 2 standard of independent review. • Change and improvement unlikely • Very few deaths in MH detention proceed to FAIs or MWC investigation. • Rare MWC or external involvement in review of 'natural' deaths	• Current inconsistency or lack of involvement of family in local reviews. • Rare for family involvement in review of 'natural' deaths	• Despite reissuing guidance, inconsistent reporting and review of deaths	• Change and improvement unlikely	• Change and improvement unlikely. • Wide variation within and between services in time taken to initiate and complete review	• Change and improvement unlikely
Peer Review	• Does not meet article 2 standard of independent review. • Most peer review/accreditation reviews are optional and dependant on the support of individual managers to release staff time. • Potential difficulties in establishing and sustaining reciprocal arrangements.	• Family involvement is a key factor in these reviews when they occur	• Standards for peer review will be matched to those of the body directing it e.g. RC Psych	• Peer review would have these as clear intentions.	• Local boards can lack practitioner/admin resource to adopt peer review. • Review of several cases at one time can lead to distancing from timeline of original local review	• Unclear how learning from local peer review would lead to national learning. • May be financial cost
SAER Framework Alone	• Does not meet article 2 standard of independent review. • Not all MH detention deaths meet criteria for level 1 SAER. • Some local health boards have reciprocal arrangements with one or more other boards to carry out periodic reviews of	• The importance of family involvement is integral to the guidance in relation to carrying out SAERs but evidence that this is not always carried out	• National SAER Standards interpreted at local board level, variation in policies, guidance and practices. HIS currently reviewing.	• Adverse event review reports not published in standard way	• One to two years can be average timescale in practice. • Local Boards can lack practitioner/admin resource.	• Tracking of actions and dissemination of learning at local boards inconsistent. • HIS currently lacks resource to review all suicide reports.

	cases or to offer an independent Chair or other personnel or specialist expertise. • Local boards cannot resource full hierarchical or institutional independence • HIS do not carry out independent investigation of individual cases.	• Not all services have adequate resource to ensure family involvement at level required. • Families view local Board reviews as having conflict of interest and may have degree of discomfort in dealing exclusively with the local service provider.	• Current wide variation in staff training, adequate resources and competence and confidence of staff in reviews of deaths in detention.		• MWC aware of significant delays in receiving SAERs	
MWC Proposal	• Meets article 2 standards of independence • Level of review proportionate to the individual case. • The Commission can track and quantify issues faced by Boards in securing independence for local reviews.	• Introduction of new role of Commission Liaison Officer • Early involvement of family and ongoing liaison.	• Applying an overarching national set of minimum standards to the review of deaths in detention which are Human Rights compliant (based on tools MWC continue to pilot)	• In partnership with boards, HIS, COPFS, will develop a national quality assurance framework to drive up the quality of reviews of deaths of people under detention and a national set of publicly reportable measures that reflect best practice in the investigations of deaths in detention. • Extend review to 4 weeks post discharge from detention. • Ensuring that barriers to accessing evidence from sources such as primary care, acute care services or other third party agencies when relevant are overcome	• Clear expectations of timeline standards • Ensuring there is local quality assurance of practice to eliminate when avoidable delays go unchecked, or poorly resourced clinical governance arrangements	• The Commission team will follow up on recommendations made at a local and national level and have a clear escalation policy to the Scottish Government when it considers that local services have not complied with recommendations made or there has been an unacceptable response to recommendations made • Ensuring that Organisational Duty of Candour requirements are met in full, and to publish an annual report on reviews carried out with a focus on learning • MWC will collaborate with NES to progress

						• requirements for training • Parity of care – physical and mental healthcare treatment to be considered fully where relevant
New Independent Review Body (same as prison model)	• Meets article 2 standards of independence	• Integral to proposals for review	• Would need to be specific standards for mental health detention- not generic across prison and health/social care	• Proposals if agreed would accomplish this	• Proposals if agreed would accomplish this	• Removes local accountability for review.
Mandatory FAI for all Deaths in MH Detention	• Meets article 2 standards - process formal to a set standard, currently under discretion of the Lord Advocate. • Level of review may be unnecessary /disproportionate in some cases	• The Family Liaison Officer supports family relationship with PF and FAI process.	• Scottish Ministers required to report on Inquiries	• All FAI Sheriff determinations publically reported	• Often lengthy timescale , loss of opportunity for systems improvement • Many healthcare relateddeaths , are handled by NHS in faster timeframe leaving little added scope for FAI to recommend	• Recommendations need to be followed up with published actions but no further sanction. • Review of deaths in prison custody- no outcomes in 92% of FAIs • Legal limitations – emphasis towards no repeat of the cause of death but no locus to improvement along the way

22 Appendix 6 – Programme Support

22.1 DIDR Programme Support

Death in Detention Programme Support*

Alison Thomson	Executive Lead (Nursing), Mental Welfare Commission
Andy Grierson	Head of Projects, Mental Welfare Commission
Anne Birch	Researcher, Mental Welfare Commission
Carolin Walker	Project Consultant, Mental Welfare Commission
Kate Fearnley	Project Consultant, Mental Welfare Commission
Dr Moira Connolly	Consultant Psychiatrist, Mental Welfare Commission

From spring 2021*

Additional Professional Support

Paula John	Investigation practitioner, Mental Welfare Commission
Mark Manders	Casework Admin Manager, Mental Welfare Commission
Paloma Alvarez	Information Governance Manager, Mental Welfare Commission

Programme Support - Phase one & two

Alison Thomson	Executive Lead (Nursing), Mental Welfare Commission
Anne Birch	Head of Projects, Mental Welfare Commission
Anne Buchannan	Nursing Officer, Mental Welfare Commission
Callum Macleod	Systems Analyst, Mental Welfare Commission
Dr Moira Connolly	Consultant Psychiatrist, Mental Welfare Commission
Kathleen Taylor	Engagement & Participation Officer, Mental Welfare Commission

Mark Manders	Casework Manger, Mental Welfare Commission
Martin McKee	Research Officer, Mental Welfare Commission
Paloma Alvarez	Information Governance Manager, Mental Welfare Commission
Paula John	Investigation Practitioner, Mental Welfare Commission
Dr Peter LeFevre	Consultant Psychiatrist, Mental Welfare Commission
Dr Simon Webster	Human Rights Policy Manager, Mental Welfare Commission


deaths in
detention
reviews