Review of the arrangements for investigating the deaths of patients being treated for mental disorder

Scottish Government
Riaghaltas na h-Alba
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This report is published and laid before the Scottish Parliament in accordance with section 37(4) of the Mental Health (Scotland) Act 2015

SG/2018/210

Contents

Ministerial foreword

There are a number of actions in this review report which will make important changes to the way we investigate and learn from deaths of people being treated for mental disorder. Crucially these changes will mean that investigations will involve, and be more accessible, to families and carers.

The Scottish Government is committed to creating a modern, inclusive Scotland. A country which protects, respects and realises internationally recognised human rights, and is working with the whole of Scottish society to deliver a shared vision for a Scotland where everyone can live a life of human dignity.

People affected by mental disorder have the same rights as everyone else. This includes the right to life, protection from discrimination as well as participating in those decisions which involve them. The Scottish Government is taking a human rights approach which empowers people to know and claim their rights. This increases the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights. We also recognise the needs and rights of carers and families. Their experiences have rightly formed a central part of this review.

Ensuring effective investigation of the deaths in the circumstances covered by this review is essential if services are to improve in the way that families, carers and staff have told us they need to.

Clare Haughey MSP
Minister for Mental Health

Chair's foreword

I would like to thank everyone who has contributed to the work of this Review. I would particularly like to acknowledge the contribution of the people who, through their own direct experiences, shared their views on what works well and what needs to be improved.

I heard first-hand from staff, families and carers about the importance to them of compassionate, timely and thorough investigation following the deaths of people they have cared for.

I heard of the way in which investigations can be helpful for all those affected, in supportively considering factors that contributed to individual circumstances, recognising through action the importance of communication, information, involvement and, when the investigation has been completed – ensuring that requirements for change and improvement can be described clearly.

Support to make the necessary improvements and provide transparent public assurance that this has happened was consistently raised as the hallmark of best practice in this area.

I also heard of the distress that insensitive, defensive and unresponsive actions can cause to people who were already finding it difficult to makes sense of what had happened.

Organisations told me how they were taking steps to continuously learn and improve the way they investigate deaths and their commitment to do what is required to address the findings of this review.

This review has confirmed that there is widespread recognition across the country that there is a pressing need to ensure consistently high standards of investigation,

that this is accompanied by timely scrutiny of the quality of that investigation and that greater transparency in the way in which changes and improvements are being effectively delivered is prioritised.

Although the review identified several areas of improving practice in the investigation of deaths, staff, families and carers were united in identifying a need for further focus, resource and support to undertake what is often complex, difficult and distressing work.

All those who were engaged with this work agreed that our collective response to this report, its findings and proposed actions will be vital in creating the conditions for change that everyone we spoke to wants to see.

I look forward to supporting the further work that is needed, involving people whose lives have been changed forever following deaths of the sort our review has focused on.

All members of the Review Group have expressed their willingness to contribute to the further work that will be required through responses to this Review and other commitments, building on what works well and in identifying new nationally supported systems and processes.

Professor Craig White
Divisional Clinical Lead,
Directorate for Healthcare Quality and Improvement, Scottish Government

Definition of terms used in this report

Mental disorder

In this report the term 'mental disorder' is used to reflect the language of section 37 of the Mental Health (Scotland) Act 2015. 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.[1]

Legislation

The Mental Health (Scotland) Act 2015 is referred to as 'the 2015 Act' throughout this report.

Orders for compulsory treatment/detention are made under two laws covered by this review. Reference is made to these in this report as follows:

- the Mental Health (Care and Treatment) (Scotland) Act 2003 is referred to as 'the 2003 Act'
- the Criminal Procedure (Scotland) Act 1995 is referred to as 'the 1995 Act'

Investigation and review

Section 37 of the 2015 Act refers to the arrangements for investigating deaths and, in line with that, this report frequently uses the term 'investigation'. However, it is recognised that there are different uses and interpretations of the terms 'review' and 'investigation'. The usage of these terms throughout this report predominantly reflects the various meanings, uses, and preferences encountered in the course of gathering evidence for this review.

The term 'Review' (capitalised) is used in this document to refer to this review of the arrangements for investigating deaths, and 'Review Group' is used to refer to the group whose membership is provided at Annex A.

[1] Section 328, Mental Health (Care and Treatment) (Scotland) Act 2003, https://www.legislation.gov.uk/asp/2003/13/section/328

Summary of actions

1 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.

2 The Scottish Government will consider the further actions required to better support multi-agency co-ordination of investigations.

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

4 The Scottish Government will work with the Mental Welfare Commission for Scotland, Healthcare Improvement Scotland, and NHS National Services Scotland to identify an appropriate set of publicly reportable measures that reflect best practice in the investigation of deaths and can be used to identify where improvement is required.

5 The Scottish Government will ask Healthcare Improvement Scotland to make changes to its Suicide Reporting and Learning System to immediately reintroduce the suicide notification requirement and scrutiny of NHS boards' suicide reviews. Healthcare Improvement Scotland will also be asked to describe how it will support boards to continuously improve the quality of the suicide review reports. There should be a clearer link between the scrutiny of these reports and specific improvement support

that is directly designed and targeted around the common contributory processes identified in suicide review reports. This will be aligned to the new investigation process referred to in action 1.

6 The Scottish Government will work with partner organisations to produce resources for carers and families which provide information on how deaths are reviewed.

7 The Scottish Government will work with partner organisations to improve the co-ordination of support available for families and carers. This will include the creation of a single point of contact for families and carers in relation to all investigations and reviews. It will also include investigation of any barriers that need to be addressed in order to ensure that co-ordination of support is able to operate effectively across the various organisations involved.

8 The Scottish Government will establish an implementation group to oversee the implementation of actions arising from this report. This group will include equal representation from carers and families.

9 The Scottish Government will work with partner organisations to consider what support and advice staff need to involve families and carers in a meaningful way.

10 The Scottish Government will work with the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland to improve the ways in which investigation findings and recommendations are disseminated, and explore options to support healthcare providers to use this information to commission improvement support. The new system of investigations referred to in action 1 should include a mechanism for transparent follow up and public assurance of changes.

Background

1. The 2015 Act sets out a requirement for Scottish Ministers to undertake a review of the arrangements for investigating deaths of patients in hospital for treatment of mental disorder. This report gives the findings of the Scottish Ministers' Review and the actions that will be taken to address those findings.

2. In response to an investigation report by the Mental Welfare Commission for Scotland and a petition before the Scottish Parliament, Ministers agreed that the Review would look at two additional circumstances.

3. The Mental Welfare Commission for Scotland published a report, in January 2016, on its investigation into the death of Ms MN, a person with complex needs.[2] Ms MN was subject to a hospital-based compulsory treatment order (CTO) and subject to suspension of detention when she died by suicide in 2012. The investigation report made a recommendation to the Scottish Government that the Review should also consider deaths by suicide of patients subject to suspension of detention. This recommendation was accepted.

4. In response to petition PE1604, submitted to the Scottish Parliament by Catherine Matheson, the Minister for Mental Health agreed that the Review should also include the arrangements for investigating the deaths of people being treated in the community while subject to an order under the 2003 Act or part VI of the 1995 Act. [3]

5. Once the remit of the review had been finalised, the Minister for Mental Health asked Professor Craig White, Divisional Clinical Lead, Scottish Government Directorate for Healthcare Quality and Improvement to chair a group to review existing arrangements and develop a series of actions for improvement. Policy support to the Review Group was provided by the Law and Protection of Rights Team, Scottish Government Directorate for Mental Health.

6. The Review Group met for the first time in October 2017 and subsequently in April, June, August, and October 2018. A list of group members is provided at Annex A.

[2] Mental Welfare Commission for Scotland, Investigation — the death of Ms MN (2016), https://www.mwcscot.org.uk/about-us/latest-news/investigation-into-the-death-of-ms-mn/
[3] PE01604: Inquests for all deaths by suicide in Scotland, http://www.parliament.scot/GettingInvolved/Petitions/inquestsfordeathsbysuicide

Introduction

7. The Scottish Government recognises the importance of people being able to get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma. Mental health legislation plays a part in this by promoting rights and providing safeguards for patients. The 2015 Act strengthened measures in the 2003 Act that promote support for decision making, including those for independent advocacy, advance statements and named persons.

8. People in Scotland receive care and treatment for mental disorder in an array of settings. When people die in hospital there may be a review of their death in some circumstances. The type and complexity of investigation of any particular death depends on a number of factors, including whether the death was unexpected or unexplained; staff action (or inaction) which may have contributed to the death; as well as organisational policies, procedures or practices which may have contributed to the death.

9. According to the Inpatient Census 2018 (Part 1: Mental Health & Learning Disability Inpatient Bed Census) there were 3443 patients occupying a psychiatric, addiction, or learning disability inpatient bed in an NHS Scotland facility at the point of the 2018 Census. A total of 1460 of those patients were subject to an order under either the 2003 Act or part VI of the 1995 Act.[4] These figures do not include independent hospitals but give an indication of the number of people being treated for mental disorder. The Census also tells us that a total of 1196 patients had been admitted to hospital for at least one year or more with 366 of those having dates of admission of 5 years or more.

10. Healthcare providers are required to notify the Mental Welfare Commission for Scotland of the revocation or termination of any order under either the 2003 Act or part VI of the 1995 Act (with the patient's death being one of several reasons for revocation or termination). In 2017-18 the Commission received 100 reports of deaths of people subject to an order. Table (i) provides the number of deaths reported to the Commission since 2014-15.

11. The information and data currently available to describe systems and processes of investigation are not sufficient to provide assurance of timely and effective delivery. Further action will be required to identify a broader range of process and outcome measurements that more explicitly inform scrutiny, assurance, and improvement support.

[4] Scottish Government, Inpatient census 2018: part one (2018) https://www.gov.scot/publications/inpatient-census-2018-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/

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

Scope of the review

12. The aim of this Review was to establish whether the current arrangements for investigating the deaths of people being treated for mental disorder are adequate, and how well hospitals and other organisations support and engage with the families of people who have died.

13. The Review considered the arrangements for investigating the deaths, including deaths by suicide, of people who were:

Detained by powers set out in 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 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

Admitted voluntarily to hospital

Many people are admitted to hospital on a voluntary basis for treatment of mental disorder.

14. Alongside consideration of the arrangements for investigating the deaths of people in hospital for treatment for mental disorder, the Review also looked at the arrangements of those people who were not in hospital but who died while either being treated in the community (and subject to a community based compulsory treatment order, or a compulsion order) or while their detention (under a 2003 Act or 1995 Act order) was suspended.

15. A key requirement of section 37 of the 2015 Act is that where practicable there must be consultation with the nearest relatives of people who died while subject to care or treatment for mental disorder.

Method

16. The Review has sought the advice of professional experts, organisations and people with lived experience in order to fully understand the current arrangements for investigating deaths. The membership of the Review Group included representatives from a range of organisations with expertise in the review of deaths and in care or treatment for mental disorder. A list of Review Group members is provided at Annex A

17. At the first meeting of the Review Group it was agreed that evidence gathering in three main areas was needed: organisational views on current arrangements; staff experiences of those arrangements; and the experiences of carers and families of those arrangements.

18. The Review Group agreed that, given the importance of recognising the experiences of carers and families across the country, a Carers and Families Sub-Group would be created to take forward the work to engage with the experiences of carers and families on the issues within the scope of this review. The Sub-Group membership is provided at Annex B.

19. To obtain details on corporate governance arrangements in respect of investigation of deaths, a questionnaire was sent to NHS board chief executives; local authority chief executives; chief social work officers; independent hospitals; integration joint board officers; the Crown Office and Procurator Fiscal Service (COPFS); the Health and Safety Executive; the Mental Welfare Commission for Scotland ('the Commission'); and Police Scotland.

20. The questionnaire sought information on: the role that the organisation plays in reviewing deaths; the statutory powers available to it; the resources and policies it has it place; the triggers for initiating an investigation; how it works with other organisations and shares information; how it involves families and carers; and how it uses the findings from investigations. A list of respondents is provided at Annex C. The Review Group Chair undertook a series of visits to organisations to speak to staff face to face about their processes for investigating deaths.

21. The Carers and Families Sub-Group developed a survey to enable families and carers to provide their experiences of the arrangements for investigating deaths. The survey ran from 2 July to 24 September 2018 (12 weeks) on the Scottish Government's consultation website.[5] A total of 42 responses were received. A summary report of the responses received (quantitative questions only) is provided at Annex D.

22. The survey for carers and families was followed up with the offer to meet for one-to-one discussions. This was facilitated by members of the Carers and Families Sub-Group and the organisations they represented. At these meetings, carers and families had an opportunity to discuss their experiences and put forward what would have improved things for them. Additionally, the Chair of the Review Group met with several family members in separate meetings to hear from them about their experiences of investigation.

23. A survey for staff was also produced and ran from 2 July to 24 September 2018 (12 weeks) on the Scottish Government's consultation website.[6] The survey received 172 responses. A summary report of the responses (quantitative questions only) is provided at Annex E.

24. Both surveys were publicised using social media channels and were available to anyone visiting the Scottish Government's consultation website. Links to the surveys were widely disseminated through stakeholder networks, NHS boards, local authorities and members of the Review Group. Printed copies of the leaflet to accompany the carers and families survey were sent to main libraries across Scotland.

25. The Scottish Government and the Review Group are grateful to everyone who took the time to tell us about their experiences of how deaths are investigated. Especially so to those carers and families who responded to the survey or met face to face to speak about the impact of these processes on their adjustment to the tragic deaths of the people they loved.

[5] Scottish Government, Learning from Loss: family and carers survey https://consult.gov.scot/mental-health-law/investigation-of-deaths-survey-for-families-carers/
[6] Scottish Government, Learning from Loss: staff survey https://consult.gov.scot/mental-health-law/investigation-of-deaths-survey-for-staff/

Existing systems of review and related policies

26. The Scottish Government and NHS Scotland have a shared vision for an open and learning culture. We want to learn when there has been dissatisfaction or harm and encourage organisations to identify improvements. Health and social care organisations need to learn effectively from best practice, from past experiences and have effective processes to translate this learning into improvements in the delivery and management of care. When someone dies, either in hospital or in the community, there may be investigations or reviews of varying levels by a number of different organisations. In some cases there can be two or three investigations running in parallel often with very different aims and processes.

27. The following sections provide a summary of the work that has been identified as an element of the arrangements for investigating deaths of people being treated for mental disorder in Scotland.

Health boards — adverse event reviews

28. An adverse event can be defined as an event that could have caused, or did result in, harm to people or groups of people. All adverse events should result in a review, although the level of review will depend on the seriousness of the adverse event. The term used to describe these reviews and how they are carried out varies between health boards. Boards' adverse event policies and processes apply to all care provided, including that provided in mental health and learning disability settings.

29. Healthcare Improvement Scotland (HIS) published the latest edition of its adverse events framework in July 2018. The national framework is intended to support a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland.[7]

30. For category I adverse event reviews (which includes those that have contributed to or resulted in death), the framework states: 'Full review team: commissioning manager to agree review lead and Terms of Reference (the review team should be sufficiently removed from the event, and have no conflict of interest, to be able to provide an objective view).' The framework goes on to say that: 'An event being subject to a significant [adverse event] review does not automatically indicate a causal link between care or service delivery and the outcome, or that the event was avoidable. It reflects the perceived need to review the event in detail to establish the facts of what happened to determine any links between the

[7] Healthcare Improvement Scotland, Learning from adverse events through reporting and review: A national framework for Scotland, (2018) http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx

care delivery and the outcome or that there is potential for learning to inform system/service improvement.'

31. Health boards may choose to share the results of any adverse event review with others, including the Crown Office and Procurator Fiscal Service, and the Commission. The framework's focus is on sharing any learning that could inform service improvement and any learning that could inform organisations' adverse event management processes to improve the quality of care delivered. An 'Adverse Events Community of Practice' website has been set up to support care providers to share learning for improvement following adverse events reviews.[8]

Crown Office and Procurator Fiscal Service (COPFS)

32. 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.

33. The role of COPFS in relation to the deaths of detained patients 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).[9] 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.'

34. In carrying out its investigations, COPFS will usually review evidence, such as post-mortem and other medical reports. Statements may also be taken from witnesses. COPFS will make decisions about how to proceed, including on whether or not to instigate criminal proceedings, or whether an FAI should be held. FAIs are judicial inquiries which are held in the public interest to establish the time, place and cause of a death and to identify reasonable precautions which may be taken to prevent deaths in similar circumstances.[10]

35. The Lord Advocate's role in relation to investigating the deaths of those in mental health detention was explored during the parliamentary passage of the Bill for the

[8] The Knowledge Network: Adverse Events, http://www.knowledge.scot.nhs.uk/adverse-events.aspx
[9] Scottish Government/COPFS, CMO(2015) 20, https://www.sehd.scot.nhs.uk/cmo/CMO(2015)20.pdf
[10] Inspectorate of Prosecution in Scotland: Thematic Review of Fatal Accident Inquiries, https://www.gov.scot/publications/thematic-review-fatal-accident-inquiries/pages/0/

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. In response to the proposal to have mandatory FAIs for people who die in mental health detention, the Scottish Government acknowledged that there may be a case for the various inquiries and investigations in these situations to be rationalised and formalised but did not believe that this Bill was the vehicle for this.[11]

Health and Safety Executive (HSE)

36. The Health and Safety Executive is responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in Great Britain.

37. HSE is responsible, under section 18 of the Health and Safety at Work etc. Act 1974 for making adequate arrangements for the enforcement of health and safety legislation with a view to securing the health, safety and welfare of workers and protecting others, principally the public. This does, in certain circumstances, include the deaths of NHS patients who have died by suicide. HSE would normally receive relevant reports on deaths by suicide from COPFS. Following an investigation HSE may report its findings to COPFS for consideration of prosecution where there is evidence of inadequate health and safety management as a significant causative factor in a death.

38. HSE has information sharing agreements in place with both HIS and the Commission.

The Mental Welfare Commission for Scotland

39. The Commission was established by the Mental Health (Scotland) Act 1960, with modifications 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. The Commission is a member of the UK National Preventative Mechanism (NPM), a body that brings together independent monitoring organisations that all have a role in protecting people in detention.

40. Through a programme of regular visits and published reports, the Commission helps NHS and independent mental health and learning disability services to improve the care and treatment they provide. Through its telephone and email enquiry service, the Commission provides advice to service users, carers and professionals on rights in relation to mental health and incapacity law and care and treatment.

[11] Policy Memorandum, Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (SP Bill 63) http://www.parliament.scot/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd-pm.pdf

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'. 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.

42. 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.

43. 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.

44. Since Q2 2018, 11 cases involving the death of a patient have been referred to the Commission's Investigations Group.

Police

45. Where there are suspicious circumstances in relation to a death, Police Scotland will be called upon to support investigation of that death. In the absence of any suspicious circumstances, a death will be classified as a medical death. The police may receive reports of concern from other organisations such as the Commission or the Care Inspectorate.

46. In February 2016 a new joint protocol, between NHS Scotland, COPFS and Police Scotland, was introduced. This provides guidance to colleagues in NHS Scotland and Police Scotland, clarifying the roles and responsibilities of individuals and organisations in the management of deaths in the community.[12]

Organisational duty of candour

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

[12] Scottish Government/Police Scotland/COPFS, CMO(2016) 2 https://www.sehd.scot.nhs.uk/cmo/CMO(2016)02.pdf

48. The organisational duty of candour, established by the Health (Tobacco, Nicotine etc. & Care) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018, came in to force on 1 April 2018.[13]

49. The duty of candour procedure applies when unexpected or unintended harm occurs which results in one of a number of outcomes (including death). The responsible person (the organisation) will be required to contact the relevant person (where death is involved, this could be someone acting on behalf of the person who died) to provide a notification which includes:

    - an account of the incident insofar as the responsible person is aware of the facts at the date the notification is provided;
    - an apology on behalf of the responsible person, (unless the responsible person considers that such an apology has been provided at an earlier date);
    - an explanation of the actions that the responsible person will take as part of the procedure.

50. Relevant persons must be invited to attend a meeting and be given the opportunity to ask questions in advance. At the meeting, they must receive an explanation of further steps being taken regarding the investigation and be given an opportunity to express their views about the incident. They will be provided with details of an individual member of staff who will become their point of contact.

51. In carrying out the review of an incident, the relevant person's views must be sought and organisations must take account of the views expressed. The responsible person must prepare a written report of the review which must be offered to the relevant person along with any other relevant documentation.

52. The relevant person must receive information about actions taken in accordance with the provisions in respect of improvement in quality of service.

53. The organisational duty of candour applies to health services, care services, and social work services.

54. The first annual reports following the introduction of the organisational duty of candour will be published during 2019.

Other reviews

55. If the person died in a registered care setting there may be an investigation by the Care Inspectorate. If the death involves someone who has been supported by the local authority, there may be a Significant Case Review under the local authority processes.

[13] Scottish Government, Duty of Candour. https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour

FINDINGS
Independence, timeliness, and scrutiny

56. The purpose of investigation of deaths is to protect the right to life (Article 2 of the European Convention on Human Rights, Human Rights Act 1998) by:

    - Securing the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility.[14]
    - Recognising a particular obligation to provide explanations for deaths in custody or detention, due to their vulnerable position and the authorities' duty to protect them.[15]

57. Where people are detained under orders made under the 2003 Act or part VI of the 1995 Act they are considered to be in state detention.

58. A number of agencies can be involved in investigating the deaths of people being treated for mental disorder. However, the most common way these deaths are investigated is by means of NHS boards' significant adverse event review processes.

59. All NHS boards who responded to our survey reported following the HIS adverse events review framework when carrying out reviews. In order to comply with the requirements set out in Article 2, investigations should be independent of those implicated in the death. Evidence submitted to the review from staff suggested that there is often difficulty in securing that independence at a local level. However, any NHS board review cannot be said to be independent in the way that Article 2 requires, as it is not carried out by a body with institutional or hierarchical independence as well as practical independence.

60. As referred to in paragraph 30, HIS guidance requires that the review team should be sufficiently objective and that there should be no conflict of interest. The Review heard from carers and families who thought this was an issue. They felt that those investigating had insufficient independence from the service who provided care or treatment at the time of death and consequently they did not feel assured that an effective and proper investigation of their relative's death had been carried out.

61. Responses from the staff survey provided further detail on the possible reasons for the perceived lack of independence in reviews. There was some indication that pressure of time and staff availability was an important factor in determining who would be involved in reviews. Staff are often expected to carry out these reviews as an additional requirement to their day to day work. However responses suggested there is an understanding of the desirability for

[14] *Jordan v United Kingdom* (2003) 37 EHRR 2
[15] *Salman v Turkey* (2002) 34 EHRR 17

independence and external scrutiny. Respondents were able to provide examples of how this was achieved, to an extent, in some circumstances although it was not clear that this was always achieved reliably and consistently in practice.

62. Independence can mean different things to different people. The requirement of Article 2 is that the investigation is independent of the people and institutions implicated by the events under investigation. It is clear that many organisations recognise the importance of adverse event reviews being implemented with a degree of objectivity and independence of those involved in the events under investigation. However, it is also evident that in reality it can be difficult to secure this independence when staff have other competing demands. Where there is review by the HSE, Police or where a FAI is held, then that independence is assured, however as these investigations do not happen with all deaths of detained patients then that independence is not guaranteed in every instance, despite best efforts.

63. The carers and families survey highlighted wide and unacceptable variation in the time taken to carry out reviews. Timeliness was given as a reason by some staff for not involving families and carers in adverse event reviews. Responses indicated that between one to two years was an average timescale for reviews to be carried out. Reviews must be carried out in a timely manner, however this should not be used as an excuse to exclude families and carers from the review process.

64. Some health boards published anonymised versions of their adverse event review reports, however this practice has been largely discontinued. Publication of such reports in the interests of transparency does not meet the related aim of public reporting of learning and improvement action. HIS did routinely receive adverse event review reports relating to suicide and disseminate learning from their review of these under its Suicide Reporting and Learning System (SRLS). HIS has made changes to the SRLS which mean that from June 2017 it no longer requires suicide notifications or completed suicide review reports to be submitted. Instead, the SRLS requires learning summaries, where available, to be submitted for analysis to identify any themes which can be shared nationally. Although concerns were expressed during the Review about the effectiveness of the SRLS prior to June 2017, the requirement to notify HIS and subsequently submit copies of suicide review reports, provided the opportunity for external scrutiny.

65. Article 2 requirements for public scrutiny and transparency are not sufficiently met by current systems and processes.

> It cannot be right that organisations are investigating themselves with their own staff when things go wrong. There should be a specialist investigation organisation that stands separate from the NHS staffed by skilled and well trained investigators from medicine, nursing, AHPs [allied health professions] and managers.
>
> *Staff Member*

66. In response to the Scottish Parliament's Health and Sport Committee review of NHS governance, the Cabinet Secretary for Health and Sport stated that HIS has been asked to develop and bring forward a new approach that addresses unacceptable variations in the way that the adverse events review framework is applied by different NHS boards.[16] The response also notes that the Scottish Government is in discussion with HIS about the development of a national reporting process covering a small number of specific harms in key clinical areas. This could usefully be linked with the reintroduction of the SRLS.

67. The Commission has extensive powers to investigate the care and treatment of people being treated for mental disorder (see paragraphs 42 to 44). It is independent of the Scottish Government. Feedback from surveys and discussion with carers, families and staff indicates that it is generally a well-trusted organisation. The Commission has the necessary powers and expertise to develop a system to investigate the deaths of those detained under the 2003 Act or the 1995 Act which would be proportionate with respect to the circumstances of the death and any other investigation or review which takes place. Where warranted, it could convene an inquiry for the purposes of an investigation and compel people to attend if necessary. The new system of investigation could be subject to standard timescales and publish any resulting reports (anonymised where appropriate) including any recommendations made to organisations. This would bring an improved level of scrutiny and transparency. It could also involve families and carers.

[16] Scottish Government, Cabinet Secretary for Health and Sport's response to the Health and Sport Committee of the Scottish Parliament (The Governance of the NHS in Scotland) http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/20181011_Response_IN_from_Cab_Sec_re_NHS_Gov_ltr_of_02.10.18.pdf

SUMMARY OF FINDINGS

Deaths of people being treated for mental disorder are not investigated consistently in a way that can be guaranteed to be independent. Not all deaths are being investigated, especially so where they are not classed as unavoidable or unexpected, despite the fact that people can spend long periods of time subject to orders under the 2003 Act or part VI of the 1995 Act. Every death where the person was subject to an order should be subject to a proportionate level of review. The review process should be timely and should have a sufficient element of public scrutiny.

ACTIONS

(1) 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.

(2) The Scottish Government will consider the further actions required to better support multi-agency co-ordination of investigations.

(3) The Scottish Government will begin an options appraisal in conjunction with partner organisations, to determine an appropriate process of review for the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder. This will support delivery of action 10 in the Scottish Government's 'Suicide prevention action plan' to review every death by suicide and ensure the importance of clarity, alignment and integration of review and investigation processes for maximum impact.

(4) The Scottish Government will work with the Mental Welfare Commission for Scotland, Healthcare Improvement Scotland, and NHS National Services Scotland to identify an appropriate set of publicly reportable measures that reflect best practice in the investigation of deaths and can be used to identify where improvement is required.

(5) The Scottish Government will ask Healthcare Improvement Scotland to make changes to its Suicide Reporting and Learning System to immediately reintroduce the suicide notification requirement and scrutiny of NHS boards' suicide reviews. Healthcare Improvement Scotland will also be asked to describe how it will support boards to continuously improve the quality of the suicide review reports. There should be a clearer link between the scrutiny of these reports and specific improvement support that is directly designed and targeted around the common contributory processes identified in suicide review reports. This will be aligned to the new investigation process referred to in action 1.

FINDINGS
Involving families and carers, and making improvements across the system

68. Dealing sensitively, respectfully and compassionately with families and carers of people who have died is crucially important. The principles of openness, honesty, and transparency as set out in the organisational duty of candour should also be applied by providers in all their dealings with bereaved families and carers.

69. Understanding the experiences of families and carers has been a central part of this Review. They can offer a perspective that other people involved in the person's care cannot. Their involvement can help to provide an understanding of the full history of a person's care and they know the complex needs that person had thereby providing healthcare providers with additional crucial information to inform the investigations and any learning or improvement resulting from that.

70. The main messages from the Review's engagement with families and carers have been that they want investigations which tell them what happened, and which provide learning for the organisation and system to ensure that what happened to their relative does not happen to anyone else.

71. There appears to be a lack of a single source of information available that sets out the processes involved when someone dies while being cared for or treated for mental disorder. As a result of this it appears that families and carers have to spend to spend considerable time and effort in researching and understanding the current processes of review and investigation. It is clear that information which gives advice on the processes, along with descriptions of relevant terminology and rights would be very helpful to people who are trying to understand these in the midst of their grief.

72. Responses to the Review suggested that the initial discussions with the healthcare provider often characterised the rest of their experience of review and investigation in the following months. Survey responses indicated that most people felt their experience of the investigation they had been involved with was a negative one. Families and carers described how they felt there was a lack of respect for them resulting in what they perceived to be tokenistic investigations. Some described that the lack of openness in respect of information, particularly information on the care of their relative, was frustrating and led them to feel that healthcare providers were actively trying to withhold information.

> They said an action plan was implemented to prevent it happening again but there are still very negative reports in the press about this hospital.
>
> *Family Member*

73. In cases where families and carers are not satisfied with the healthcare provider's response there can be a protracted and uncoordinated process of trying to obtain

further information either through complaints procedures, or taking a complaint to the Scottish Public Services Ombudsman (SPSO). In some instances people may seek legal assistance to obtain medical records or reports which healthcare providers have refused to provide. Meetings held with families and carers as part of the Review have often focussed on the work that they themselves have had to undertake to review medical records, correspondence, processes and other relevant pieces of information. This can add to the sense that the whole review process is unnecessarily drawn-out.

74. From survey results it appears that healthcare providers are willing to meet with families and carers but families and carers feel that they were not involved as much as they wanted to be and that their views were not taken into account. Furthermore it seems that in some instances, healthcare providers are not providing important information on how any changes had been implemented in response to the recommendations of any investigation. Many people who contributed to the review talked of the importance of there being some legacy to the sad death of their relative and that legacy being that lessons had been learned and acted upon.

> It was a relief to know someone wanted to listen… It was stressful waiting for the report but ultimately worth the wait to get the results and was so good to know the team really wanted to make changes to the way people are treated.
>
> *Family Member*

> I feel that our current processes are operating reasonably well. We could do better to ensure that the report feedback to clinicians occurs, and we do not have any input into the system from service users. I am personally aware of a number of changes which have occurred as a direct result of incident investigations
>
> *Staff Member*

75. One issue that was referred to in a number of responses was that of errors or inaccuracies in the investigation/review reports. There was a sense of frustration that there was no effective way to challenge information contained in reports that that the family or carer did not agree with.

76. The process of investigation can be confusing and traumatic for both services and families, as it can sometimes involve different organisations investigating in different ways without any overall co-ordination.

77. Language and terminology was another issue highlighted in responses to the survey for families and carers. Use of terms such ‘adverse event’ when speaking with families and carers was experienced by some as insensitive and this language can give the impression of a lack of compassion. Such terminology is

widely used across healthcare and there is an opportunity in developing the new system of investigation and support for healthcare organisations to ensure that investigation processes of all types use language that is sensitive to those affected.

> More involvement, explanation of the process. Written explanations of what is going on because people grieving cannot always take information in. Leaflets to explain how investigations can be launched by family members once they are in less pain.
>
> *Family Member*

78. In order to comply with the organisational duty of candour the provider's representative is required to offer a face-to-face meeting with the relevant person as soon as possible. This will provide an opportunity for organisations to be open and honest with families and carers where someone has died in detention. However the duty will only apply to cases where there has been an unexpected or unavoidable incident that has, or appears to have, resulted in death or harm.

79. The organisational duty of candour recognises the power of apology and the legislation establishing the duty provides that: 'An apology or other step taken in accordance with the duty of candour procedure under section 22 does not of itself amount to an admission of negligence or a breach of a statutory duty'.[17]

80. In respect of investigations which precede criminal prosecution there may be limited opportunities for sharing of information on the progress or results of these, and consequently any plans for enhancing the provision of information available to families and carers will need to take account of this.

SUMMARY OF FINDINGS

Carers and families find it difficult to navigate and understand the various processes involved in the review of a death. They have told the Review that they are not consistently treated in an honest and respectful way. There is variation in the level of involvement that families and carers have in investigations despite people being clear about how involved they want to be.

ACTIONS

(6) The Scottish Government will work with partner organisations to produce resources for carers and families which provide information on how deaths are reviewed.

[17] Section 23(2), Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, http://www.legislation.gov.uk/asp/2016/14/section/23/enacted

(7) The Scottish Government will work with partner organisations to improve the co-ordination of support available for families and carers. This will include the creation of a single point of contact for families and carers in relation to all investigations and reviews. It will also include investigation of any barriers that need to be addressed in order to ensure that co-ordination of support is able to operate effectively across the various organisations involved.

(8) The Scottish Government will establish an implementation group to oversee the implementation of actions arising from this report. This group will include equal representation from carers and families.

(9) The Scottish Government will work with partner organisations to consider what support and advice staff need to involve families and carers in a meaningful way.

81. Responses to the staff survey indicated that organisations have policies in place to support dissemination of learning, however there was also evidence that despite these policies this dissemination and sharing of learning does not happen reliably, consistently or routinely. Some staff felt that more needed to be done at a national level and referred to investigations making the same recommendations as previous investigations. Even where improvement plans had been implemented they are not always sustained.

82. HIS works to encourage and support continuous improvement in healthcare practice. The introduction of a new system of investigation will provide recommendations which can be analysed and shared at a national level. It is therefore important that appropriate support is available to healthcare organisations to learn from these investigations.

SUMMARY OF FINDINGS

There is evidence that dissemination of learning and implementation of the required changes in relation to these deaths does not always happen at local and national levels. It is important that this does happen in order to deliver the changes and improvements that staff, carers and families want to see when improvement actions are identified.

ACTIONS

(10) The Scottish Government will work with the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland to improve the ways in which investigation findings and recommendations are disseminated, and explore options to support healthcare providers to use this information to commission improvement support. The new system of investigations referred to in action 1 should include a mechanism for transparent follow up and public assurance of changes.

ANNEX A
Review Group membership

Professor Craig White (Chair) Divisional Clinical Lead, Directorate for Healthcare Quality and Improvement, Scottish Government	
Barry Baker Health and Safety Executive	**David Pinkney** Police Scotland
John Crichton Royal College of Psychiatrists in Scotland	**George Fernie** Healthcare Improvement Scotland
Linda Findlay Chief Officers Group for Health and Social Care Scotland	**David Green** SFIU, Crown Office and Procurator Fiscal Service
Colin Adams Scottish Independent Hospitals Association	**Paul Hawkins** NHS Scotland Board Chief Executives Group
Carolyn Lochhead SAMH, the Scottish Association for Mental Health	**Joanna Macdonald** Social Work Scotland
Wendy McAuslan VOX Scotland	**Colin McKay** Mental Welfare Commission for Scotland
Mark Richards Scottish Executive Nurse Directors	**Cathy Asante** Scottish Human Rights Commission

ANNEX B
Carers and Families Sub-Group membership

Frances Simpson	Support in Mind Scotland
Ruth Rooney	Edinburgh Carers Council
Karen Martin	Carers Trust Scotland
Graham Morgan Kathleen Taylor	Mental Welfare Commission for Scotland

ANNEX C
Organisational survey respondents

Scottish Fatalities Investigation Unit (SFIU), Crown Office and Procurator Fiscal Service

Health and Safety Executive

Healthcare Improvement Scotland

Health and Social Care Partnership - Fife

Health and Social Care Partnership - Glasgow City (on behalf of Glasgow City Council)

Mental Welfare Commission for Scotland

NHS 24

NHS Ayrshire and Arran

NHS Borders

NHS Dumfries and Galloway

NHS Forth Valley

NHS Grampian and Health and Social Care Partnership - Aberdeen City, Aberdeenshire and Moray

NHS Greater Glasgow and Clyde

NHS Highland

NHS Lanarkshire

NHS Lothian

NHS Orkney

NHS Shetland

NHS Tayside

Police Scotland

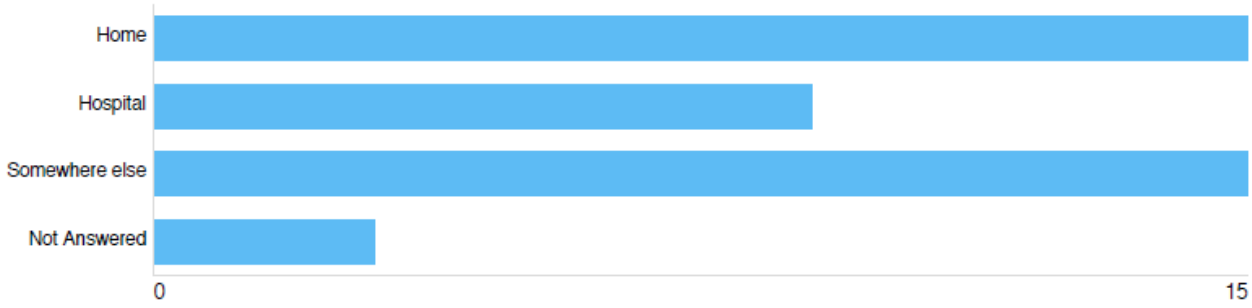
State Hospitals Board for Scotland

ANNEX D
Carers and families survey — responses to quantitative questions

The survey ran from 2 July to 24 September 2018 (12 weeks). A total of 42 responses were received. Responses to closed questions are provided below. Responses to other questions have been omitted.

Question 2

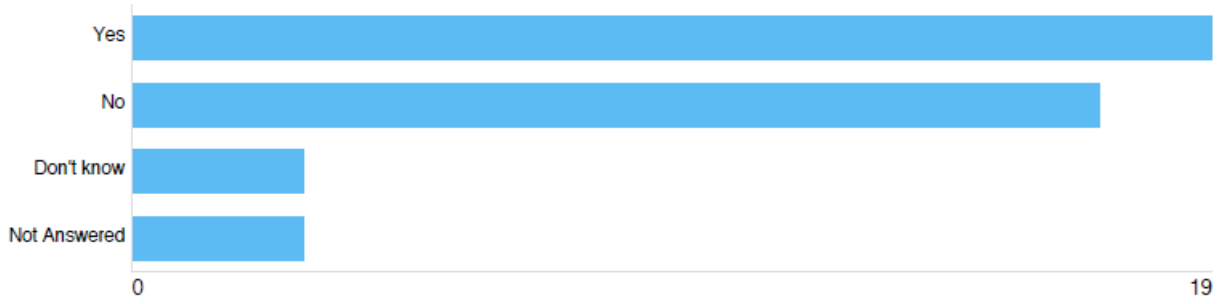
2. Did the person die at home, in hospital or somewhere else?



Option	Total	Percent
Home	15	35.71%
Hospital	9	21.43%
Somewhere else	15	35.71%
Not Answered	3	7.14%

Question 3: Was the person receiving treatment under the Mental Health Act when they died? (This could mean that they were receiving compulsory treatment, or were detained in hospital against their wishes. This is sometimes known as being 'sectioned'.)

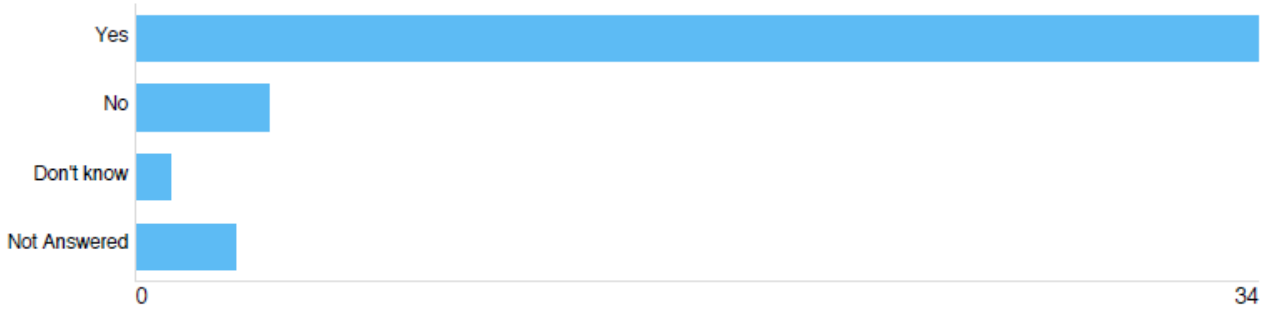
3



Option	Total	Percent
Yes	19	45.24%
No	17	40.48%
Don't know	3	7.14%
Not Answered	3	7.14%

Question 4: Do you know if the death was investigated in any way?

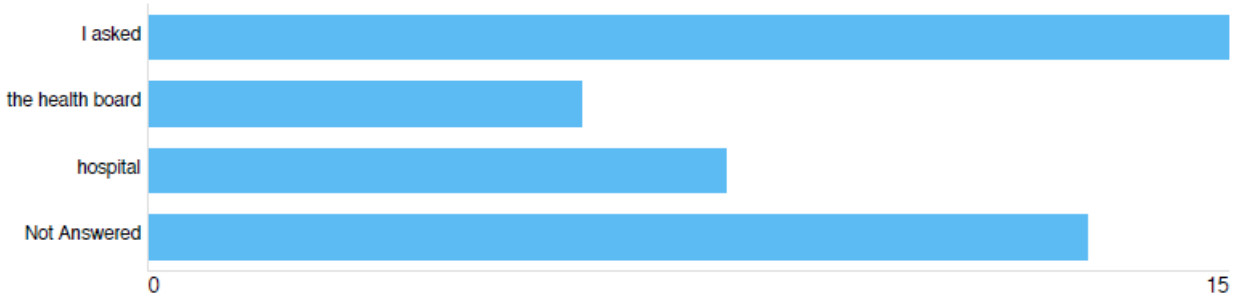
4



Option	Total	Percent
Yes	34	80.95%
No	4	9.52%
Don't know	1	2.38%
Not Answered	3	7.14%

Question 5: Did you have to ask for an investigation or did the health board or hospital start it themselves?

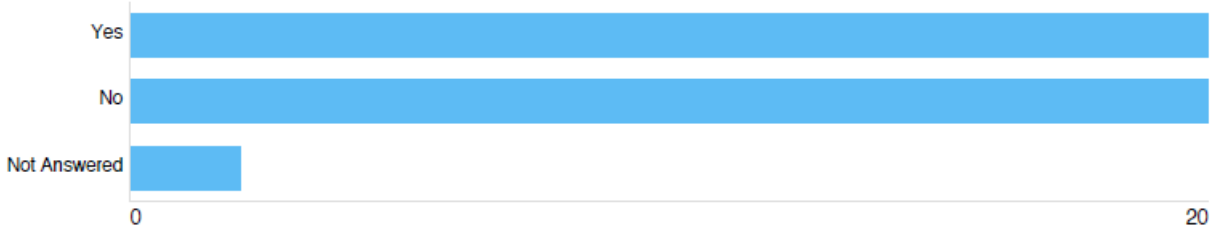
5



Option	Total	Percent
I asked	15	35.71%
the health board	6	14.29%
hospital	8	19.05%
Not Answered	13	30.95%

Question 8: Were you kept informed about the progress of the investigation?

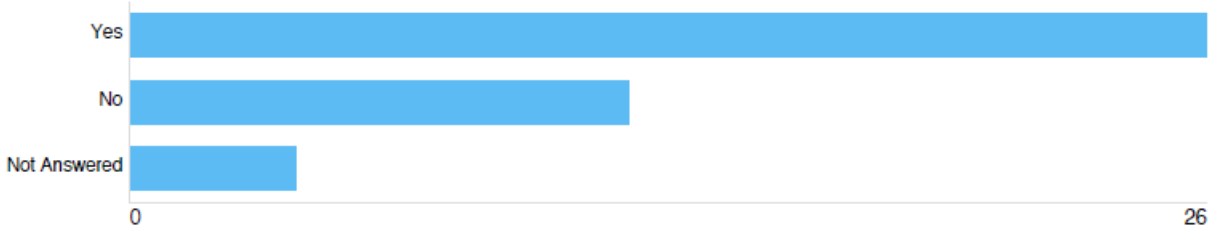
8. Were you kept informed about the progress of the investigation?



Option	Total	Percent
Yes	20	47.62%
No	20	47.62%
Not Answered	2	4.76%

Question 9: Were you offered a meeting with anyone as part of the investigation process?

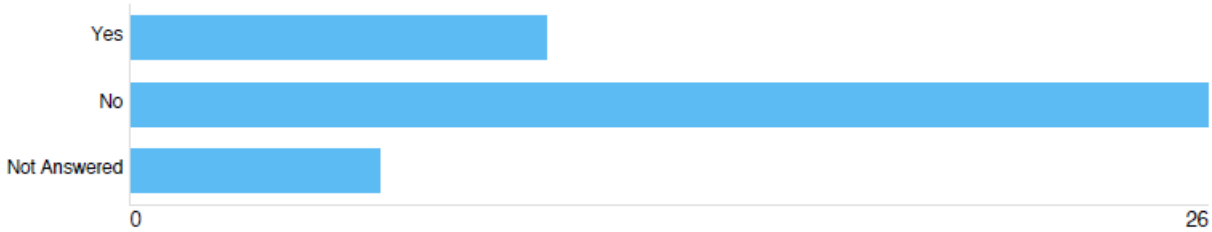
9



Option	Total	Percent
Yes	26	61.90%
No	12	28.57%
Not Answered	4	9.52%

Question 10: Did you feel you and your family were involved enough and that your views were taken into account?

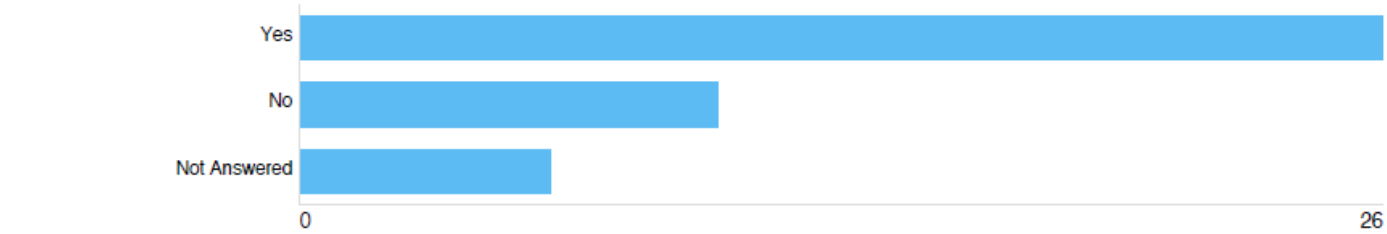
10



Option	Total	Percent
Yes	10	23.81%
No	26	61.90%
Not Answered	6	14.29%

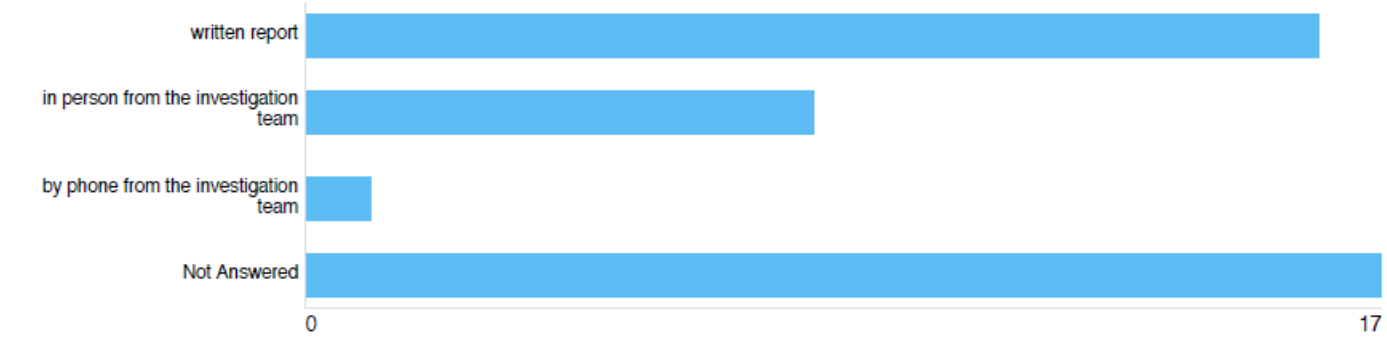
Question 11: Were you informed about the result of the investigation?

11



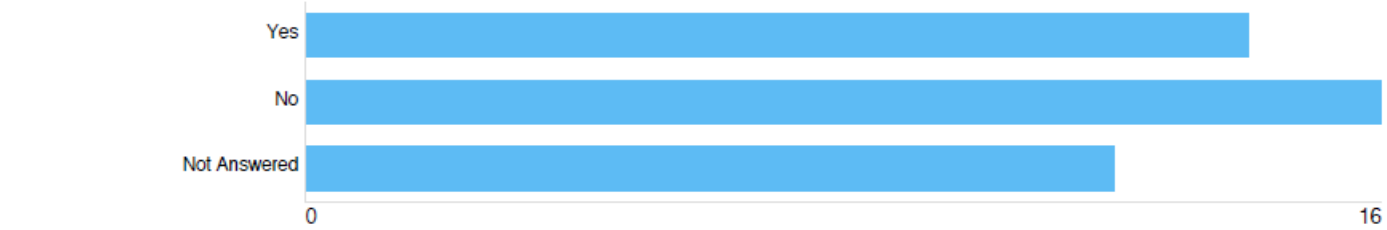
Option	Total	Percent
Yes	26	61.90%
No	10	23.81%
Not Answered	6	14.29%

11 If so was this done by:



Option	Total	Percent
written report	16	38.10%
in person from the investigation team	8	19.05%
by phone from the investigation team	1	2.38%
Not Answered	17	40.48%

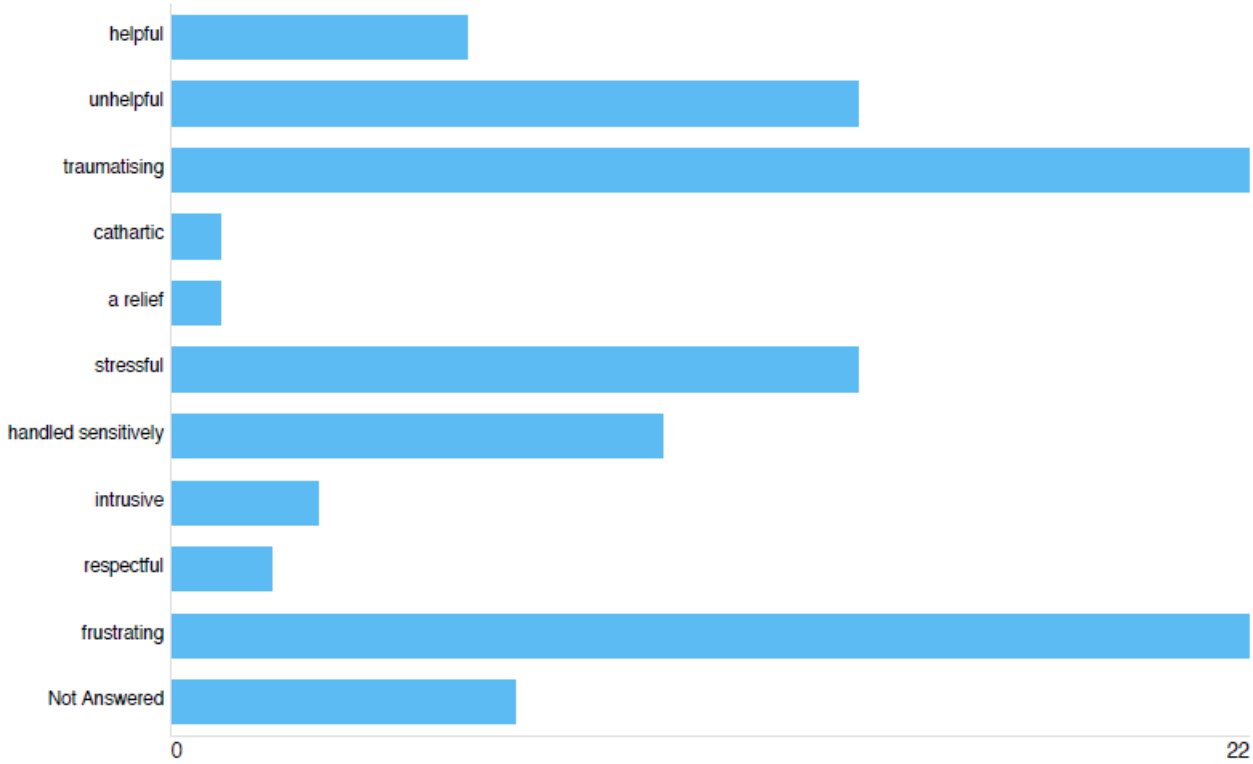
Di you have to ask for feedback or have you not received any?



Option	Total	Percent
Yes	14	33.33%
No	16	38.10%
Not Answered	12	28.57%

Question 13: How did you feel about the investigation overall? Was it:

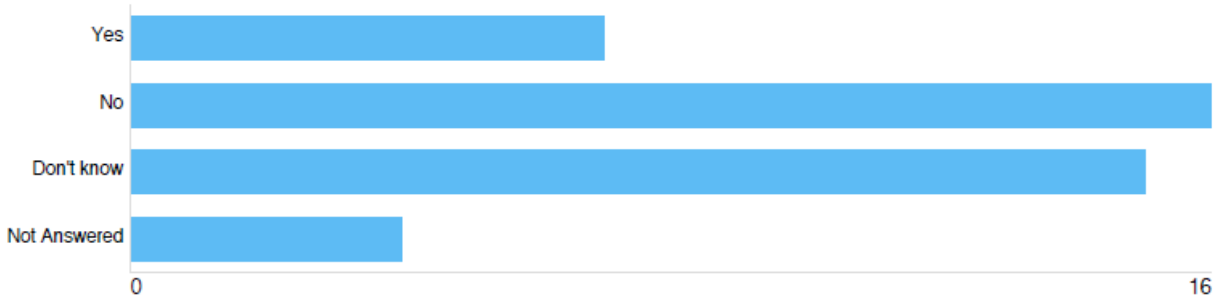
13



Option	Total	Percent
helpful	6	14.29%
unhelpful	14	33.33%
traumatising	22	52.38%
cathartic	1	2.38%
a relief	1	2.38%
stressful	14	33.33%
handled sensitively	10	23.81%
intrusive	3	7.14%
respectful	2	4.76%
frustrating	22	52.38%
Not Answered	7	16.67%

Question 14: As far as you know, did anything change as result of the investigation?

14



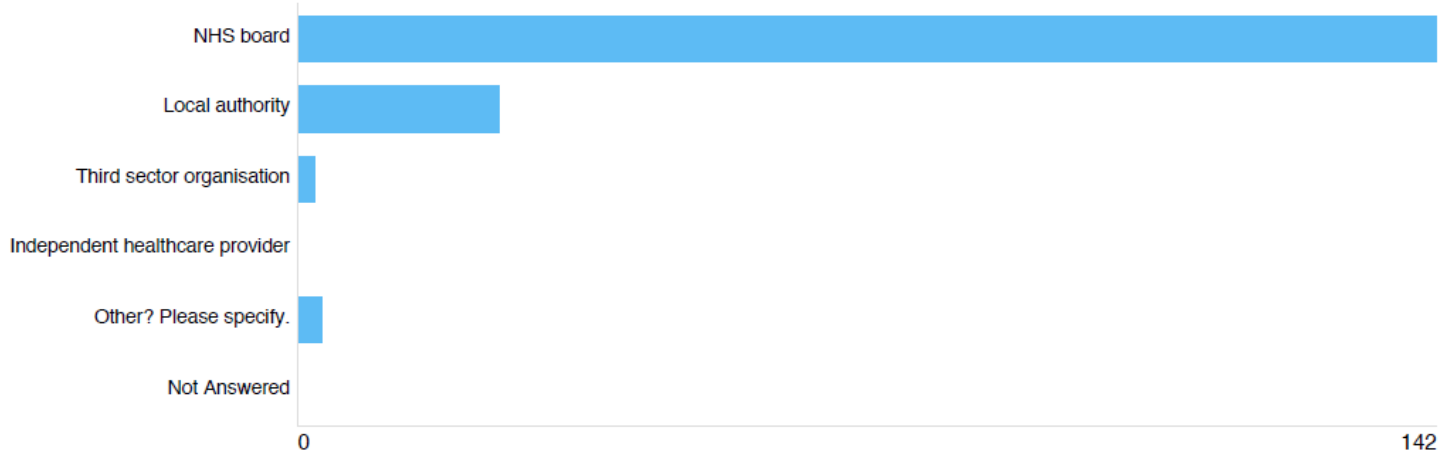
Option	Total	Percent
Yes	7	16.67%
No	16	38.10%
Don't know	15	35.71%
Not Answered	4	9.52%

ANNEX E
Staff survey — responses to quantitative questions

The survey ran from 2 July to 24 September 2018 (12 weeks) on the Scottish Government's consultation website. A total of 172 responses were received. Responses to closed questions are provided below. Responses to other questions have been omitted.

Question 2: Who is your principal employer?

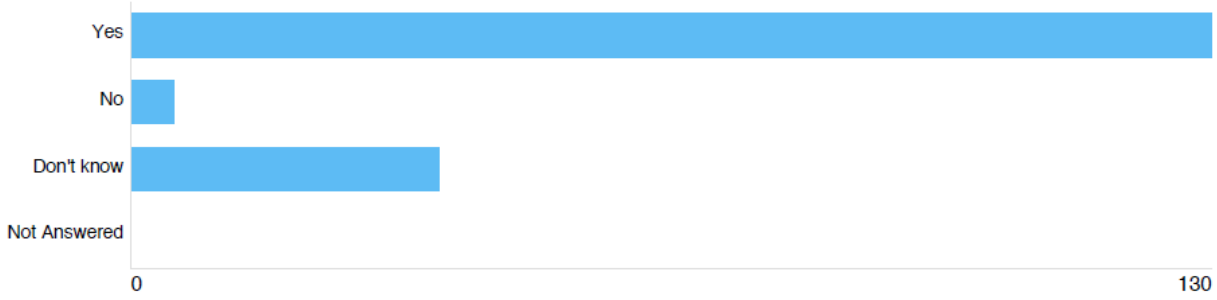
2



Option	Total	Percent
NHS board	142	82.56%
Local authority	25	14.53%
Third sector organisation	2	1.16%
Independent healthcare provider	0	0%
Other? Please specify.	3	1.74%
Not Answered	0	0%

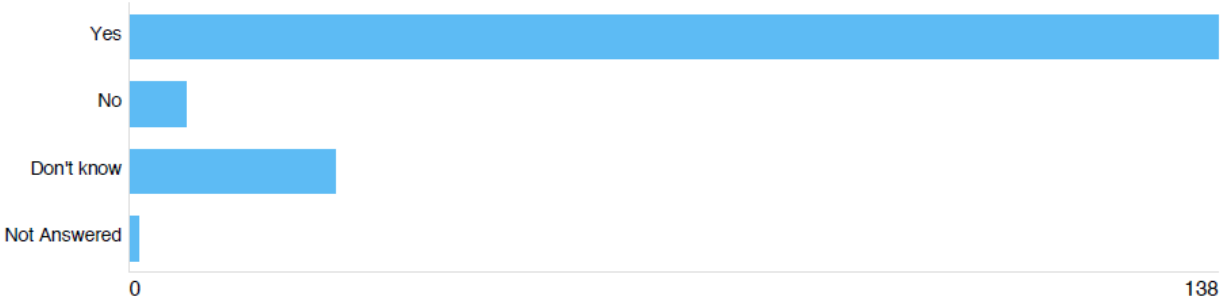
Question 3: Does your organisation have a policy and/or operating procedure that includes reference to the following aspects of internal investigations/adverse incident reviews:

3 - openness and transparency of such investigations?



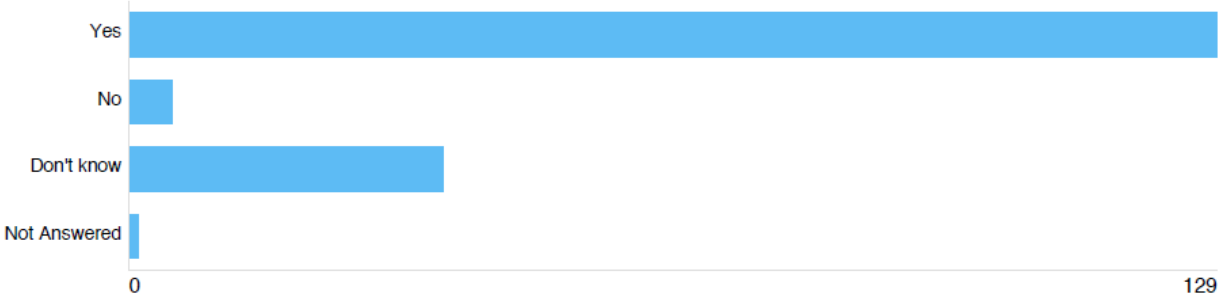
Option	Total	Percent
Yes	130	75.58%
No	5	2.91%
Don't know	37	21.51%
Not Answered	0	0%

3 - commissioning and organising such investigations?



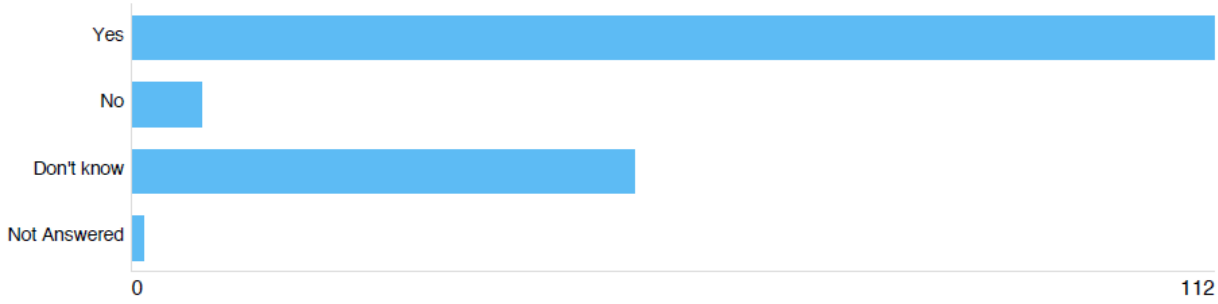
Option	Total	Percent
Yes	138	80.23%
No	7	4.07%
Don't know	26	15.12%
Not Answered	1	0.58%

3 - communication and information sharing with families and carers in such circumstances?



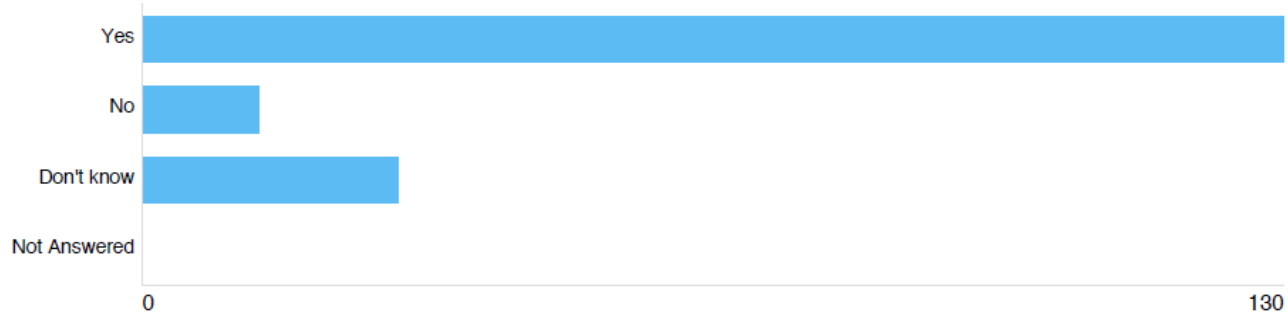
Option	Total	Percent
Yes	129	75.00%
No	5	2.91%
Don't know	37	21.51%
Not Answered	1	0.58%

3 - scrutiny and assurance of the quality of an investigation?



Option	Total	Percent
Yes	112	65.12%
No	7	4.07%
Don't know	52	30.23%
Not Answered	1	0.58%

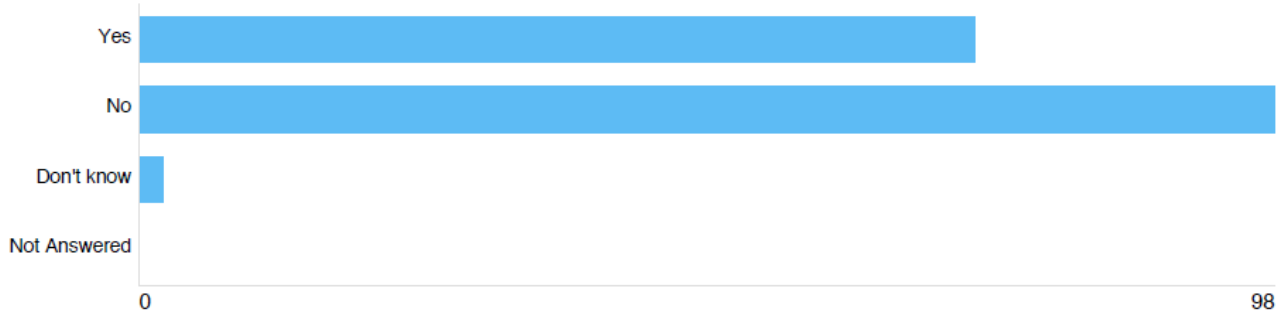
3 - disseminating learning from such investigations?



Option	Total	Percent
Yes	130	75.58%
No	13	7.56%
Don't know	29	16.86%
Not Answered	0	0%

Question 4: Have you received any training to understand the investigation process after a patient or service user dies?

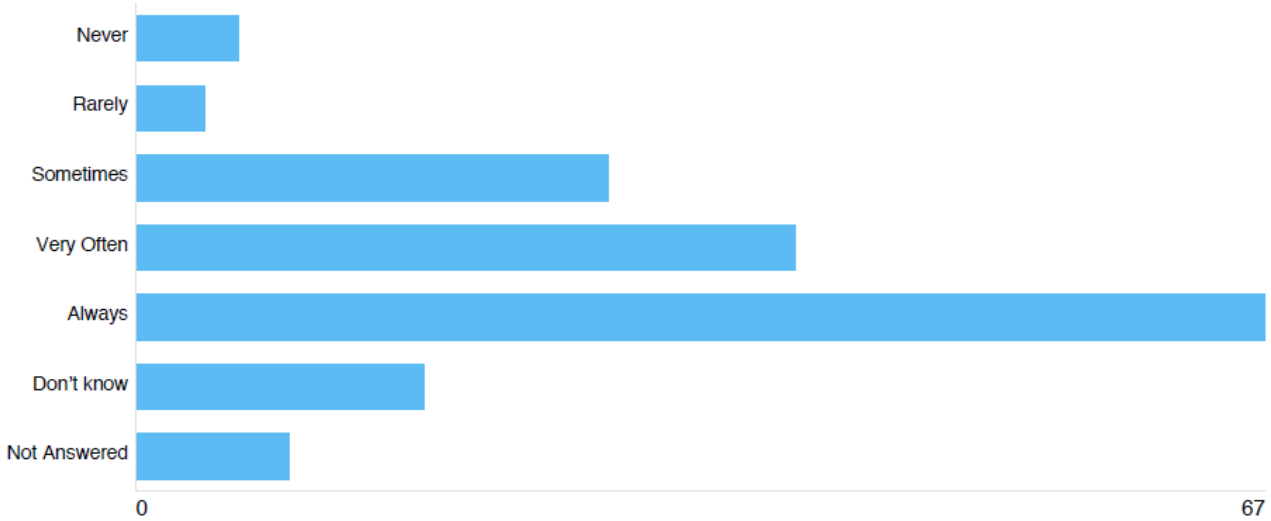
4



Option	Total	Percent
Yes	72	41.86%
No	98	56.98%
Don't know	2	1.16%
Not Answered	0	0%

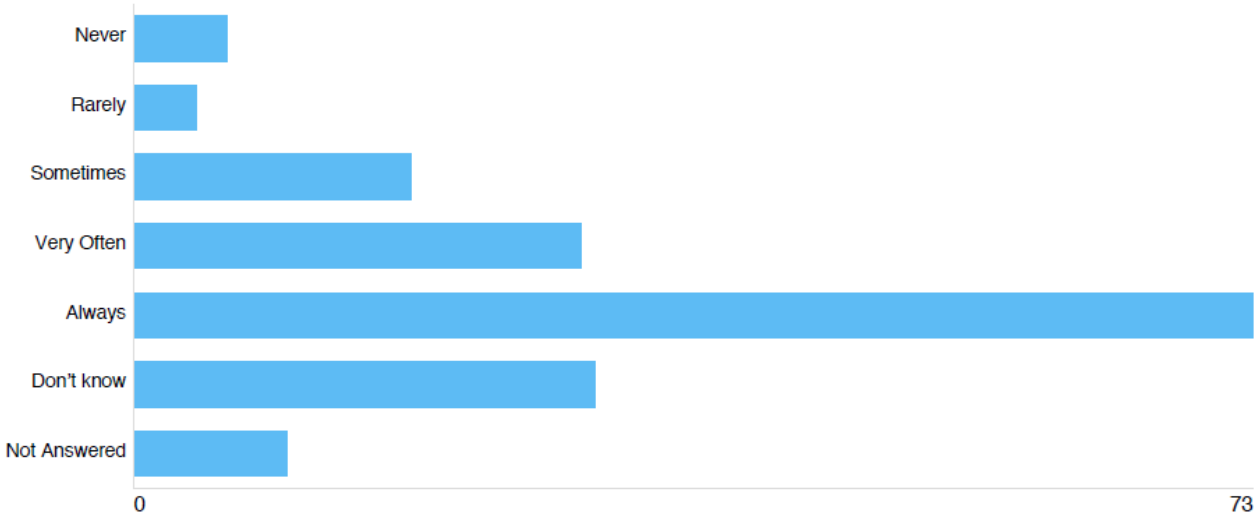
Question 5: When you have participated in INTERNAL investigation(s) has there been:

A - (A) clarity of purpose and method, in other words was it clear why the investigation was being carried out and how it was being carried out?



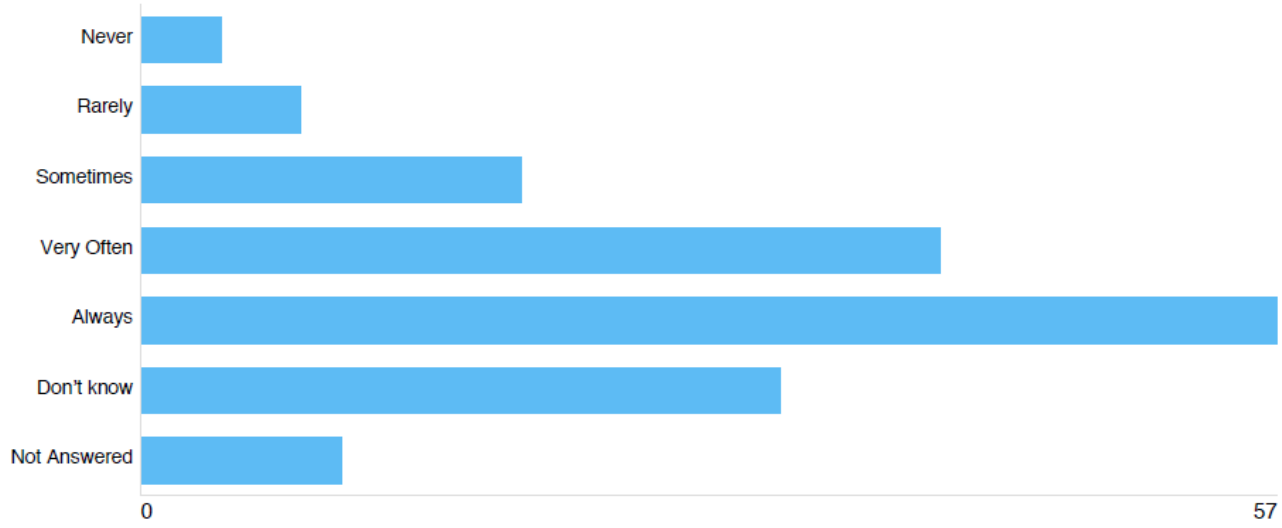
Option	Total	Percent
Never	6	3.49%
Rarely	4	2.33%
Sometimes	28	16.28%
Very Often	39	22.67%
Always	67	38.95%
Don't know	17	9.88%
Not Answered	9	5.23%

B - (B) sensitivity to the needs of families, carers, victims and other service users?



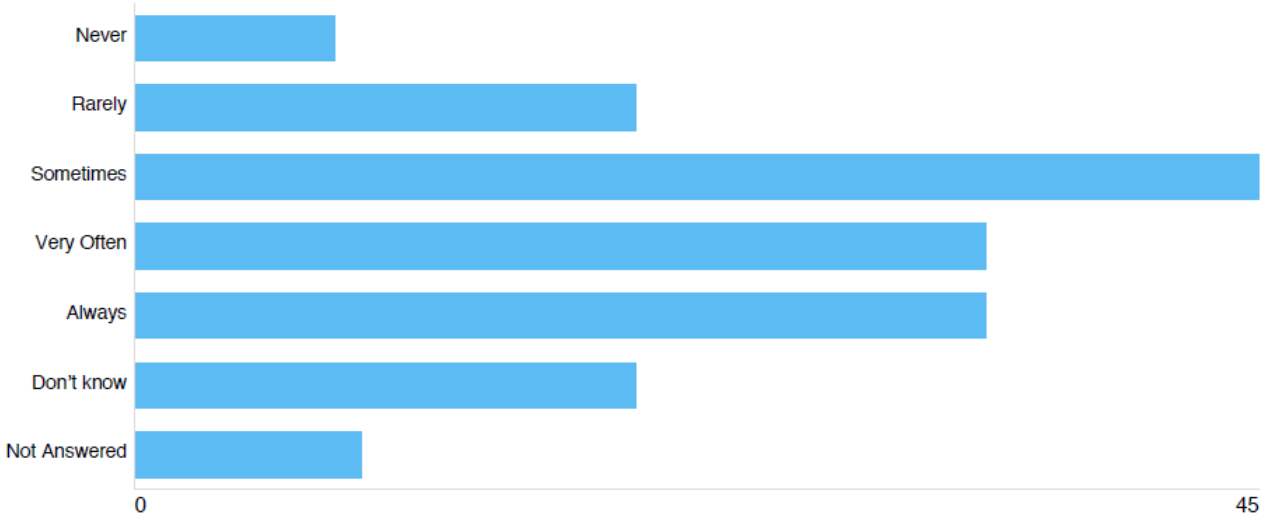
Option	Total	Percent
Never	6	3.49%
Rarely	4	2.33%
Sometimes	18	10.47%
Very Often	29	16.86%
Always	73	42.44%
Don't know	30	17.44%
Not Answered	10	5.81%

C - (C) an investigation team which had the appropriate membership?



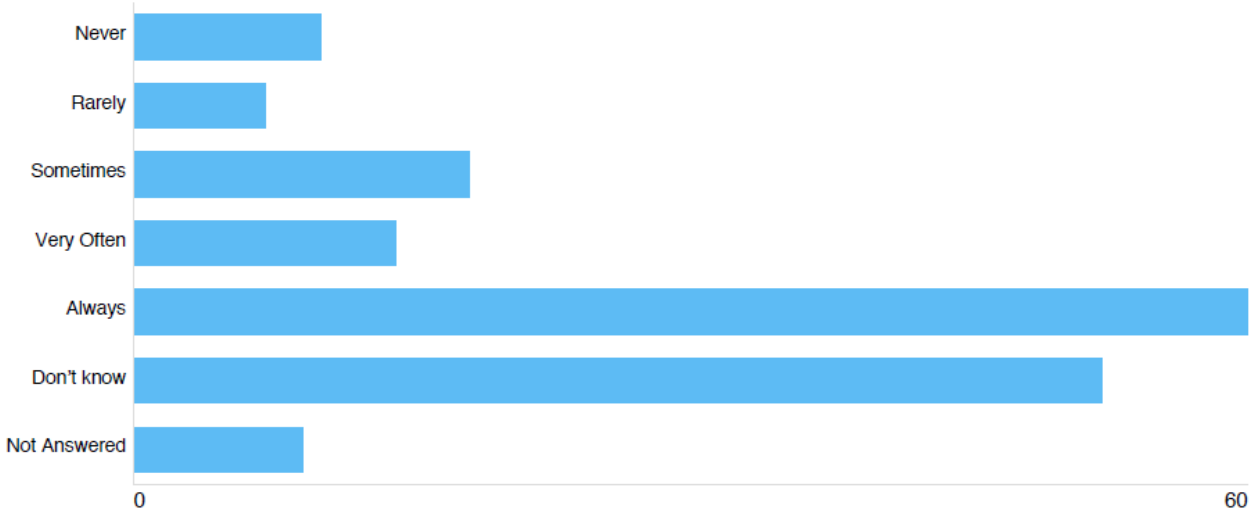
Option	Total	Percent
Never	4	2.33%
Rarely	8	4.65%
Sometimes	19	11.05%
Very Often	40	23.26%
Always	57	33.14%
Don't know	32	18.60%
Not Answered	10	5.81%

D - (D) an investigation in a timely and proportionate manner?



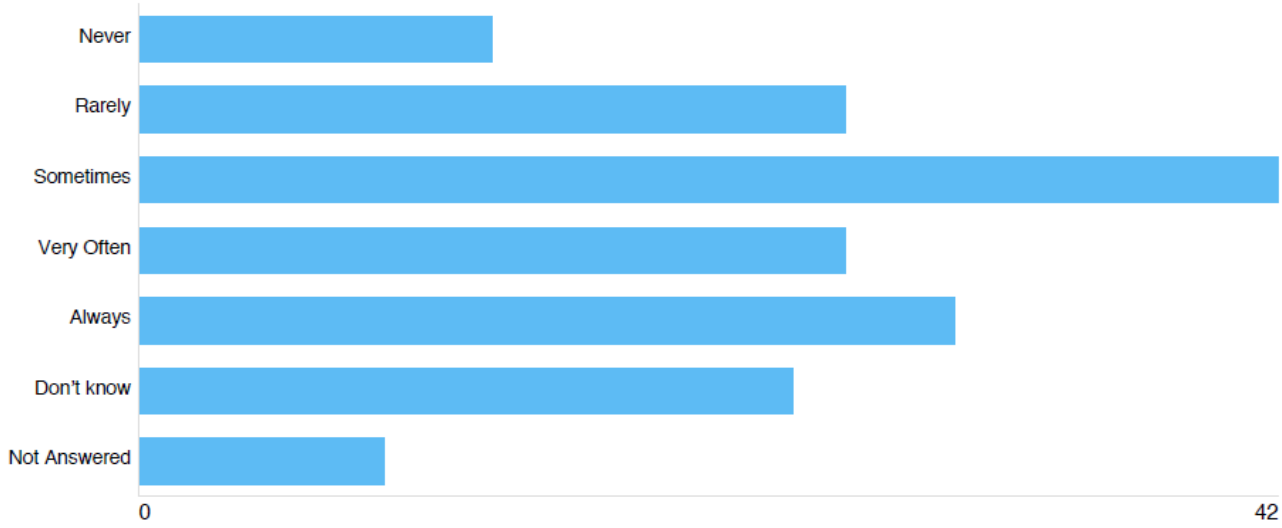
Option	Total	Percent
Never	8	4.65%
Rarely	20	11.63%
Sometimes	45	26.16%
Very Often	34	19.77%
Always	34	19.77%
Don't know	20	11.63%
Not Answered	9	5.23%

E - (E) openness to external scrutiny? In other words someone separate from the investigation team reviewing their findings.



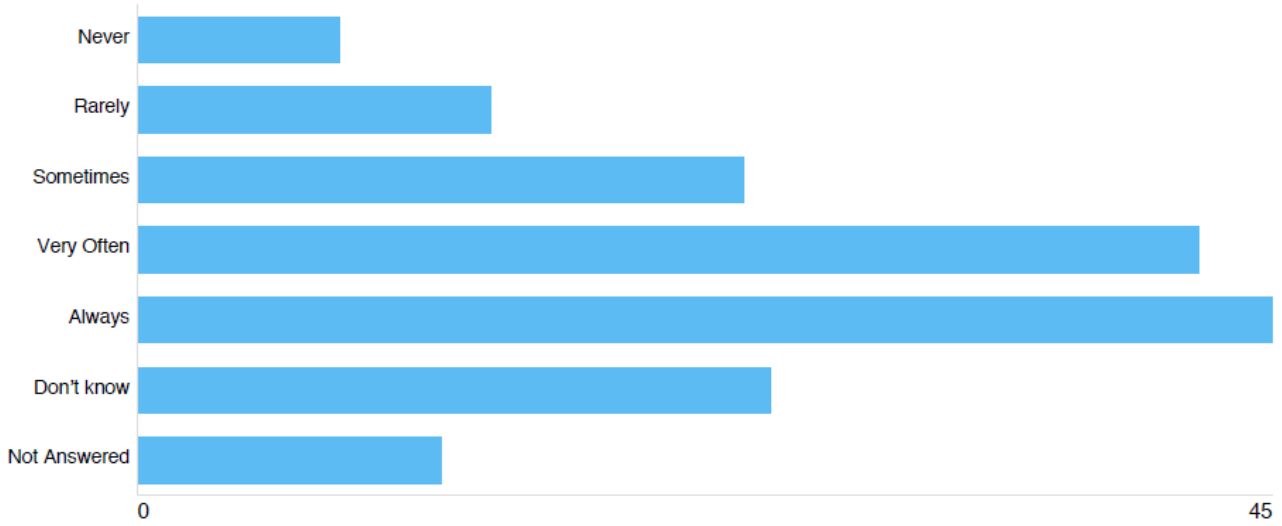
Option	Total	Percent
Never	10	5.81%
Rarely	7	4.07%
Sometimes	18	10.47%
Very Often	14	8.14%
Always	60	34.88%
Don't know	52	30.23%
Not Answered	9	5.23%

F - (F) appropriate support for staff members?



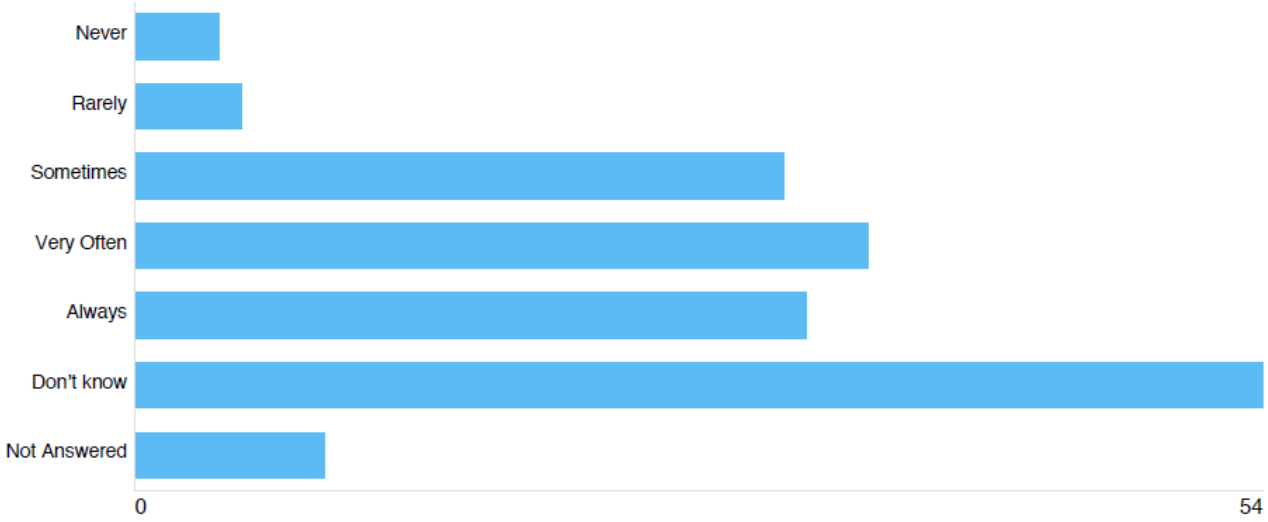
Option	Total	Percent
Never	13	7.56%
Rarely	26	15.12%
Sometimes	42	24.42%
Very Often	26	15.12%
Always	30	17.44%
Don't know	24	13.95%
Not Answered	9	5.23%

G - (G) clarity in the presentation of findings?



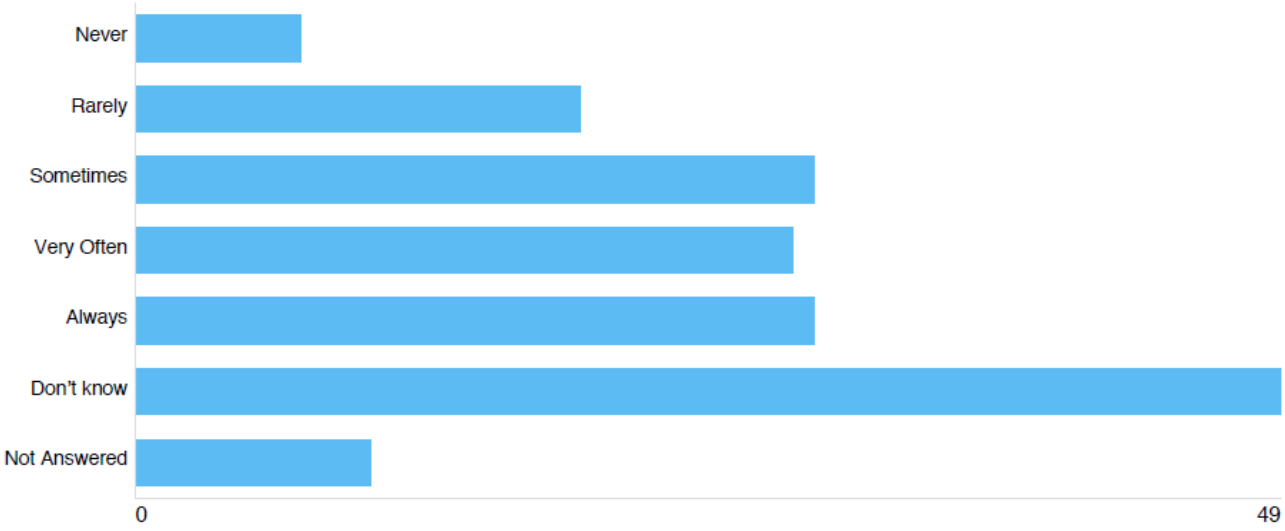
Option	Total	Percent
Never	8	4.65%
Rarely	14	8.14%
Sometimes	24	13.95%
Very Often	42	24.42%
Always	45	26.16%
Don't know	25	14.53%
Not Answered	12	6.98%

H - (H) appropriate links made with other agencies and sources of information?



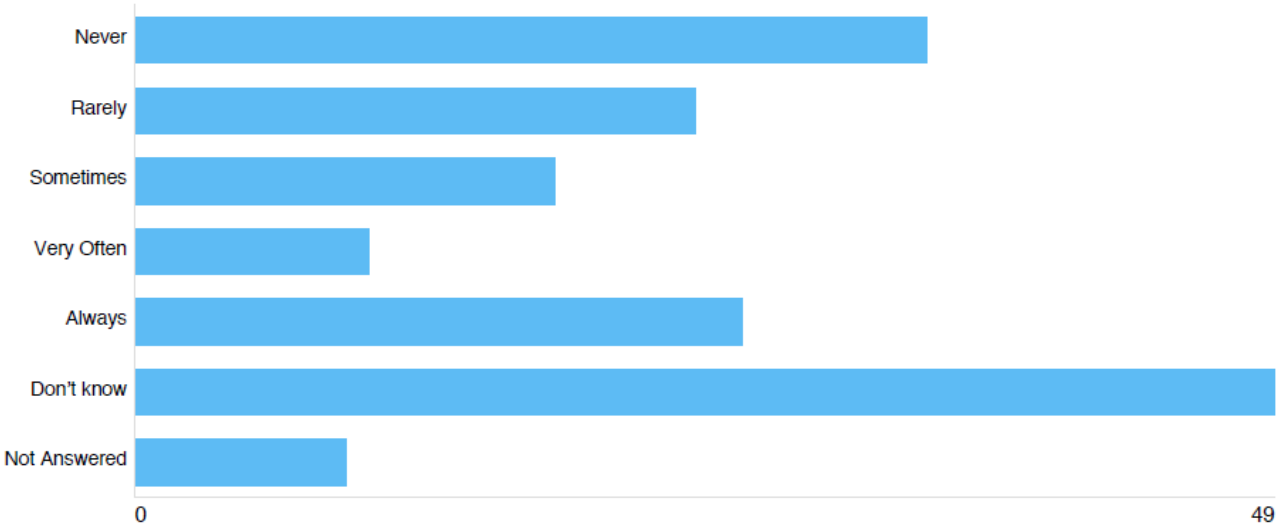
Option	Total	Percent
Never	4	2.33%
Rarely	5	2.91%
Sometimes	31	18.02%
Very Often	35	20.35%
Always	32	18.60%
Don't know	54	31.40%
Not Answered	9	5.23%

I - (l) a process and opportunity for complaints be made or issues you disagree with brought to the investigation team's attention and satisfactorily addressed?



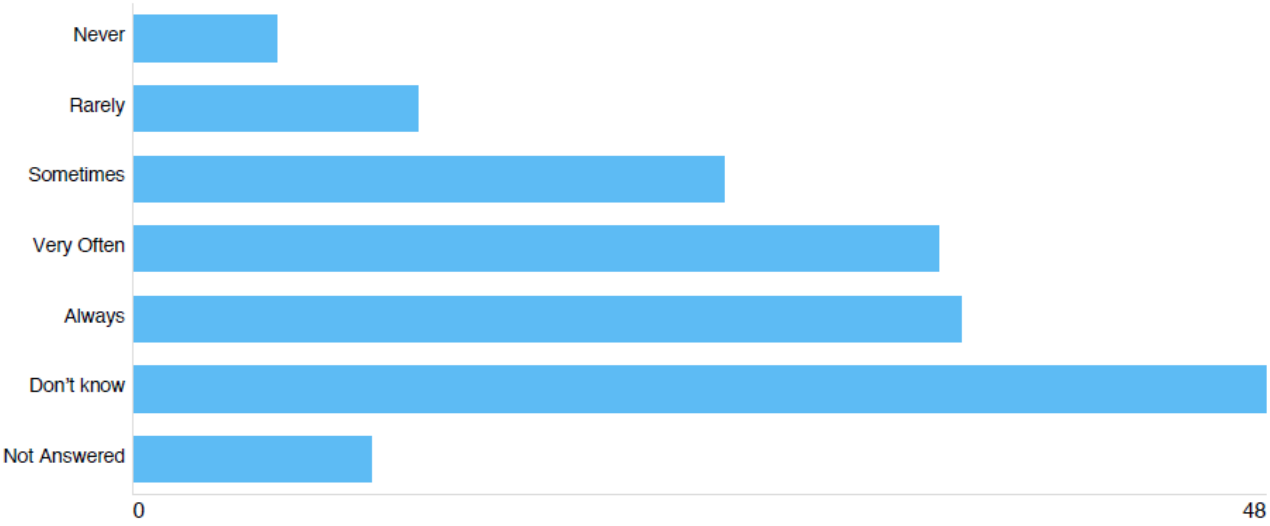
Option	Total	Percent
Never	7	4.07%
Rarely	19	11.05%
Sometimes	29	16.86%
Very Often	28	16.28%
Always	29	16.86%
Don't know	49	28.49%
Not Answered	10	5.81%

Please use the space to tell us more about this. - (J) a system of evaluation so that participants can give feedback regarding the process?



Option	Total	Percent
Never	34	19.77%
Rarely	24	13.95%
Sometimes	18	10.47%
Very Often	10	5.81%
Always	26	15.12%
Don't know	49	28.49%
Not Answered	9	5.23%

K - (K) a mechanism to ensure that recommendations made are implemented?



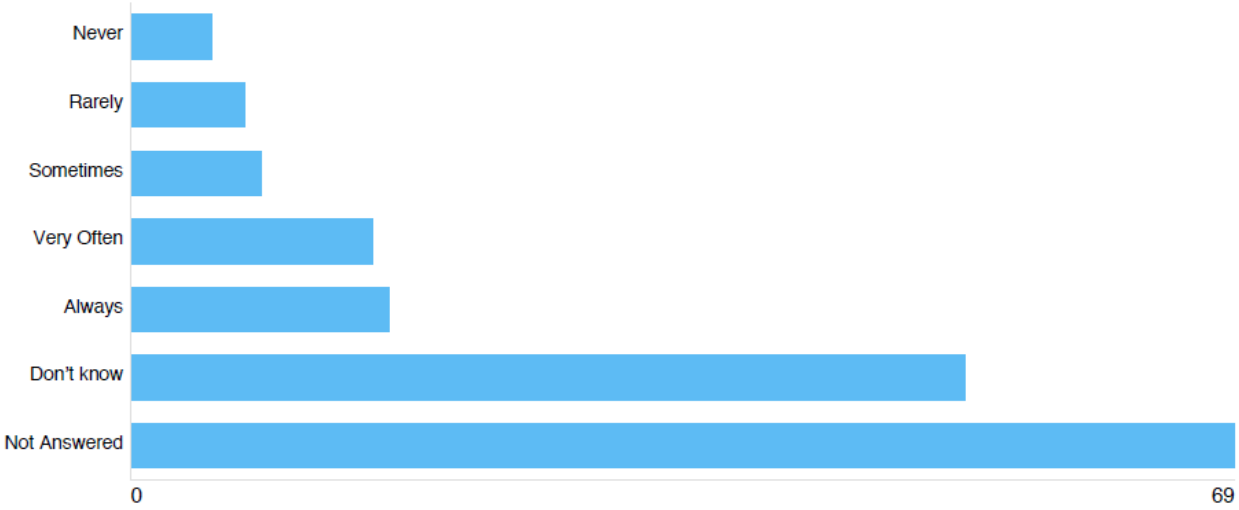
Option	Total	Percent
Never	6	3.49%
Rarely	12	6.98%
Sometimes	25	14.53%
Very Often	34	19.77%
Always	35	20.35%
Don't know	48	27.91%
Not Answered	10	5.81%

Question 6: When you have participated in **EXTERNAL** investigation(s):

(A) Which organisations were involved in commissioning the investigation?

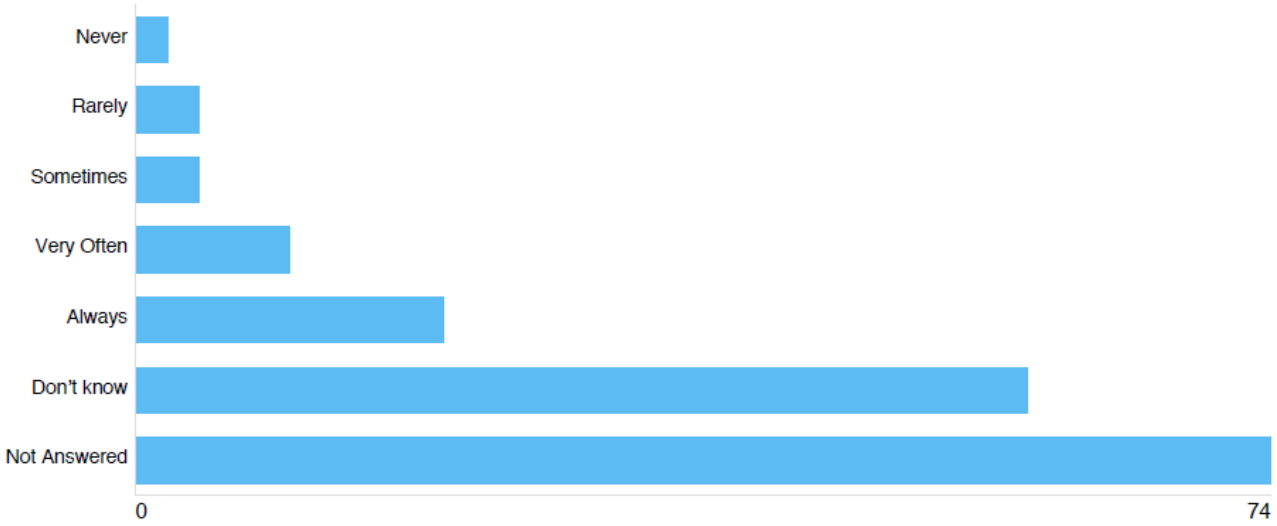
There were **103** responses to this part of the question.

6B - (B) Clarity of purpose and method, in other words was it clear why the investigation was being carried out and how it was being carried out?



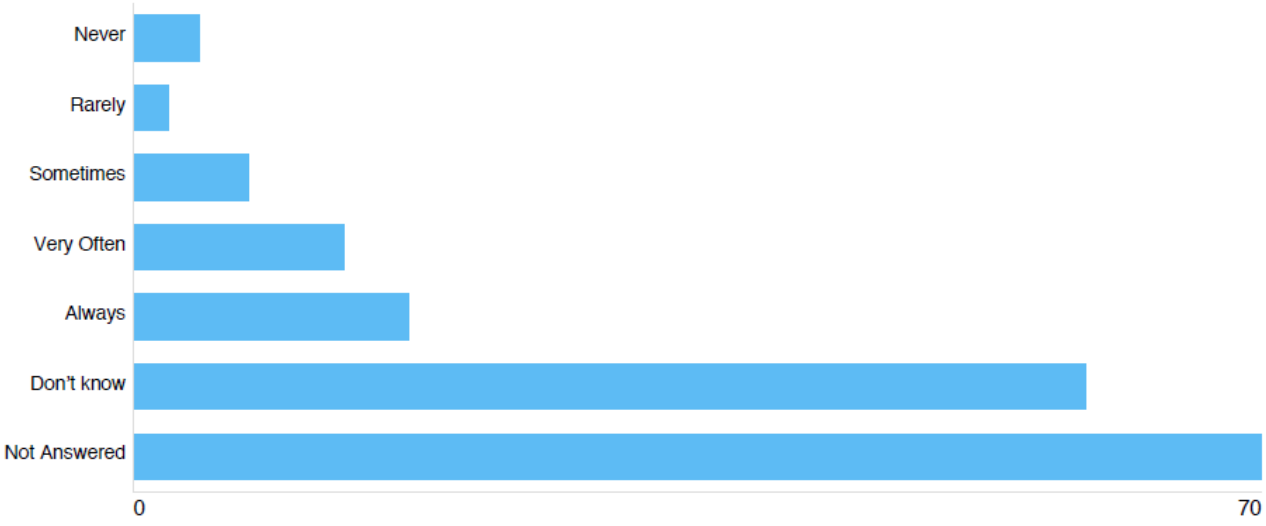
Option	Total	Percent
Never	5	2.91%
Rarely	7	4.07%
Sometimes	8	4.65%
Very Often	15	8.72%
Always	16	9.30%
Don't know	52	30.23%
Not Answered	69	40.12%

6C - (C) sensitivity to the needs of families, carers, victims and other service users?



Option	Total	Percent
Never	2	1.16%
Rarely	4	2.33%
Sometimes	4	2.33%
Very Often	10	5.81%
Always	20	11.63%
Don't know	58	33.72%
Not Answered	74	43.02%

6D - (D) an investigation team which had the appropriate membership?



Option	Total	Percent
Never	4	2.33%
Rarely	2	1.16%
Sometimes	7	4.07%
Very Often	13	7.56%
Always	17	9.88%
Don't know	59	34.30%
Not Answered	70	40.70%

6e - (E) an investigation in a timely and proportionate manner?

Option	Total	Percent
Never	6	3.49%
Rarely	11	6.40%
Sometimes	14	8.14%
Very Often	6	3.49%
Always	9	5.23%
Don't know	55	31.98%
Not Answered	71	41.28%

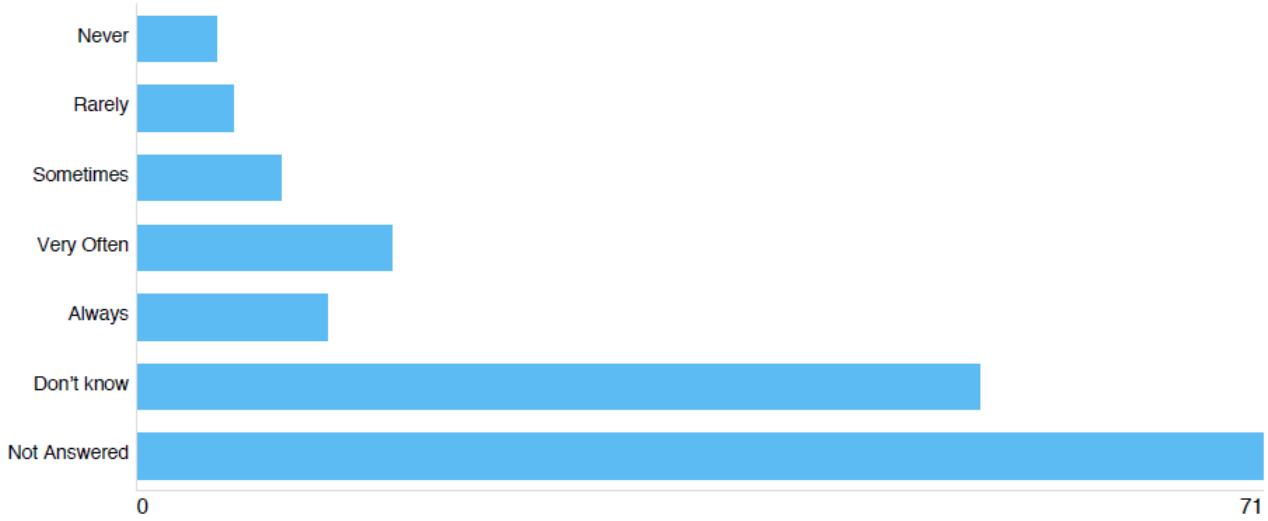
6f - (F) openness to external scrutiny? In other words someone separate from the investigation team reviewing their findings.

Option	Total	Percent
Never	6	3.49%
Rarely	4	2.33%
Sometimes	6	3.49%
Very Often	6	3.49%
Always	9	5.23%
Don't know	70	40.70%
Not Answered	71	41.28%

6g - (G) appropriate support for staff members?

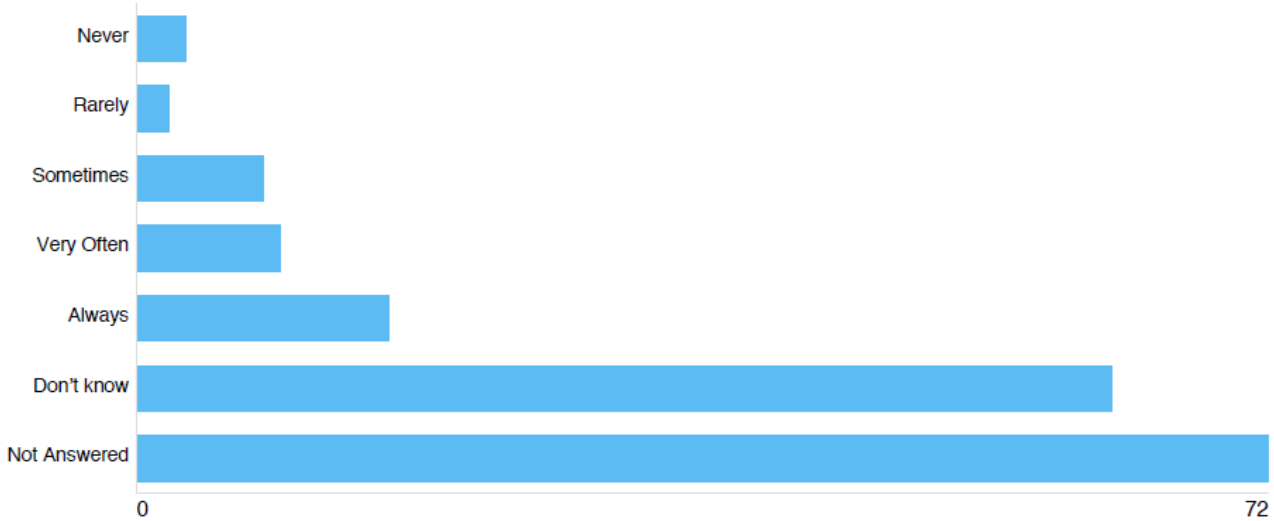
Option	Total	Percent
Never	9	5.23%
Rarely	13	7.56%
Sometimes	9	5.23%
Very Often	9	5.23%
Always	6	3.49%
Don't know	56	32.56%
Not Answered	70	40.70%

6h - (H) clarity in the presentation of findings?



Option	Total	Percent
Never	5	2.91%
Rarely	6	3.49%
Sometimes	9	5.23%
Very Often	16	9.30%
Always	12	6.98%
Don't know	53	30.81%
Not Answered	71	41.28%

6i - (I) appropriate links made with other agencies and sources of information?

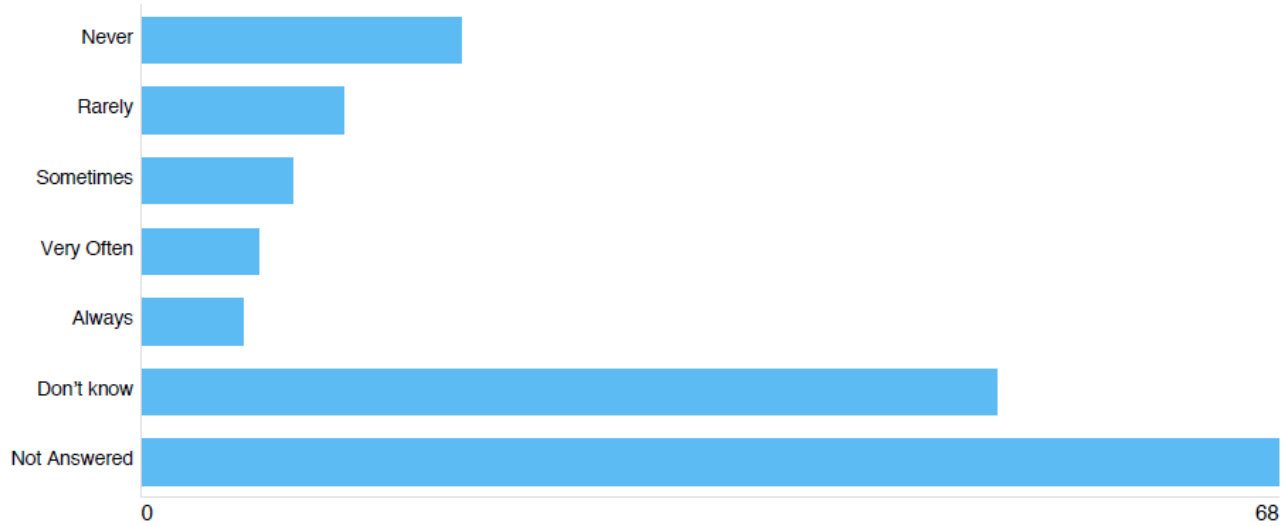


Option	Total	Percent
Never	3	1.74%
Rarely	2	1.16%
Sometimes	8	4.65%
Very Often	9	5.23%
Always	16	9.30%
Don't know	62	36.05%
Not Answered	72	41.86%

6j - (J) a process and opportunity for complaints be made or issues you disagree with brought to the investigation team's attention and satisfactorily addressed?

Option	Total	Percent
Never	11	6.40%
Rarely	13	7.56%
Sometimes	11	6.40%
Very Often	5	2.91%
Always	10	5.81%
Don't know	53	30.81%
Not Answered	69	40.12%

6k - (K) a system of evaluation so that participants can give feedback regarding the process?



Option	Total	Percent
Never	19	11.05%
Rarely	12	6.98%
Sometimes	9	5.23%
Very Often	7	4.07%
Always	6	3.49%
Don't know	51	29.65%
Not Answered	68	39.53%

6l - (L) a mechanism to ensure that recommendations made are implemented?

Option	Total	Percent
Never	4	2.33%
Rarely	5	2.91%
Sometimes	13	7.56%
Very Often	11	6.40%
Always	13	7.56%
Don't know	57	33.14%
Not Answered	69	40.12%

ANNEX F
Documents referenced by the Review

Deaths in Mental Health Detention: An investigation framework fit for purpose?, INQUEST, 2015

Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, 2016

Preventing Deaths in Detention of Adults with Mental Health Conditions, Equality and Human Rights Commission, 2015

Malcolm, J., Patrick, H., Stavert, J., *The right to life, and to proper inquiries on death: a human rights perspective on the investigation of deaths of psychiatric patients in Scotland,* Juridical Review, 2012, 1(51)

Learning from adverse events through reporting and review: A national framework for Scotland, Healthcare Improvement Scotland, 2018

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
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ISBN: 978-1-78781-446-2 (web only)

Published by The Scottish Government, December 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS508466 (12/18)