PE1604/X
Minister for Mental Health submission of 20 June 2017

Thank you for your letter regarding petition PE1604, and the opportunity to respond to the issues raised at the meeting of the Public Petitions Committee on 11 May 2017.

There is a requirement for the review under section 37 of the Mental Health (Scotland) Act 2015, where practicable, to consult the nearest relatives of patients whose deaths are to be covered by the review, and any other persons considered appropriate. Meaningful engagement with families will offer an opportunity to gain valuable insight to what families need from review processes. As part of this consultation process the review will include the views of the petitioner.

Given the complex nature of suicide there is no target, as such, for the 'commencement and completion of suicide reviews'. There is guidance on adverse event review timelines provided in Healthcare Improvement Scotland's national framework for learning from adverse events to which all NHS boards' adverse events policies are aligned. The Scottish Government provides funding to Healthcare Improvement Scotland to operate the Suicide Reporting and Learning System (SRLS); this system supports NHS boards to learn from and improve the way that suicide reviews are carried out and to help to reduce future risk.

The Suicide Reporting and Learning System programme supports NHS boards to meet the timescales for the review processes set out in their adverse event policies, the expectations subsequently set out for families and carers, and to ensure progress with reviews is communicated. We know from the reports received by the SRLS, that for a variety of reasons, the process of carrying out the review, writing the report and responding to recommendations may need to take longer than the 3 months, including the importance of taking into account the complex support, engagement and communication needs of families and carers.

It is important that there is regular and consistent communication with families and carers, including when the process has been delayed and the reasons why. Healthcare Improvement Scotland ensures that the Mental Welfare Commission for Scotland has been notified of relevant cases where further investigation may be required.

The SPSO operates independently and always checks with organisations to make sure that they have done as recommended by its investigations. The SPSO expects to see firm evidence that its recommendations have been implemented. If they have not, SPSO will go back to the organisation until it is satisfied that its recommendations have been implemented. The Scottish Government expects NHS boards to co-operate fully with SPSO investigations and act on their recommendations.