PE1604/I

NHS Grampian Letter of 14 October 2016

Re: Consideration of Petition PE1604

The Committee also seeks clarification on certain procedures in place in your health board as detailed below: –

(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?

All patients receiving care on release from hospital or receiving care in the community under a Compulsory Treatment Order will have the support of the Community Mental Health Team with regular reviews by staff involved.

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?

NHS Grampian has a 'Policy for the Learning from and Management of Adverse Events and Feedback' which is followed for example, when a patient under our care commits suicide or while receiving care in the community under a Compulsory Treatment Order.

This policy reflects the definitions and principles outlined in the recent Healthcare Improvement Scotland (HIS) publication 'Learning from adverse events through reporting and review: A national framework for NHS Scotland (2013).'

All suicides of patients are reported to HIS and have a review undertaken. This will involve the carers when possible who will be interviewed by the investigating panel if they wish. We have a clinical governance system in place to monitor this process.

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?

When a patient under our care commits suicide, the Responsible Medical Officer (this would be the patients Consultant Psychiatrist) along with a member of the Community Mental Health Team who was known to the person, would routinely make contact with the person(s) identified Next of Kin, to invite to a meeting to give the opportunity to discuss these tragic events and offer condolence.

Additional to the contact with the deceased's clinical team above, the Lead Reviewer of the Adverse Events Team process would routinely invite the person's Next of Kin to be invited to be part of the Adverse Event Review process; to contribute to the gathering of information, sharing of outcomes and recommendations of shared learning.

Yours sincerely

Malcolm Wright
Chief Executive, NHS Grampian