PE1604/P

Petitioner Letter of 25 November 2016

The suicide rate of patients whilst on Compulsory Community Treatment Orders in Scotland is far too high, and it is clear that this system needs to be improved. SAMH states that: 'There were 31 suicides in patients subject to a compulsory treatment order in the community between 2007-2014. Forty-two per cent of those who died were not receiving care as intended despite compulsory treatment order powers.' Most of the responses appear to be following the Care Plan Approach. NHS Western Isles, however, states that care plans for those on Compulsory Community Treatment Orders would detail trigger/intervention points whereby someone who is deteriorating is assessed expeditiously by the clinical team and SAMH: 'would expect that frequent non-engagement with services while on a community CTO would lead to follow-up action.' My family and I believe that there should be a more consistent approach across health boards to ensure that these extremely vulnerable patients are properly monitored by health care professionals and that this should be mandatory.

Some of the health boards consulted, for example, Orkney and Shetland, believe that a comprehensive review of patients who die by suicide whilst on Compulsory Treatment Orders, should involve relatives as much as possible, to the point of, in the case of Shetland, promoting that an inquest should be held.

Most of the health boards state that they do carry out reviews in accordance with Health Improvement Scotland guidance, but, as some health boards have their review meetings chaired by independent consultants from other health boards, and others are chaired internally, with one health board having the meeting chaired by someone who is not involved in mental health care, there is no uniformity in how the review process is carried out to try to ensure objectivity.

Health boards also seemed to differ widely in who is invited to their review meetings and very few health boards involve relatives in the actual review meeting, tending to talk to them before and after the meeting has taken place, but NHS Dumfries and Galloway however, seems to employ a model of good practice, as, although they do not invite relatives routinely, they: 'have involved families at the actual review meeting in a minority of cases. These occasions have broadly been successful, and have been positive experiences for those involved.'

Some of the health boards appear to be fearful that blame may be apportioned to employees if relatives were to attend the review meetings, but this can lead to lack of accountability within the service and a very biased version of events being presented, which can then be reported subjectively, widely circulated and accepted as a true version of events. (After four years, I have finally received - just a week ago - a report commissioned by NHS Tayside about my son's care, which is inaccurate, incomplete and extremely subjective – despite a request from my MSP to provide it to me in June 2015, and after the COPFS and SPSO have completed their investigations Our experience demonstrates that, once an 'official' version of events is documented, it becomes impossible to challenge that version.)

NHS Dumfries and Galloway, however, invites relatives: 'to meet with the chair of the review, the patient's treating psychiatrist, or both, to discuss the findings of the review and the recommendations for action, and also how these recommendations are going to be implemented. The family members are also offered a non-redacted copy of the review. If the family member has any comments or issues around the content of the report then the report will be modified to incorporate the changes and the family member will receive a copy of the modified version.'

NHS Tayside states that: '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.' My family and I believe this would be an excellent idea, as trying to help prevent other families from having to suffer the loss of loved ones to suicide is our ultimate aim.

None of the health boards made any reference to the time scale for Critical Incident Reviews to be completed. Although this was not requested by the Committee, I have spoken to Health Improvement Scotland about this, and they suggest a three-month period, but that is not mandatory, whereas Scottish Government Minister for Mental Health, Maureen Watt, outlines the COPFS procedure for dealing with relatives of the deceased, which 'sets out what information they may expect to receive about death investigations which may lead to criminal proceedings or FAIs, and in what timescale.'; she also gives details of their commitment to a 'Family Liaison Charter' to ensure that relatives are kept up to date with the progression of their investigation, within specific time limits. I believe this will lessen the impact of distress on family members, as they will not be subjected to the uncertainty of not knowing when the investigatory process will be complete, and I also believe that a similar time scale process could be applied to an inquest-type system in Scotland.

Some of the health boards have commented that relatives may be distressed by attending review meetings or a potential inquest-type system, but I note that the health boards who do involve relatives in their proceedings do so by invitation, and I cannot see why an inquest system could not be conducted in a similar manner.

All deaths in Police custody are subject to a FAI, without differentiation, yet those who are opposed to scrutiny of deaths by suicide in a similar fashion argue that each case is different – surely this also applies to deaths in custody?

NHS Lothian believes that this petition can 'build on the work of the team at Health Improvement Scotland, and the Health and Safety Executive to highlight some of the issues both around suicide itself' and 'give a central role to the voices of families and carers'. They also consider that this is 'a real opportunity to consider who is involved in reviewing suicides locally, what the outputs and outcomes are from each suicide review, and how, where and with whom the learning from reviews can be taken forward' and they would 'welcome an extension to the number of suicides that are reviewed, and to the staff teams involved in the review process and that learning from reviews to be disseminated widely and the lessons and themes from reviews to be available across Board areas. This is what I believe all health boards should be hoping to achieve and there is an amazing opportunity within the review of Section 37 of the 2015 Mental Health Act to enable this to happen,

As the mother of a dearly loved son lost to suicide, I cannot therefore see how my proposal for an inquest-type investigation, chaired by an independent body, to ensure that all the relevant facts surrounding death by suicide can be revealed, discussed, reviewed and learned from, for those lost to suicide in Scotland could do anything other than be beneficial to relatives, health boards and society in general, if suicide in Scotland can be further prevented or reduced by this means.