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VISIT AND MONITORING REPORT

Death in detention monitoring

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Report background

The Commission was asked how many people die while subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Compulsory orders that end when the patient dies are reported to the Mental Welfare Commission. We try to obtain further information on all these deaths to determine whether further investigation is necessary, in particular, whether there may have been any deficiency of care or treatment.

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. This paper gives an analysis of these deaths and also sets this number in context of the total number of individuals subject to the Act and the higher mortality rate among individuals known to mental health services.

All individuals who died while subject to compulsion

- Of the 78 individuals who died, the age range was 22-96. The median age at death was 60.
- 20 individuals were on community based compulsory treatment at the time of death.
- An additional 12 individuals were in the community because detention in hospital had been suspended for a period of time.
- 33 were detained in hospital on a compulsory treatment order.
- 11 were detained under a short term detention certificate.
- Two were detained under an emergency detention certificate.

We managed to obtain follow up information on 73 out of the 78 deaths. Of these

- 28 were reported to the Procurator Fiscal as sudden or unexplained.
- 15 of the 73 individuals died in general hospitals.

We categorised the individuals' deaths as shown below and include examples of the deaths reported to us.

1. Individuals whose death was expected and from natural causes

Thirty-nine of the 73 individuals on whom we have information died from natural causes where death was expected. Of these, 35 were on a compulsory treatment order and 4 were subject to short term detention certificates. All were over the age of 45 and the majority were over 65.

Examples

- A 67 year old individual with alcohol related brain damage was on a hospital based compulsory treatment order. He was found to have advanced cancer, was transferred to a palliative care ward in a general hospital where he died peacefully.
- An 81 year old woman with dementia became increasingly frail and died in hospital of bronchopneumonia.
- A 73 year old individual with dementia was admitted under a short term detention certificate because of increased confusion. She was found to have cancer and died in hospital.

None of these deaths were reported to the Procurator Fiscal or investigated further.

2. Sudden death with no direct relation to mental health

Fourteen individuals died suddenly but were found to have died from natural causes that were not directly related to mental health care and treatment. Of these, one was under 45, seven were aged 45-64 and six were aged over 65. Ten of these 14 deaths were reported to the Procurator Fiscal. In these cases, post-mortem examinations were performed, but because death was of natural causes there was no further investigation.

Examples

- A 75 year old woman on a community based compulsory treatment order had severe and enduring mental illness and diabetes. She was found dead at home. The death was reported to the Procurator Fiscal. At post-mortem, she was found to have died of a heart attack.
- A 66 year old individual died suddenly while out of hospital on suspension of detention. Again, this was reported to the Procurator Fiscal. Post-mortem examination revealed heart disease as the cause of death.
- A 55 year old individual with learning disability had multiple complex physical problems. The individual died while detained under a short term detention certificate and being transported in an ambulance from a learning disability hospital to a general hospital. Although not reported to the Procurator Fiscal, there were concerns about the individual's care leading up to these events while the individual was in a registered care service. This was investigated further by the Care Inspectorate.

3. Sudden death with no explanation or possible relation to mental illness or learning disability (or treatment)

There were six individuals in this category, of whom four were on a compulsory treatment order and two were detained under a short term detention certificate. The age range was 40-83 and all were reported to the Procurator Fiscal.

Examples

- A 50 year old individual was at home on suspension of detention from a hospital based CTO. The individual was found to have died suddenly and post-mortem revealed pulmonary thromboembolism (blood clot in the lungs). This can result from a number of factors, including periods of immobility. The Procurator Fiscal did not investigate the case further.
- A 40 year old individual with learning disability had swallowing difficulties. Tragically, the individual choked and died while out for lunch with staff and other patients. This was investigated, the food he was eating was in line with what he was judged as being able to safely swallow and there was no apparent deficiency of care.
- A 70 year old individual with dementia died shortly after admission to hospital on a short term detention certificate. At post mortem, a heart attack was found to be the cause of death. This was investigated further because of concerns about multiple medications, but these were for physical illness. The only medication she received for mental health difficulties was occasional lorazepam.

4. Suicide

We heard of 11 suicides of people subject to compulsory treatment. Five of these individuals were in hospital at the time. Three individuals were in the community under suspension of detention and three were subject to community compulsory treatment. All of these were reported to the Procurator Fiscal and were investigated further. The Commission was involved in all of these cases. Reporting of suicides and analysis of lessons from suicide are within the remit of Healthcare Improvement Scotland.

Examples

- A 22 year old individual took his own life by hanging in hospital. This is the subject of an ongoing Mental Welfare Commission investigation.
- A 30 year old individual took his own life while on suspension of detention with the intention to vary the order to a compulsory treatment order. There had been no apparent precipitants and the death was quite unexpected. This was investigated locally and the Commission was satisfied that there was no deficiency of care.
- A 41 year old individual took her own life through hanging. There was a thorough internal investigation. There were deficiencies in the observation procedure and an unexpected ligature risk from a door handle. The service has put mechanisms in place to reduce the chance of recurrence. This incident report has been sent to Healthcare Improvement Scotland.

5. Special Category: Delirium

We found three individuals who were admitted with delirium to general hospital wards and died shortly after admission. Two of these were subject to short term detention certificates. They had multiple physical problems (one had cancer with widespread secondary tumours and one had severe lung disease). The reason for admission under the Mental Health Act had been that they required hospital treatment, had delirium, did not understand they were ill and refused to go to hospital. The third individual was admitted to a general hospital ward with alcohol withdrawal under an emergency detention certificate. He had numerous physical problems and died suddenly shortly after admission. The cause of death was unclear, the Procurator Fiscal was informed and a post-mortem recorded the death as still unexplained.

Age and cause of death

We divided the individuals who died into two groups: those under the age of 65 and those aged 65 and over. The categories of death for both groups are shown in the table below.

Category of cause of death	Under 65	65 and over
Expected, natural causes	11	28
Sudden, natural causes	8	6
Sudden unexplained or related to mental illness/learning disability	4	2
Suicide	11	0
Delirium as reason for detention	3	0
Insufficient information available	2	3

This is relevant when comparing the number of deaths of individuals receiving compulsory treatment with the general population and with deaths of individuals with a history of hospital treatment for mental illness, learning disability or related conditions (see below).

Comparisons: general population and population with a history of admission to mental health services

In order to address concerns that individuals died while subject to compulsory treatment, we decided to compare the risk of death while subject to compulsion with the general population and with a comparable population that was not subject to compulsion. We obtained statistics on deaths in order to compare the proportion of individuals who died while subject to compulsion with the general population. We also compared this with the proportion of individuals who had received in-patient mental health care and treatment.

Tables: Crude, national mortality rates by age group (18+ years), 2011-2012 (source ISD and MWC)

General Population			
Age Group (years)	No. of deaths	Total pop	Mortality rate per 1000 (95% CIs)
18-64	9365	3102477	3.0 (2.9, 3.1)
65+	39464	819597	48.2 (47.7, 48.7)

Mental Health Population				
Age Group (years)	No. of deaths	Total pop	Mortality rate per 1000 (95% CIs)	Rate ratio comp to gen pop
18-64	187	21882	8.5 (7.4, 9.8)	2.8
65+	685	6751	101.5 (94.5, 108.9)	2.1

Compulsory treatment population					
Age Group (years)	No. of deaths	Total pop	Mortality rate per 1000 (95% CIs)	Rate ratio comp to gen pop	Rate ratio comp to MH pop
18-64	39	5292	7.4 (5.4, 10.1)	2.5	0.9
65+	39	1429	27.3 (20.0, 37.1)	0.6	0.3

To interpret the mortality rate in people who have been subject to a detention, it is helpful to make comparisons with mortality in both the general population and the mental health population. The mental health population is defined by ISD as anyone who has had an admission to a general or old age inpatient unit within the last three years.

In adults under 65 years, mortality is almost three times higher in the mental health population compared with the general population (rate 8.5 per 1000 vs. 3 per 1000). This is a well known and longstanding inequality. Mortality in the detained population is very similar to mortality in the mental health population (7.4 per 1000 vs. 8.5 per 1000, difference is not statistically significant and could be due to chance). This suggests that the higher mortality in the detained population (compared with the general population) is explained by the underlying condition of those detained, rather than the detention per se.

In adults aged 65 and over, mortality in the mental health population is two times that of the general population. However, mortality in the detained population is significantly lower than both the mental health population (27.3 per 1000 vs. 101.5 per 1000) and the general population (27.3 per 1000 vs. 48.2 per 1000).

Commentary

It is reassuring that individuals who are subject to compulsory treatment are no more likely to die than anyone else who is, or has been, treated for mental illness, learning disability or related conditions. The death rate in 2012-13 was slightly lower for individuals subject to compulsory treatment. This is reassuring as compulsory treatment, where it is indicated due to the risk to the individual's own health, safety or welfare should reduce the risk of death.

The relative risk of death for individuals over 65 is much lower for individuals who are subject to compulsory care and treatment. A likely explanation for this is that this population will contain comparatively more individuals with "functional" mental illness (e.g. depression, bipolar disorder and schizophrenia). Individuals with dementia have a shorter life expectancy and are more likely to be discharged to care homes, often with the appointment of a welfare guardian. We do not think the comparative rates of death in the over 65 age group are meaningful.

There has been much discussion about the need for fatal accident inquiries into the deaths of all individuals detained under mental health legislation. In 2009, Lord Cullen recommended a mandatory fatal accident inquiry into the death of any person who is subject at the time of death to compulsory detention by a public authority. The Scottish Government's response in 2011 noted this recommendation, considered that it would result in unnecessary inquiries and looked at a range of options to produce a more proportionate response.

Our latest data may help in formulating such a response. Of the 73 deaths where we have sufficient information, 17 were either suicides or sudden deaths that may have required further examination. In considering the final response to Lord Cullen's report, the Scottish Government should consider this, and also consider:

- Do individuals subject to community-based compulsory treatment or suspension of detention come under the category of "compulsory detention" in terms of Lord Cullen's report?
- What about deaths of individuals subject to welfare guardianship? Many of these individuals will have a care home specified as the place of residence. They may therefore be regarded as "detained". Where the Chief Social Work Officer is the guardian, these individuals are being detained by a public authority. Where the guardian is a private individual, the State has granted the power through the court system and could still be regarded as having detained the person subject to guardianship. There will be a large number of individuals in this category.

The most important issue is the higher death rate in general of individuals with a history of mental health admission. It is not compulsory treatment that is associated with death: it is the presence of mental illness, learning disability and related conditions. See the Scottish Government's "Equally Well" report for more on this[1]. In our view, this needs much more attention that whether or not the individual is subject to compulsory treatment.

[1] http://www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf


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Mental Welfare Commission (Mar 14)