# Notifications to the Mental Welfare Commission for Scotland

* **Deaths in Detention Reviews**
* **Mental Health Homicide Reviews**

## Background

The Mental Welfare Commission for Scotland is currently progressing two important projects that were the subject of Ministerial commitments during the passage of the 2015 Mental Health Act.

The first of those is to deliver on recommendation 1 in the Scottish Government’s review of the process of the investigation of deaths of people who were subject to mental health legislation or being treated for mental illness (including dementia) or learning disability at the time of their death (known as the s37 review). The recommendation states:

*“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 is in the context of the work being co-ordinated by Scottish Government on all the recommendations from this review, and the actions of the Suicide Prevention Action Plan, particularly that there are appropriate reviews into all deaths by suicide.

It is vital to the development of the work which the Commission has agreed to undertake that they are notified of all deaths of patients who come within the above categories.

The second strand of the work is to progress developing a system of review when people who have been in touch with mental health services commit homicide. Ministers have assured the Scottish Parliament of their support for this work by the Commission.

## Notifications to the Com**m**ission

We recognise that Boards already make many notifications to the Commission, in line with the guidance on the Commission’s website, which is included at Part C of the attached document, and they should continue to do so.

In particular, though, we ask that as from the start of this year (01 January 2020) all deaths of patients subject to mental health detention or a community based order under the 2003 Act of the Criminal Procedure (Scotland) Act *and* all homicides committed by people with recent contact with mental health services are notified to the Commission. These requirements are stated in the recently updated *Learning from adverse events through reporting and review – A national framework for Scotland* [[1]](#footnote-1) (December 2019: Page 16) issued by Healthcare Improvement Scotland.

The full descriptions and definitions of requirements for notifying the Commission are set out in the attached document.

The Scottish Government Mental Health Directorate DL (2020) 3 (21 February 2020) supports these requirements for notification to the Commission.

## Deaths in Detention engagement and consultation

The Deaths in Detention Reviews project is overseen by the s37 Review Implementation Group and the Scottish Government Mental Health Directorate. We are also in conversation with Healthcare Improvement Scotland’s Adverse Events team and officers working on the National Suicide Prevention Leadership Group (NSPLG) agenda and other relevant reviews and initiatives.

The core aim of the DIDR project is to establish a complete and proportionate system of review for **all** deaths in detention, irrespective of the cause, in collaboration with other agencies.

As an initial exercise we have begun working towards establishing a complete baseline data set of deaths in detention over the past three years (2017/18; 2018/19; 2019/20). We are examining a download of the Commission’s database of notifications, mental health act forms and case records; we will request from boards copies of some significant adverse event reviews (SAERs) we do not already hold; and we will work with others on data linkage exercises. This exercise will help inform questions and criteria for further exploration at boards.

In 2020 we will be inviting a number of health boards to engage with us in pilot work towards understanding boards’ current experience, exploring the above identified questions and identifying areas for improving and streamlining the reviews processes. We aim to plan our approach during March-May and conduct fieldwork at health board sites in June-September 2020. Fieldwork will involve consultation work with officers involved in local review processes and with family representatives.

We are inviting interest from boards who may wish to take part; our choice of pilot sites may also be informed by our examination of the above dataset and discussion with other agencies.

## Engaging with families bereaved via deaths in detention

An essential part of the DIDR project is to ensure that the voices of families bereaved by deaths in detention are heard and contribute to the project.

As a first step, we have commissioned INQUEST[[2]](#footnote-2) to facilitate a family consultation day in May 2020.

Please address any enquires to mwc.review@nhs.net (21 February 2020)

# Appendix: Mental Welfare Commission definitions (February 2020)

* **Deaths in Detention Reviews**
* **Mental Health Homicide Reviews**
* **Other notifications to Mental Welfare Commission for Scotland**

## Deaths in Detention

As a result of the Review of the arrangements for investigating the deaths of patients being treated for mental disorder (December 2018), the Scottish Government asked 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).*** *(Action One)*

### Mental disorder

The definition of mental disorder is found in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and refers to any mental illness; personality disorder; or learning disability, however caused or manifested[[3]](#footnote-3).

### Detained by powers set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act)

The 2003 Act allows for people to be placed on different kinds of compulsory order according to their particular circumstances. There are three main types of compulsory powers:

* emergency detention
* short-term detention
* compulsory treatment order

Additionally, the 2003 Act gives Scottish Ministers the power to make a transfer for treatment direction in respect of prisoners with mental disorder.

### Detained by powers set out in part VI of Criminal Procedure (Scotland) Act 1995 (the 1995 Act)

The 1995 Act sets out the orders that courts can make when dealing with a criminal case where the accused has a mental disorder. It allows people to receive care and treatment for their mental disorder when they are, or have been, prosecuted for a criminal offence. The courts can make a number of different types of order depending on the stage of criminal proceedings and how much care the accused will need for their illness. These orders are:

* assessment order
* treatment order
* temporary compulsion order
* interim compulsion order
* compulsion order
* restriction order (only made in conjunction with a compulsion order)
* hospital direction

### Legislation

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’. It has extensive powers to carry out 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.

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 2003 Act Code of Practice[[4]](#footnote-4) states (page 30):

*In view of the Commission’s statutory protective, investigatory and monitoring functions, it is essential that the Commission is provided with the required notifications under the Act and within the specified timescale.*

Annex A sets out a list of what should be notified, the person responsible for providing written notification and the corresponding timetable. The Commission should be informed of all revocation of detention: an emergency detention certificate (by hospital managers); a short term detention certificate or extension, and compulsory treatment order or revocation of suspension of detention (by RMO). ‘Death of patient’ is cited as a reason for Termination of detention on revocation forms (REV1 etc).

The RMO should also inform the Commission of revocation/termination of orders under the 1995 Act and ‘Death of patient’ is cited as a reason.

Further Good practice guidance on notifying the Commission is set out on the Commission website[[5]](#footnote-5).

## Homicides committed by people with recent experience of mental health services

In some cases, a person who is accused of homicide may have had recent contact with mental health or learning disability services. They may be identified as having a mental disorder, and may have had a mental disorder at the time of the offence.

The Commission wishes to be notified of any homicides committed by any individual who has had contact with mental health or learning disability services up to 12 months before the offence. Mental health services include inpatient and outpatient services from which care and treatment for mental illness is delivered.

We propose that homicides by service users who have had contact with drug and alcohol services will not qualify under this process unless the individual has a co-morbid mental health condition

The requirements for reporting deaths in detention and homicides committed by people with recent experience of mental health services are stated in the recently updated *Learning from adverse events through reporting and review – A national framework for Scotland* (December 2019: Page 16) issued by Healthcare Improvement Scotland.

*All deaths of patients subject to mental health detention or a community based order under the Mental Health (Care and Treatment)(Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995; all homicides committed by people with recent contact with mental health services; and serious crimes (serious assault, serious sexual assault) by an individual who is receiving care from mental health or learning disability services are notified to the Mental Welfare Commission for Scotland*

## Other notifications to the Mental Welfare Commission for Scotland

<https://www.mwcscot.org.uk/good-practice/notifying-commission>

We are often asked about what issues and incidents should be reported to the Mental Welfare Commission.

It is difficult to be prescriptive as each and every circumstance will be different. However, the following guidance is intended to assist staff in the NHS, local authority, or independent sector services in determining whether an incident or issue should be notified to us and the form that notification should take.

Any such notification is in addition to any other notification required by, for example, the Care Inspectorate, adult support and protection officer, or Healthcare Improvement Scotland.

The term 'individual' is used throughout this guidance to refer to a person with mental illness, learning disability, dementia or a related condition.

On receipt of such a notification, the Commission will determine whether any further information is required, or any action is to be taken.

Despite this guidance, it is not possible to be prescriptive about all cases which should be reported to the Commission as circumstances vary so much. Anyone in doubt as to whether a matter is significant enough to report to the Commission should contact the Commission to discuss the situation.

### Specific

* The death of any individual who is subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 [as outlined above].
* The suicide of any inpatient receiving psychiatric care at the time of death or who has been discharged from inpatient psychiatric care within the preceding month.
* The death of any individual where there is a significant concern regarding any aspect of their care and treatment prior to death.
* Where it is felt that a Fatal Accident Inquiry should, or will, be held.
* All cases where an individual who is receiving care from mental health or learning disability services is accused of or convicted of, a serious crime, e.g. homicide, serious physical assault, or sexual assault
* Where it appears that an individual is being or has been detained in any care setting without appropriate legal authority.

### General

* Incidents where it appears there has been a deficiency in care or treatment and, as a result, an individual suffers a serious injury or adverse physical effects. This includes as a result of restraint, or where the injury has been caused deliberately by another person.
* Where an individual is living alone or without care and is unable to look after themselves, their property, or financial affairs and no intervention is taking place to remedy the situation.
* Incidents or circumstances in which a deficiency in care has led to the property of an individual suffering significant loss or damage, or has led to it being at risk of significant loss or damage.

In addition to the above, local authorities should notify the Commission of:

Any significant investigation the local authority carries out under Section 33 of the Mental Health (Care and Treatment) (Scotland) Act 2003, Section 10(1)(c) of the Adults with Incapacity (Scotland) Act 2000, or where a Protection Order under the Adult Support and Protection (Scotland) Act 2007 has been taken out in relation to an individual.

### Information required by the Commission

The information provided to the Commission should be relevant and proportionate to the circumstances of the case and would normally include:

* A brief account of the circumstances of the incident or situation, its antecedents, and any other relevant information
* Information on the diagnosis, treatment, and the mental state of the person
* Information on any other person involved
* What further action is being taken or considered, including any changes in procedure, policy, or the physical environment
* An indication of any further investigation, enquiry, or review that is being carried out or considered, and a copy of the outcome of these when available
1. <http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=968c1d9d-7439-41d7-83d5-531afebaebcc&version=-1> (Page 16: Footnote 24) [↑](#footnote-ref-1)
2. INQUEST is a charity with expertise in consulting families on state related deaths. <https://www.inquest.org.uk> [↑](#footnote-ref-2)
3. Section 328, Mental Health (Care and Treatment) (Scotland) Act 2003,

<https://www.legislation.gov.uk/asp/2003/13/section/328> [↑](#footnote-ref-3)
4. Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1

<https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/0/> [↑](#footnote-ref-4)
5. <https://www.mwcscot.org.uk/good-practice/notifying-commission> [↑](#footnote-ref-5)