**PE1604/M**

Scottish Government Letter of 27 October 2016

Thank you for your letter regarding petition PE1604, lodged by Catherine Matheson. I am replying as I have portfolio responsibility for this matter. I welcome the opportunity to contribute to the Committee's consideration of this petition.

Every suicide is a tragedy that has far reaching impacts on family, friends and the community long after a person has died. In its Suicide Prevention Strategy (2013-16), the Scottish Government is committed to continuing the downward trend in suicides, based on known and emerging evidence about factors which can be associated with suicide.

The Scottish suicide rate fell by 18% between the periods 2001-2005 and 2011-2015. The number of deaths by suicide in 2015 was the lowest in a single year since 1974. The petition suggests that an inquest-type system for all deaths by suicide in Scotland is needed. Scotland already has a robust system for reviewing suicides: after a suicide in Scotland, a number of reviews and investigations are carried out by different organisations for distinct purposes and I will summarise these.

All suicides in Scotland are reported to the Scottish Fatalities Investigation Unit (SFIU), a specialist unit within the Crown Office and Procurator Fiscal Service (COPFS). A link to the 2015 COPFS guidance on reporting deaths to the procurator fiscal is below. Please see section 3 (Unnatural cause of death).

http://www.crownoffice.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202015.pdf

The SFIU is responsible for investigating all sudden, suspicious, and unexplained deaths. Where appropriate, COPFS will discuss these cases with the Health and Safety Executive. A key issue which the SFIU will consider is whether there has been a systematic failure in care which contributed to the person taking their life.

In addition, when the suicide of a patient takes place, NHS boards need to understand what happened and learn from any lessons identified. The lessons learned are important to improve services and help staff recognise where risk exists.

NHS boards notify Healthcare Improvement Scotland when a person has completed suicide (or when suicide is the probable cause of death), and that person has had contact with mental health services within 12 months before their death. The relevant NHS board then carries out a suicide review. Suicide reviews are the way that NHS boards, and their mental health services, analyse what happened and recognise where anything can be done to make things safer for other people at risk.

Suicide reviews carried out by NHS boards are often conducted in parallel with criminal, civil or regulatory investigations and NHS complaints and human resources procedures. Involvement of families and carers in the review process is considered

on a case by case basis taking into account what is known about the patient's personal wishes and the circumstances of their care.

The SFIU will ordinarily request and consider the relevant NHS board's suicide review reports. In addition, when investigating cases, SFIU may consider instructing an independent expert to consider the circumstances of the suicide, which may include consideration of the review report and its learning outcomes. At the conclusion of its investigation, the SFIU will consider whether there should be a Fatal Accident Inquiry (FAI).

There are particular categories of deaths that require an FAI to be held on a mandatory basis. Under section 2(3) and (4) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, which is expected to be commenced in May 2017, these are:

- where the death occurred as a result of an accident in the course of a person's work;
- where the deceased person was held in legal custody (for example by the prison authorities or by the police); or
- the deceased was a child required to be kept or detained in secure accommodation.

The Lord Advocate may also decide to hold an FAI on a discretionary basis where he or she considers that it is in the public interest to do so and a sudden, suspicious or unexplained death has occurred in circumstances giving rise to serious public concern.

Under section 1(3) of the 2016 Act, the purpose of an FAI is defined as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. Section 1(4) of the Act makes it clear that it is not the purpose of an inquiry to establish civil or criminal liability. When considering whether an FAI is appropriate, COPFS will assess if identified learning has already been shared nationally to prevent a similar event occurring in the future.

COPFS has recently brought forward a Family Liaison Charter for bereaved families which is statutorily underpinned by section 8 of the 2016 Act. This sets out what information they may expect to receive about death investigations which may lead to criminal proceedings or FAIs, and in what timescale. This was formally laid in the Scottish Parliament on 5 September and may be found at:

http://www.copfs.gov.uk/images/Documents/Deaths/COPFS%20Family%20Liaison%20Charter%20September%202016.pdf

COPFS has, in particular, committed to contacting a bereaved family no later than 12 weeks after the date a death has been reported to them to inform them of the progress of the death investigation. A personal meeting will be offered at this time which will take place within 14 days unless the family indicate that they do not wish a personal meeting, in which case COPFS will communicate according to the needs and wishes of the family.

COPFS will thereafter contact the bereaved family every six weeks to allow the family to be updated on the progress of the investigation and if the family members wish a personal meeting this will be arranged. This will continue throughout the duration of the death investigation by the procurator fiscal. If at any stage there is a significant development, contact will be made with the family to advise them, unless this would be likely to prejudice any potential prosecution.

The Charter makes clear that, when a report is to be submitted for Crown Counsel's instructions on whether or not there is to be an FAI (in circumstances where this is discretionary), the family will be given an opportunity to to say whether they wish an inquiry to take place and the family's views will be taken into account in reaching a decision. The family's view cannot be conclusive, however, since FAIs are held in the public interest, principally to determine the circumstances of death and to establish whether precautions may be taken to avoid such deaths in the future.

Where a decision has been taken not to hold an FAI, a meeting will be offered to the family within 14 days of notifying them of that decision to explain the reasons. These reasons will also be confirmed in writing unless the family have indicated that they do not wish to be provided with these.

I hope this reassures you that death investigations by COPFS do therefore offer the kind of support to bereaved families suggested in your letter and they will be kept informed of the progress of death investigations throughout, until its conclusion, if that is what they want. Some families might find this information distressing and would not want the same levels of information and involvement as others.

In respect of the measures 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, a range of guidance, both from the Scottish Government and the Mental Welfare Comission for Scotland is available to health boards on delivering good quality care planning.

The duty of candour, introduced by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, will help to promote an open learning culture and accountability for safer systems. The Act requires that when an organisation becomes aware that there has been an adverse event resulting in harm, the duty of candour procedure must be followed. The procedure, which will be set out in regulations, will require organisations to take action to meet with the affected person (or the person's family or carer in the case of suicide) and provide support to them. It is appropriate that improving health care is taken forward by health professionals and appropriate regulatory bodies.

The Scottish Government is currently considering the form and extent of the section 37 Mental Health (Scotland) Act 2015 review into of the arrangements for investigating the deaths of those detained in hospital and voluntary inpatients.
The statutory review will include deaths by suicide in hospital. It will be extended beyond the statutory duty to include deaths by suicide where someone is on suspension of detention, following a recommendation from the Mental Welfare Commission. The review will be carried out by December 2018 and it will take views

from the nearest relatives of patients who are included in the remit of the review, as is required by section 37.

**MAUREEN WATT**