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**The Scottish Human Rights Commission**

Written evidence to the Justice Committee

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

**April 2015**

The Scottish Human Rights Commission is a statutory body created by the Scottish

Commission for Human Rights Act 2006. The Commission is a national human rights institution (NHRI) and is accredited with ‘A’ status by the International Co-ordinating Committee of NHRIs at the United Nations. The Commission is the Chair of the European Network of NHRIs. The Commission has general functions, including promoting human rights in Scotland, in particular to encourage best practice; monitoring of law, policies and practice; conducting inquiries into the policies and practices of Scottish public authorities; intervening in civil proceedings and providing guidance, information and education.

The Commission welcomes the opportunity to comment on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. We welcome the implementation of Lord Cullen’s recommendations, which have the potential to increase human rights protection. In particular, the issue of investigations into deaths in mental health detention is a matter on which we have called for action[[1]](#footnote-1). We take this opportunity to comment on the proposals in relation to this issue. Therefore we direct ourselves towards the question of **whether the circumstances for mandatory FAIs provided for in the Bill are sufficient.**

**Legal Framework**

* European Convention of Human Rights (ECHR)
* Scotland Act 1998
* Human Rights Act 1998
* UN Convention on the Rights of Persons with Disabilities (UNCRPD)

1. Article 2 ECHR provides that “*Everyone’s right to life shall be protected by law*”. This includes positive obligations to protect individuals from real threat to life. These positive obligations include a procedural element which requires effective domestic investigation of deaths to ensure the protection of life.
2. The procedural obligation has particular weight in circumstances where there is potential for State responsibility. The European Court of Human Rights (the Court) has found that *“Where lives have been lost in circumstances potentially engaging the responsibility of the State, Article 2 entails a duty for 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 repressed and punished”* [[2]](#footnote-2).
3. The essential purpose of investigation is to secure 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[[3]](#footnote-3). Within those bounds, the Court has allowed flexibility as to the form of investigation.
4. There are, however, certain essential requirements:

* **Independence**: The investigation must be carried out by a body with both institutional or hierarchical independence, and also practical independence from those implicated in the events[[4]](#footnote-4).
* **Effectiveness**: The investigation must be effective in the sense that it is capable of leading to a determination as to whether or not the behaviour or inactivity was justified and to the identification and punishment of those responsible. The authorities must take reasonable steps to secure the evidence concerning the incident including, amongst other things, eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death[[5]](#footnote-5).
* **Promptness and reasonable expedition[[6]](#footnote-6)**
* **Public scrutiny**: there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory[[7]](#footnote-7).
* **Involvement of next of kin**: The next of kin must be involved to the extent necessary to safeguard their legitimate interests[[8]](#footnote-8).
* **Initiated by the State**: The authorities must act once the matter comes to their attention rather than leaving it to the next of kin to instigate[[9]](#footnote-9).

1. In considering when the procedural obligation of Article 2 arises, there is a particular obligation to provide explanations for deaths in custody or detention, in recognition of the fact that people in custody are in a vulnerable position and the authorities are under a duty to protect them[[10]](#footnote-10). 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[[11]](#footnote-11).

**Comments on the Bill**

1. The Bill does not take forward Lord Cullen’s recommendation that mandatory FAIs should extend to cases where the deceased is subject to compulsory detention by a public authority within the meaning of Section 6 of the Human Rights Act, such as those subject to mental health detention. The Commission considers that a gap remains in the investigation of deaths in mental health detention, in respect of which a clear system requires to be set up to adequately meet the procedural requirements of Article 2, set forth by the Court.
2. The policy memorandum expresses the view that the current system, of a graduated scale of investigations[[12]](#footnote-12), is broadly sufficient. The Commission, however, concurs with the MWC who, in their response to the consultation preceding this Bill, said *“there needs to be a clearer set of arrangements which provides appropriate assurance in all such deaths, with a proportionate hierarchy of investigations. The current system is confusing, with gaps, overlaps and uncertainties.”[[13]](#footnote-13)*
3. The policy memorandum also explains that *“Article 2 is realised in Scotland by systems of general application such as an effective criminal and civil justice system (for example damages actions for wrongful deaths), the regulation of dangerous activities, and high ethical and professional standards in the field of medicine*”. These systems do not, however, address the obligation (highlighted above) to provide explanations for deaths in custody or detention, nor do they meet the Article 2 requirements set out earlier, such as independence, public scrutiny or initiation by the state. In addition, these systems do not serve the same purposes as an FAI, in that they would not provide a forum to consider what precautions or improvements might be taken or made to prevent other deaths in similar circumstances in the future.
4. The Commission appreciates the concern that there would be little public interest in holding a mandatory FAI in all situations of detention, without distinction, given that many of those deaths will occur from natural causes. We do not therefore propose such a blanket requirement. We do, however, believe that steps need to be taken, to ensure that systems of investigation meet the Article 2 requirements outlined above and to remedy the current gaps and confusion. In responding to the consultation[[14]](#footnote-14), we expressed the view that a case review by a public authority such as the MWC, combined with a discretionary power to hold an FAI, could comply with Article 2 requirements if implemented in the following form: an initial investigation by an independent public body to rule out deaths from natural causes; in all other circumstances, a mandatory FAI would be triggered. The Commission considers this a reasonable proposal which could meet Article 2 requirements while providing a degree of flexibility, as endorsed by the Court.
5. The Commission also considers that the proposals by the MWC in their response to the consultation merit further consideration, as a means of addressing Article 2 requirements and meeting the goals of an FAI, as follows:

*“We propose that there should be a statutory requirement to notify any death of a patient subject to a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003 to the fiscal and the Mental Welfare Commission. Following such notification, the Commission would undertake a review of the case notes by a medically qualified person, to determine if there are any factors requiring more detailed investigation. If there are, a Commission investigator would initiate a more formal review, which would be in a form consistent with the procedures for healthcare critical incident reviews. In more straightforward cases, that review might be run locally but monitored and quality assured by the MWC. Where there is significant concern, the review would be conducted independently by an investigator appointed by the MWC. The MWC would keep the fiscal advised throughout the process, and would advise the fiscal if it believed there were grounds for an FAI, either instead of or following the review overseen by the MWC. The Lord Advocate would retain full discretion to initiate an FAI at any stage.”[[15]](#footnote-15)*

1. There are various options to design a proportionate system in this regard. The Bill could, for instance, provide for mandatory FAIs in all cases where a person is subject to mental health detention, with an exclusion where the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established during the course of an inquiry by the MWC (in the manner of Section 3 of the Bill).
2. However the specifics of investigations are designed, it is key that they result in a robust system which provides for the investigation of all deaths in mental health detention, and the triggering of an FAI where there are any factors of concern. Taking steps within the Bill to implement such a system would be a significant step in addressing Article 2 concerns.
3. If the Mental Welfare Commission is to perform an investigative role, the Commission considers that the following elements would be necessary in order to ensure Article 2 requirements are met:

* **Independence**: We would support the MWC as an appropriate body to carry out an initial investigation. The MWC appears to have the necessary degree of institutional and practical independence from the NHS and health boards.
* **Effectiveness**: Assuming any new system of investigation is in addition to the MWC’s existing investigatory powers, consideration should be given as to whether the MWC will require powers to aid their investigations, such as compelling witnesses and evidence gathering.
* **Promptness and reasonable expedition**
* **Public scrutiny**: Publication of reports of MWC inquiries could provide the necessary degree of scrutiny.
* **Involvement of next of kin**: Relatives and carers of the deceased must be involved with the investigation.
* **Initiated by the State**

1. The Commission notes that the MWC has raised the question of whether individuals subject to community-based compulsory treatment orders, suspension of detention and welfare guardianship orders may also fall within the definition of compulsory detention[[16]](#footnote-16). The Commission recommends that further consideration be given to this point. While we recognise that a large number of individuals subject to these measures would not be regarded as in the custody of the state, there may still be a significant number who reside in specified accommodation and care arrangements against their will, as a consequence of such orders. Those individuals should be afforded the same protections as those in the custody of the state in a hospital setting.

*End.*

1. See SHRC’s “Submission to the United Nations Human Rights Committee: List of issues on the United Kingdom’s 7th periodic report under the International Covenant on Civil and Political Rights” (July 2014) <http://www.scottishhumanrights.com/publications/consultationresponses/article/iccprjuly14> and “Consultation on draft proposals for a Mental Health (Scotland) Bill, Response to Scottish Government Consultation” (March 2014)

   <http://www.scottishhumanrights.com/publications/consultationresponses/article/submissiondraftmentalhealthbill> [↑](#footnote-ref-1)
2. *Öneryildiz v Turkey* (2005) 41 E.H.R.R. 20 at para 91 [↑](#footnote-ref-2)
3. *Jordan v United Kingdom* (2003) 37 E.H.R.R. 2 at para 105 [↑](#footnote-ref-3)
4. *McKerr v United Kingdom* (2002) 34 E.H.R.R. 20 [↑](#footnote-ref-4)
5. *Nachova v* Bulgaria (2006) 42 E.H.R.R. 43 [↑](#footnote-ref-5)
6. *McKerr*, supra at footnote 3 [↑](#footnote-ref-6)
7. ibid [↑](#footnote-ref-7)
8. *Güleç v Turkey* (1999) 28 E.H.R.R. 121 [↑](#footnote-ref-8)
9. *Ilhan v Turkey* (2002) 34 E.H.R.R. 36 [↑](#footnote-ref-9)
10. *Salman v Turkey* (2002) 34 E.H.R.R. 17 [↑](#footnote-ref-10)
11. *Herczegfalvy v Austria* (1993) 15 E.H.R.R. 437 at para 82 [↑](#footnote-ref-11)
12. Graduated scale of investigations:

    adverse incidents (an internal review);

    critical incident reviews (these involve a consultant from another Health Board area);

    significant adverse incident reviews (involving another Health Board);

    independent investigations by the Mental Welfare Commission Scotland;

    independent investigation by the procurator fiscal and possibly a discretionary FAI. [↑](#footnote-ref-12)
13. <http://www.gov.scot/Resource/0046/00460923.pdf> [↑](#footnote-ref-13)
14. <http://www.scottishhumanrights.com/resources/policysubmissions/consultationonreformoffai> [↑](#footnote-ref-14)
15. <http://www.gov.scot/Resource/0046/00460923.pdf> [↑](#footnote-ref-15)
16. “Death in Detention Monitoring”, Mental Welfare Commission (March 2014) [↑](#footnote-ref-16)