PE1604/O

NHS Borders Letter of 31 October 2016

Thank you for your letter of 16 September 2016 seeking the views of NHS Borders on Petition PE1604.

NHS Borders works in line with the Scottish Government requirements in regard to investigating the deaths of patients under Section 37 of the Mental Health (Care and Treatment) (Scotland) Act 2015.

Detailed below are our responses in regard to your specific questions:-

(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?

Any patient discharged from NHS Borders inpatient psychiatric care receives a Post-Discharge Follow up appointment with a doctor or psychiatrist within 7 days of leaving hospital in order to check their mental state, wellbeing, living arrangements, and to monitor their settling back in to the home environment. This is monitored as a Key Performance Indicator for Mental Health and we aim for 100%. In addition, patients on Compulsory Treatment Orders would be considered, prior to discharge, for the Care Programme Approach to ensure their package of care and follow up is rigorously monitored and implemented, and adapted as required to changing circumstances.

(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 circumstances of any patient (including those subject to compulsory measures) who commits suicide within a year of contact with NHS Borders Mental Health service would be subjected to a Serious Adverse Event Review (SAER), chaired by a senior NHS Borders clinician from outwith the Mental Health service. NHS Borders SAER policy gives further details about the nature of the process.

(iii) 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?

Any family bereaved by suicide of a patient known to the NHS Borders Mental Health service would be written to in order to offer personal support and the opportunity to meet with the patient's consultant. This provides an opportunity to explain the SAER process; to obtain further information from the family which might assist in that process; and to obtain any questions the family would like the SAER to explore. Once the SAER

is complete, the senior clinician or chair would offer to meet with the family to go through the outcome, findings and any learning derived from the finished review.

Yours sincerely

Jane Davidson
Chief Executive