PE1604/D

NHS Western Isles Letter of 11 October 2016

Calling on the Scottish 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 (Care and Treatment) (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.

(i) What measures are in place to provide protection for the health and safety of patients who are released from hospital or receiving care in the community under a Compulsory Treatment Order?

Patients residing in the community who are subject to CTO's are subject to periodic review by consultant psychiatrists and CPN service. This may be at out patient clinics and/or case conferences to review the person's community care plan. Care plans would detail trigger/intervention points whereby someone who is deteriorating is assessed expeditiously by the clinical team. The consultant feedbacks to the GP on the patient's progress.

(ii) How are investigations conducted in cases where a patient who was released from hospital or was receiving care in the community under a Compulsory Treatment Order commits suicide to ensure that lessons are learned to improve patient care in the future?

The arrangements for conducting a suicide review for patients who are subject to CTOs are the same for any patient who is a patient of mental health services, and for patients discharged from mental health services within 12 months of the suicide. The procedures for suicide review fall within the framework and guidance issued by Health Improvement Scotland (HiS). HiS are informed of the suicide and will receive a copy of the report of the investigation which will, where appropriate, contain recommendations that HiS will then share across NHS Scotland. NHS Western Isles is in the process of incorporating its suicide review policy into its adverse incident and reporting policy. Suicides are considered category 1 incidents which will require a full root cause analysis commissioned by an Executive director. A local action plan is developed and progress monitored via the Board's clinical governance arrangements, and reported back to HiS.

The Committee also heard evidence from the petitioner on the impact on families when a patient commits suicide and families' desire to be involved in the investigation process. What support is offered to families by your health board and how are families involved in the process in such a way that it is clear to them that the incident is being taken seriously and lessons learned from it?

Families are invited to be involved in the suicide review process (although we understand that that will change in the future) and a named person, usually PASS, is assigned to maintain contact with family members.