PE1604/K

NHS Tayside Letter of 20 October 2016

Thank you for your letter dated 16 September 2016 regarding the above matter.

Please find NHS Tayside's response to each section below:

Further to your request for NHS Tayside's view on what is called for by the petition.

NHS Tayside response:

From reading the petition, our interpretation is that it is calling for an Inquest system for *all deaths by suicide in Scotland* (not just those of patients subject to legal detention under mental health legislation). Taking this interpretation, we have considered the data in respect of suicides in Scotland:

- There were 672 suicides registered in Scotland in 2015 (NRS, 2016).
- 79% (n=3465) of all people who were suspected of dying by suicide (n=4388) from 2009-2014 had not been inpatients within psychiatric hospital in the five years preceding death (ScotSid, 2016).
- 550 individuals (13%) were discharged from psychiatric hospital or outpatient care within 12 months prior to death and 923 (21%) within 5 years prior to death.
- Of the 923, 116 (13%) were patients who were detained under the Mental Health legislation.

We recognise suicide is a major public health concern and national suicide prevention programmes have been successful in reducing rates of suicide. NHS Tayside is reported through NRS 2016 to have been one of three NHS Board areas in Scotland to have seen a marked reduction in suicide rates. For an Inquest process to be introduced for all suicides in Scotland it would need to be coupled with a further major national suicide prevention programme to support transfer of learning into initiatives aimed at further reducing suicides. If the purpose of an Inquest system was solely to provide families with information in respect of their loved one's suicide, whilst respecting the grief of the individuals involved, it is our view an Inquest system would not be conclusive in this respect.

In respect of people who have been subject to detention under the Mental Health (Care & Treatment)(Scotland) Act 2003, It is not clear how the proposed Inquest approach would further enhance the processes already in place. The external scrutiny and support provided by Healthcare Improvement Scotland and the Mental Welfare Commission, through NHS / Healthcare Improvement Scotland Adverse Events Management processes and the National Suicide Reporting and Learning System and Network, enables NHS Boards to learn from patient suicides in a way that supports understanding and practice review in a non defensive / accusatory

way. Internal reviews by NHS Boards could perhaps be made more objective by having colleagues from neighbouring Boards participating in the review processes.

An expansion of the remit of the Review under Section 37 for all patients, who are subject to powers under the Mental Health (Care and Treatment) (Scotland) Act 2003 to include an inquest-type arrangement for patients who are on Suspension of Detention or Community Based CTOs, from a clinical perspective, could potentially result in defensive practice in clinical care. Concerns by individual practitioners that clinical judgements would be subject to an Inquest process in the event of a patient suicide could negatively impact on patients, with less positive risk taking for patients, longer lengths of stay in hospital, and perhaps even a reluctance to use suspension of detention and community-based Compulsory Treatment Orders (CTOs), conversely creating more risks for patients if they are discharged without the protection of a community detention order.

On balance, we therefore do not support what is called for in the petition, although would welcome a strengthening of the objectivity of the current process through peer review by colleagues from other Board areas.

We note the petitioner is concerned that the process for Fatal Accident Inquiry is a lengthy one; given the numbers involved an Inquest-type arrangement could potentially be an even lengthier process as presumably there would be no ‘filtering’ of those cases that would benefit from more detailed analysis.

The Committee sought clarification on certain procedures in place in NHS Tayside 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?

NHS Tayside response:

The Mental Health (Care and Treatment) (Scotland) Act 2003 requires that a care plan is in place for all patients who are subject to a Community Based Compulsory Treatment Order (CTO). The Mental Health Tribunal has powers to be specific about any requirement which will provide protection to individuals. These include input from a named and approved Section 22 registered psychiatrist and a named Mental Health Officer. A CTO can stipulate where someone lives, what services need to support an individual, where the patient is required to attend, and that the patient must accept treatment. It also has the powers to recall someone from the community and place them in hospital if their condition deteriorates and they are judged to be at risk. In addition, the Mental Welfare Commission has powers which enable it to protect the rights of service users. Patients have a legal right to advocacy support and named persons also have rights in respect of their views being taken into consideration by the tribunal.

The Care Programme Approach is also used where patients have multi-agency service requirements or have particularly complex needs. This is a coordinated case management approach involving all relevant individuals meeting regularly to discuss

care and treatment. The patient and their closest family members would be involved in these meetings.

(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?

NHS Tayside response:

NHS Tayside follow an Adverse Event Management Policy (enclosed). This details two levels of investigation:

- A Local Adverse Event Review (LAER) conducted by the local clinical team with an independent reviewer (trained in Root Cause Analysis methodology) for all cases.
- A Significant Clinical Event Analysis (SCEA) for patients who commit suicide within 12 months of contact with mental health services. The purpose of a SCEA is to identify organisational / systems learning. SCEAs are chaired by senior directors or associate directors within the organisation.

In addition all suicides of patients who have been in contact with mental health services in the preceding 12 months are reported to Healthcare Improvement Scotland (HIS) Suicide Reporting Team.

NHS Tayside also has representation in the work of The Suicide Reporting and Learning System. Each locality in Tayside is a member of the local Choose Life / Suicide Intervention network, all of which support shared learning.

(iii) 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?

NHS Tayside response.

This is an area we continue to learn from and develop our processes. Not all families wish to be involved however our standard is for nearest relatives / next of kin to be contacted by either the manager of the service or the senior clinician, or both, after a patient suicide to offer condolences and the opportunity to meet.

An explanation is provided on the LAER and SCEA processes, and HIS (Healthcare Improvement Scotland) and SAMH (Scottish Association for Mental Health) booklets are provided to relatives. Relative(s) are invited to have any questions considered during that process. Views and questions will be taken to both LAER and SCEA meetings and feedback will be provided to families sensitively. This is sometimes in writing only or in face-to-face meetings, dependent on the wishes of the relatives. Section 9.1 of the Adverse Event Management Policy provides more guidance.

Yours sincerely

Lesley McLay

Chief Executive