**PE1604/S**

Mental Welfare Commission Letter of 19 January 2017

1. Thank you for your letter of 9th December, seeking our views on the actions called for by the above petition. We are grateful for the opportunity to comment.

2. Firstly, I would like to acknowledge the courage and determination of the petitioner, in her efforts to ensure that lessons are learned from the tragedy experienced by her, and by hundreds of other families every year.

3. I will respond to the two specific proposals in the petition, and make some comments on other issues which have been raised.

*The review to be established under section 37 of the Mental Health (Scotland) Act 2015[1] should be expanded to include patients who have been released from hospital or are being treated under a community based Compulsory Treatment Order.*

4. We are sympathetic to this proposal, which could be readily incorporated into the terms of reference of the s37 review. As has been acknowledged in earlier discussions, the Government has already agreed to include deaths by suicide occurring while patients are in the community under suspension of detention, in response to a recommendation by the Commission in our investigation into the death of Ms MN[2].

5. In relation to community-based Compulsory Treatment Orders, their situation is not greatly different to patients under suspension of detention. They are clearly under the care of the NHS. The nature of a CTO is that aspects of that care have been imposed without the consent of the patient.

6. This does not of course mean that the NHS can prevent every suicide of a person subject to compulsory care in the community. But it does raise legitimate issues for review, particularly given that Article 2 of the ECHR imposes a positive obligation on the State to effectively investigate any death for which the State may have some degree of responsibility[3].

7. In relation to suicides by people who have recently been discharged from hospital, there may well be cases where the decision to discharge the patient, or the care following discharge, are issues which should be reviewed.

8. Some timescale would be necessary to define which cases involve patients who have been released from hospital, and so would fall within the scope of the review. The National Confidential Inquiry into Suicide and Homicides by People

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[1] Into 'the arrangements for investigating the deaths of patients who, at the time of death, were detained in hospital by virtue of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995 or admitted voluntarily for the purpose of receiving treatment for mental disorder'

[2] Available at http://www.mwcscot.org.uk/media/244679/ms_mn_investigation_summary_report.pdf. See Recommendation 8

[3] See Chapter 4 of the EHRC Inquiry – Preventing Deaths in Detention of Adults with Mental Health Conditions published February 2015 https://www.equalityhumanrights.com/en/publication-download/preventing-deaths-detention-adults-mental-health-conditions-report

with Mental Illness[4] monitors suicides by people who have been in receipt of mental health care within the last 12 months, and a similar time period of in-patient care might be reasonable for the s37 review.

9. It is important to note that the s37 review is not specifically about suicides, but about all deaths in a particular setting. However, the investigation of suicides is obviously an area of particular concern, and we would suggest that any extension of the remit of the inquiry beyond hospital settings should be restricted to suicides.

*There should be a separate inquest system for all suicides in Scotland, which should be led by an independent body and should incorporate a system of mandatory actions to be taken where failure of mental health care systems or individuals operating within these systems is established.*

10. We have more difficulty with this proposal. The inclusion of discharged patients and patients subject to a community-based CTO is a modest but important adjustment to the review's scope; but this wider proposal would hugely expand its remit, and raises fundamental issues about the investigation of deaths in Scotland. Many of these issues were considered at length during the passage of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

11. As has been noted in previous correspondence[5], the great majority of people who complete suicide are not under the care of mental health services, so the issue of possible failures by mental health care systems would not arise. (There will be exceptions, where help may have been sought but not given, but it is not likely that this applies in the majority of cases.) It is hard to see how this wider issue could be adequately incorporated into a review which was set up by Parliament specifically to look at how deaths of patients using mental health services are investigated.

12. Scotland does not have a system of inquests, and Parliament decided in 2016 to maintain the longstanding role and discretion of the Lord Advocate and Crown Office in investigating deaths. Establishing a new independent body would be a major and complex issue.

13. Also, the 2015 Act requires that the s37 review by completed within 3 years of the commencement of that section, i.e. by 24th December 2018. We are already 16 months from the Act receiving Royal Assent, and the review has yet to be established. We fear that such a major change will both delay the commencement of the review, and make it less likely that it can do its important work in the time available.

14. That is not to say that the review itself could not consider an inquest system. But we feel it is better to start the review broadly as agreed by Parliament, and allow those conducting the review to consider all these issues as they see fit.

[4] http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

[5] See, for example, SAMH letter of 14 October 2016, which cites the National Confidential Inquiry statistic that 31% of people who died by suicide in Scotland had been in contact with mental health services in the 12 months prior to their death. A large proportion of that 31% is likely to have been people who had used out-patient rather than hospital services.

*Other issues arising*

15. The petitioner is right that we should do more to ensure that lessons are learned from suicides, as part of a wider and continuing drive to reduce the level of suicide in Scotland. But we suspect that more may be learned by targeted research into trends and common factors. Individual inquests risk being fragmented and unfocussed, and may not be the best way to identify the substantial changes that will make a real difference.

16. We have not been directly involved in Ms Matheson's case, so cannot comment on her experiences with NHS Tayside or the COPFS. However, we would say that the experience of long delays before a decision is made on whether to hold a Fatal Accident Inquiry is not unique. We are sure that the petitioner is right that delay in making decisions about such matters places a severe burden on families.

17. We are aware that the Crown Office has done much in recent years to improve its liaison with the families of people who commit suicide. We have no doubt that they wish to continue to improve. We would support further efforts by the Crown Office and other agencies involved in investigations and reviews (including Healthcare Improvement Scotland and the Mental Welfare Commission) to improve the current system of reviews and investigations, particularly with respect to the participation of relatives.