Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the from the Mental Welfare Commission for Scotland

1. The Mental Welfare Commission for Scotland is a statutory body established under the Mental Health (Care and Treatment) (Scotland) Act 2003, with powers under that Act and the Adults with Incapacity (Scotland) Act 2000 to protect and promote the human rights of people with mental health problems and learning disabilities, particularly if subject to detention or other compulsory care and treatment.

2. Those powers include a power to conduct investigations where we consider that a person with mental disorder may have been subject to ill-treatment, neglect, or deficiency in care or treatment. In some cases, we will formally investigate deaths of people subject to detention under this power. We expect to be notified of all deaths by suicide of detained patients.

3. Our response specifically concerns recommendation 6 of the Cullen report, that there should always be an independent investigation for the death of a person subject to compulsory detention by a public authority within the meaning of section 6 of the Human Rights Act. This recommendation is not being taken forward in the Bill.

4. The Policy Statement for the Bill states at para 78 that: *The Mental Welfare Commission Scotland and the Royal College of Psychiatrists both oppose mandatory FAIs for patients who are subject to compulsory mental health detention orders and have commented that deaths of this category of patient give rise to no more concern than deaths of other mental patients.*

5. It is correct that the Commission does not advocate a mandatory FAI for every death of a patient who has been subject to detention at the time of death. However, our position is more nuanced than the above comment would suggest. (We mention in passing that we also would not use the phrase ‘mental patients’, which is an old fashioned term and perceived as derogatory).

6. We investigated the deaths of detained patients in 2012/13. Our report is available at [http://www.mwcscot.org.uk/media/175822/death_in_detention_final.pdf](http://www.mwcscot.org.uk/media/175822/death_in_detention_final.pdf)

7. That report did indeed find that patients subject to detention were no more likely to die than other people being treated for mental illness, learning disability or related conditions, and that it was important to maintain a policy focus on the much wider issue of the huge inequality of life expectancy between the general population and people with mental health problems.

8. It also found that, of 73 deaths about which we had information, 39 died from natural causes where death was expected, and 14 died suddenly from natural causes not related to mental health treatment. So in at least 2/3 of these deaths, it is difficult to see what value would have been added by an FAI.
9. Eleven cases were suicides, and we would certainly argue that suicide while a patient is detained merits careful review. But even there, we are not persuaded that every such case should result in a FAI.

10. We responded to the Government’s consultation on its response to the Cullen report. See http://www.gov.scot/Resource/0046/00460923.pdf at File 039. We favoured a middle ground between the Cullen recommendation of an FAI in every case, and maintaining the status quo (which involves COPFS investigations leading to a small number of discretionary FAIs; a separate process of critical incident reviews by local services; and some investigations by the MWC.)

11. Our preference was for a streamlined, transparent, and proportionate investigatory framework, with a proper hierarchy of investigation for all cases, including an independent element of oversight into local reviews. Under this model, FAIs would be reserved for particularly troubling or difficult cases which require full public scrutiny. The details of our proposal are outlined at the response to Questions 5A and 5B of the consultation.

12. The analysis of the consultation responses suggested that the majority of responses favoured the status quo, and some had concerns about a new approach. See http://www.gov.scot/Publications/2014/11/2861/0 at paragraphs 2.38 to 2.52. However, it is not easy to follow the reasoning of some of these responses, and it may be that they had not had an opportunity fully to consider what might be proposed. We maintain our preference for this new model, for a number of reasons.

13. Firstly, while we have said that we have no reason to suppose that detained patients are more at risk of death than other patient, and certainly not that the process of detention might be a cause of death (unlike, for example, some of the concerns about restraint in police custody), we agree with the basic point that society should be particularly concerned about people who die when their liberty has been removed by the state.

14. We are also doubtful that the current system lives up to the expectations of Article 2 of ECHR, as developed by caselaw. We refer the Committee to the Equality and Human Rights Commission report on Preventing Deaths in Detention of Adults with Mental Health Conditions; particularly pages 25 and 26 which set out the responsibilities of the State to make sure there is an effective investigation into every death from non-natural causes in state detention. http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions

15. The deficiencies of the current system, judged against these standards, include:
   i. Independence is not guaranteed. Some suicides will be investigated by a local review without an independent element
   ii. Most reviews are not open to public scrutiny, even in an anonymised form
   iii. The involvement of next of kin is variable
iv. The fact that there are potentially three different modes of investigation (local review, FAI and MWC review), sometimes compounded by other investigations by bodies such as the Care Inspectorate and the Health and Safety Executive, means that investigations do not always ‘begin promptly and conclude as quickly as is reasonable’. We are aware of cases where a decision on whether to hold an FAI is outstanding, many months after the death.

v. Although Healthcare Improvement Scotland make efforts to share learning from suicides across the NHS, this is dependent on the quality and focus of local reviews, which can be highly variable.

vi. The process of investigation is unnecessarily confusing and stressful for services and families, since it can involve different agencies investigating in different ways, with a lack of overall co-ordination.

16. This picture is not universal, and we commend the efforts of HIS, COPFS and many local health boards to improve the quality and impact of investigations into suicides and other unexpected deaths. Nevertheless, we believe that more needs to be done to make the process efficient, effective and co-ordinated in every case, and to ensure compliance with Article 2 obligations.

17. We are open-minded about whether this requires to be enshrined in primary legislation or developed through protocols and joint working between the key agencies (COPFS, HIS, MWC etc.). But we urge the Justice Committee to take steps to ensure that such a system is put in place.

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