

PE1604/E

NHS Orkney Letter of 13 October 2016

CONSIDERATION OF PETITION

The response to your query from NHS Orkney is that prior to discharge a multidisciplinary meeting is held, normally by VC and with the patient present. At this meeting arrangements are made for practitioner follow up on discharge. Appointments for the MHO, RMO and any other practitioners involved in the case are made at this juncture.

We insist on up to date risk management assessments and recovery care plans being formulated by ward staff and available on discharge.

We meet people when they return to Orkney and community care plans are formulated or evaluated at this time. If this is not done on the return date then this is done within 7 days of discharge. The frequency of appointments based on a needs assessment are ascertained at this point.

We have not had a suicide of a patient whilst under a CTO. However, all deaths through suicide are investigated locally when the person is known to mental health services and any learning gained through this process is disseminated to appropriate agencies, individuals and services.

Family members of known CMHT patients are contacted by letter to offer condolences and support. Family members are given the option of being part of the investigation process if they wish to. This has been done in a variety of ways either by meeting individually with family members or as much as them being involved in the whole process alongside professionals. The findings from the investigation are fed back to the family members. The seriousness of a suicide to the team is stressed throughout the whole process.

I hope this is helpful.

Yours sincerely

Cathie Cowan
Chief Executive