Justice Committee

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

Written submission from Equality and Human Rights Commission

Summary of key points

- The Equality and Human Rights Commission (the Commission) welcomes the proposal to extend the legislation for mandatory Fatal Accident Inquiries (FAIs) to cover the death of a person in police custody irrespective of the location of the death.
- The Commission welcomes the extension of the legislation for mandatory FAIs to apply to children in secure accommodation.
- The Commission welcomes the requirement on those to whom sheriffs direct recommendations to respond.
- The Commission is concerned that the Bill does not propose to make any changes in relation to FAIs concerning the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998.
- The Commission has particular concerns about the investigation of the death of people detained in psychiatric care and children looked after under statutory orders, other than those in secure accommodation.
- The Commission is concerned that the current proposals set out in the Bill may not comply with the principles of Articles 2 and 14 of the European Convention on Human Rights.
- The Commission notes that Clause 3 of the Bill allows for exceptions to the mandatory FAI and proposes that, were mandatory FAIs relating to the death of any person in compulsory detention by a public authority introduced, similar exceptions could apply.

The Commission largely welcomes the increased flexibility of the system for designation of places where a FAI may be held, on the understanding that venues under consideration will have regard to the accessibility of the relevant premises for disabled people.

Submission

1. The Equality and Human Rights Commission (EHRC) is the National Equality Body (NEB) for Scotland, England and Wales, working across the nine protected grounds set out in the Equality Act 2010: age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. We are an "A-status" National Human Rights Institution (NHRI) and share our mandate to promote and protect human rights in Scotland with the Scottish Human Rights Commission (SHRC).We welcome the opportunity to comment on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill.

2. The Commission's response to the Consultation on proposals to reform FAIs focussed on issues surrounding the circumstances for mandatory and discretionary FAIs and we intend to follow this approach in this submission.

Proposed system of mandatory FAIs: specific concerns

3. One of the options in the Consultation was for a case review by a public authority such as the Mental Welfare Commission to be combined with a discretionary power to hold a FAI. 59% of respondents supported this option as did the Commission, on the understanding that the proposal was to meet the aim of an independent investigation into the death of a person subject to compulsory detention by a public authority. It is noted however that this option has not been fully adopted by the Bill.

4. The Commission welcomes the proposal to extend the legislation for mandatory FAIs to cover the death of a person in police custody irrespective of the location of the death, as well as the death of children in secure accommodation (clause 2). The Commission welcomes the requirement on those to whom sheriffs direct recommendations to respond in writing as this would address the issue of accountability raised in para 12 (h) below (clause 27). The Commission largely welcomes the increased flexibility of the system for designation of places where a FAI may be held, on the understanding that venues under consideration will have regard to the accessibility of the relevant premises for disabled people and others with access needs. (clauses 11- 12)

5. The Commission is concerned however, that the Bill does not propose to make any changes in relation to independent inquiries into the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998, in terms of Lord Cullen's Recommendations at para 4.20.

6. Specifically, the Commission has concerns regarding the death of children who are not in secure care but who nonetheless may be compulsorily living away from home under the authority of a Child Protection Order or a Compulsory Supervision Order (consultation question 4). Similarly, the Commission has concerns regarding the death of adults and children who may be under compulsory detention, or living in the community and subject to an order under the Mental Health (Care and Treatment) (Scotland) Act 2003, or subject to detention under the use of legal guardianship or other powers under the Adults with Incapacity (Scotland) Act 2000 (for example with a requirement to attend day care or take certain medication).

7. The Commission recently completed research in Scotland which contributed to our report on "Preventing Deaths in Detention of Adults with Mental Health Conditions"[1] . The report notes that the number of non-natural deaths of detained patients remained constant in 2010, 2011 and 2012; there were 6, 7 and 6 respectively. All were recorded as suicides. In contrast, in the same period in a prison setting there were 10, 6 and 8. In police custody the figures were 4, 2 and 0. (see table on p68).

[1] http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf

8. In 2012-13, 78 deaths were reported to the Mental Welfare Commission in Scotland where people had died while subject to compulsory treatment. Information on 73 of these deaths was provided. Over half (53) were from natural causes, 6 had no explanation or relation to mental health, 11 were suicides and 3 recorded as delirium. Of the 11 suicides, 5 individuals were in hospital at the time, 3 were subject to compulsory community treatment and the remaining 3 were in the community under suspension of detention (see page 68).

9. In contrast, when the Commission looked at the FAI Judgements on the Scotcourts website, we found only two relating to a suicide in detention (both 2007) one where the person had absconded from the ward (2007) and one suicide in a day unit (2005).

10. These figures demonstrate that under the current system of discretionary investigation, a very small proportion of deaths in mental health detention lead to a FAI whereas all deaths in police custody and prison would lead to a FAI, although deaths in both contexts engage the responsibility of a public authority.

Human Rights approach

Article 2

11. Article 2 of the European Convention on Human Rights ("the Convention"), which safeguards the right to life, ranks as one of the most fundamental provisions in the Convention. Strasbourg has emphasised that the purpose of the Convention is such that it must be applied in a way that makes its safeguards practical and effective. Article 2 creates a positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction. Where lives have been lost in circumstances potentially engaging the responsibility of the State, there is a duty on the State to ensure, by all means at its disposal, an adequate response – judicial or otherwise – so that the legislative and administrative framework set up to protect the right to life is properly implemented and any breaches of that right are properly dealt with. In this connection, the Court has held that criminal proceedings are not required in every case and civil, administrative or even disciplinary remedies can be sufficient.[2] The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and to ensure the State is held accountable for deaths occurring under their responsibility. [3]

12. The Commission therefore reiterates the importance of an independent investigation into the death of any person where the responsibility of the state is potentially engaged. In the Commission's view the following are required for a review to be compliant with Article 2:

a. The body must have authority to initiate that investigation itself
b. It must be carried out promptly and as quickly as is reasonable
c. All reasonable steps to secure the relevant evidence relating to the death must be taken

[2] *Oneryildiz v Turkey 48939/99*
[3] *Paul and Audrey Edwards v UK 464777/99*

d. All reasonable steps to uncover any discriminatory motive behind the death must be taken
e. It must be carried out by someone who is independent of those implicated in the events
f. The investigation and its results must be open to public scrutiny
g. The next of kin must be involved to ensure their interests are protected
h. Anyone found to be at fault as a result of the investigation must be held to account
i. Lessons learned from the result of the investigation must be put into practice to ensure, so far as possible, that the risk of similar deaths in the future is minimised.

These requirements have been developed into a 'Human Rights Framework for the EHRC Inquiry on Preventing Deaths in Detention of Adults with Mental Health Conditions."[4]

13. The Commission's Inquiry Report noted at page 71 that "*patients who die while subject to compulsory treatment under the "Mental Health (Care and Treatment) (Scotland) Act 2003 are reported to the Mental Welfare Commission (MWC) by the health board. If the MWC have concerns that a person may not have had the appropriate care or treatment, they may investigate further. Internal reviews into deaths and near misses are conducted across all settings. The reports relating to these are rarely published, making it difficult to ensure public scrutiny. A lack of a standardised approach to conducting and recording critical incident reviews across health boards in Scotland was a concern as a potential barrier to sharing learning. However it is clear that there has been, and continues to be, significant efforts to improve the review and learning culture. Healthcare Improvement Scotland is leading this work and a National Framework was published in 2013."*

14. Amongst the Scottish recommendations of the report, were the following: (page 73):

a. The investigative structures for the deaths of detained patients in NHS Scotland mental health wards should be strengthened in line with our Human Rights Framework and clarified,

b. To ensure adequate scrutiny of deaths in detention, responsible agencies should systematically collect, analyse and make available data by protected characteristic.

c. Lessons learned in relation to deaths in detention are not being shared across settings. Responsible agencies should consider how this could be achieved and put this into practice.

15. It is noted that at paragraph 114, the Policy Memorandum states that the MWC did not favour mandatory FAIs for the death of every person subject to compulsory detention by a public authority. Whilst this is correct, the MWC did support the second Consultation option; supporting the principle of some form of investigation into the deaths of detained patients whilst retaining the independence of the role of the Lord Advocate in relation to deaths. The MWC also went on to express concern that not every death in compulsory detention is notified to the fiscal.

[4]http://www.equalityhumanrights.com/sites/default/files/uploads/Pdfs/ADI/formatted/Human%20Rights%20Framework.pdf

The current system is confusing eg Crown Guidance to medical practitioners specifies that deaths in legal custody should be notified but does not specify that deaths under mental health detention should be notified. There is a separate system of notification for Health Improvement Scotland and a local case review for clinical services (Analysis of Consultation Responses para 2.47). The MWC proposed a solution whereby all deaths under compulsory orders would be reported to both the MWC and the PF followed by a system of review by the MWC who would liaise with the PF and advise if it was considered there were grounds for an FAI. The Lord Advocate would retain final discretion. In addition, it is noted that all deaths in prison trigger an FAI, regardless of whether they are of natural causes, unless one of the proposed exceptions apply.

16. It is the Commission's position that the current disparate system in relation to the investigation of the death of people detained by a public authority, in particular those detained in mental health detention, is confusing and may lack sufficient procedural safeguards to meet the requirements of Article 2 as outlined above.

Article 14

The European Court of Human Rights has emphasised that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them[5] . It is incumbent on the State to account for any injuries suffered in custody. The Commission is particularly concerned that people under compulsory measures of psychiatric care and children in compulsory supervision are amongst the most vulnerable in society and that there must be a robust, clear system for investigation into their deaths, where lives have been lost in circumstances potentially engaging the responsibility of the State, in order to comply with the State's obligations in terms of Article 2.

17. The Scottish Human Rights Commission stated in their response: *"The Court has (also) recognised that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with[6]."* The Commission supports this view.

18. Where states have a general obligation to conduct an effective investigation in cases of deprivation of life, that obligation must be discharged without discrimination, as required by Article 14 of the Convention[7] . The Court has held that discrimination can mean treating differently, without any objective and reasonable justification, persons in relevantly similar situations[8]. It applies, for instance, to situations where different rules for early release apply to sentences of different types[9]. It is capable of extending to discrimination in the enjoyment of the Convention rights on the grounds of physical or mental capacity[10]

[5] Paul and Audrey Edwards v UK 464777/99
[6] *Herczegfalvy v Austria* (1993) 15 E.H.R.R. 437
[7] *Nachova v Bulgaria 43577/98*
[8] *D.H. and Others v. the Czech Republic [GC], no.* 57325/00
[9] *Clift v United Kingdom, Application No 7205/05 and Laduna v Slovakia App 31827/02*
[10] *(Pretty) v DPP* [2002] 1 AC 800

19. The Commission is therefore concerned that the proposed system whereby there would be a mandatory FAI for a person in the custody of the police/ in prison but not for a person detained by a public authority in other contexts could be discriminatory.

20. It could be argued that there is an objective and reasonable justification for treating people in other forms of state detention differently. It is noted for example that the Royal College of Psychiatrists expressed the view that there would be little public interest in having an automatic FAI for a patient who dies an expected death from an unrelated physical health problem. However RCPsych did support independent case review by another body such as the Mental Welfare Commission (Analysis of Consultation Responses para 2.45).

21. Clause 3 of the Bill sets out exceptions to the mandatory FAI, allowed at the discretion of the Lord Advocate, where satisfied that the circumstances of the death have been sufficiently established in the course of certain prescribed other proceedings, which include; criminal proceedings, health and safety proceedings[11] and public inquiries. It is respectfully proposed that if there were to be mandatory FAIs for any person detained by the state, the categories of exceptions could be expanded eg where the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of other prescribed proceedings such as an investigation by the MWC. Such a system of statutory exceptions might provide a less discriminatory means of meeting the policy objective whilst still putting in place a robust system of investigation into the deaths of people detained by a public authority, in pursuit of the aim of compliance with the principles of Articles 2 and 14 set out above.

Conclusion

22. In conclusion, whilst the Commission welcomes the proposal to extend the provisions for mandatory FAIs to other categories of people in custody, the Commission has particular concerns about the position in relation to the death of people detained in psychiatric care and in relation to children looked after under statutory orders other than those in secure accommodation which have not been addressed. The Commission would welcome further consideration of the issues set out in this submission.

Equality and Human Rights Commission
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[11]The Commission notes that HSE also has a role in investigation of suicides in hospitals but that there has been only one prosecution in recent years (2014)