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Briefing for the Public Petitions Committee

Petition Number: PE 1604

Main Petitioner: Catherine Matheson

Subject: Inquests for all deaths by suicide in Scotland

Calls on the Parliament to urge the Scottish Government to expand the remit of the review into the arrangements for investigating the deaths of patients under Section 37 of the Mental Health (Scotland) Act 2015 to include an inquest-type system for all deaths by suicide in Scotland: and to include both patients who were released from hospital or receiving care in the community under compulsory treatment orders.

Background

Framework for mental health treatment in Scotland

The Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedure (Scotland) Act 1995 set out the framework for **compulsory** mental health treatment in Scotland.

The 2003 Act allows those with mental health conditions to be detained and/or treated against their will where they pose a significant risk to themselves or others. People can be detained in hospital for up to 28 days on the authority of a doctor.

Long-term treatment is given under a "compulsory treatment order" with the authority of the Mental Health Tribunal for Scotland. This can involve detention in a hospital. It can also cover treatment in the community, including a requirement to take medication or to use certain care services.

The 1995 Act deals with people involved in the criminal justice system who have a mental health condition. It covers those who lack capacity to face trial for a criminal charge as well as those who fall ill while in prison or awaiting trial. Those affected can be detained and/or treated against their will.

Many people also voluntarily choose to stay in hospital and/or receive treatment for a mental health condition.

Section 37 of the Mental Health (Scotland) Act 2015

Section 37 of the 2015 Act requires the Scottish Government to carry out a review of the way deaths of certain people with mental health conditions are investigated. It covers those who are compulsorily detained in hospital, as well as those who are being treated voluntarily in hospital. The review must be completed by December 2018.

The review will include how the deaths of those who commit suicide while in hospital are investigated. However, it will not cover those who commit suicide after being released from hospital or while receiving compulsory treatment in the community. The petitioner is calling for the remit of the review to be extended to include these categories of suicide.

NHS Scotland research[1] has found that 13% of those committing suicide had a psychiatric inpatient stay in the 12 months before their death. Fifty-nine percent had a mental health-related drug prescription and 20% had a psychiatric outpatient appointment.

The petitioner also wants the review to specifically consider a system of investigating all suicides which is based on the English "coroner's inquest" system. The inquest system is discussed below.

Current systems for investigating deaths in healthcare settings

NHS boards carry out "adverse event reviews" where there are concerns about the circumstances of a death. Their purpose is to discover if any lessons for future practice can be learned.

NHS boards set their own policies in relation to adverse event reviews, so practice varies from area to area. Healthcare Improvement Scotland has an active role in reviewing deaths from suicide and promoting any lessons learned across the NHS.

Local authorities also have systems in place to review some deaths, but the approach is not standardised.

The Mental Welfare Commission for Scotland is an independent organisation which works to support the rights of people with mental illness, learning disability and related conditions. It has statutory powers to carry out investigations or hold inquiries where there are concerns about the care or treatment of a person within its remit.

The procurator fiscal also has a role in investigating unexpected deaths. A "fatal accident inquiry" can be held where a death was sudden, suspicious, unexplained or occurred in circumstances likely to give rise to serious public concern. However, only 50 to 60 fatal accident inquiries are held each year.

[1] Information Services Division. (2015) *The Scottish Suicide Information Database Report 2015.* Figure 4 (page 19).

Concerns have been raised that the current systems may have gaps, so that lessons which may prevent future deaths are not always learned. This was the reason for introducing the requirement to review the way deaths in mental health detention are investigated, discussed above[2].

The issue was also discussed during the passage of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. Stage 2 amendments, which would have required fatal accident inquiries to be held for deaths in mental health detention, were reversed at Stage 3[3]. One of the main reasons for this was concern that such a system would be distressing for family members and stigmatising for those with mental health conditions.

Coroner's inquests

The coroner's inquest is the system used in England to investigate unexplained deaths. Many more inquests are held in England than fatal accident inquiries in Scotland. However, coroners have more limited powers to make findings and recommendations than a sheriff presiding over a fatal accident inquiry.

Coroner's inquests are held in relation to all unnatural deaths, which would include suicide.

Scottish Government Action

The Scottish Government has brought into force section 37 of the Mental Health (Scotland) Act 2015. The review must be completed within three years. However, no further information about the review's progress is available.

The Scottish Government also engages in a range of suicide prevention activities, including the Suicide Prevention Strategy 2013-16 and the Choose Life campaign.

Scottish Parliament Action

The Scottish Parliament has received several other petitions concerned with the investigation of death by suicide.

- Petition PE 1567 calls for the law relating to the investigation of unexplained deaths, suicides and fatal accidents to be changed.

- Petition PE 1501 calls for a mandatory inquiry to be held where deaths are caused by suicide or accident. Evidence on the coroner's inquest process, and on investigations into deaths in Scotland, has formed part of the consideration process.

The Scottish Parliament also debated suicide prevention on 21 January 2014 (cols 26773 to 26810).

[2] Scottish Parliament. (2015) *Official Report 24 June 2015*. Cols 78-80.
[3] Scottish Parliament. (2015) *Official Report 10 December 2015*. Cols 57-64.

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3 May 2015

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