PE1604/T

Petitioner letter of 16 February 2017

In the Mental Welfare Commission response - para.11 - I note that there are no specific details or statistics to support the suggestion that "possible failures by mental healthcare systems would not arise" or that the majority who die by suicide are not under the care of mental health services. In Para. 12, they believe the instigation of a new independent body would be a "major and complex issue", as is suicide! There are far too many deaths by suicide; it is a major killer of our young people, in particular, and this will not be remedied without a major change to the current system.

The Mental Welfare Commission response does state in Para. 14, however, that the review could consider an inquest system, and, in Para. 16, that long delays for FAI decisions to be made are "not unique": therefore, it is time for change.

Healthcare Improvement Scotland responded by raising concerns about duplication of investigative procedures, but an inquest system need not duplicate, but should replace existing practices that do not work in the way they are supposed to: we have not had a completed SCEA report that fully covers my son's final episode of care and we were not given a copy of the NHS Tayside-commissioned independent report until after the SPSO time-barred our case due to lengthy delays by the COPFS and NHS Tayside, and the COPFS did not obtain an independent report until more than three years after my son's death. This is absolutely shocking! Families are caused far more distress by being put through a lengthy, ineffective/inefficient process rather than an inquest.

I am pleased to see that the Scottish Government will now include reviewing the arrangements for investigating deaths of those who die by suicide whilst under Compulsory Community Treatment Orders under the terms of section 37 of the Mental Health Act Scotland 2015 and that the review will engage with and take account of the views and experiences of families, within a collaborative approach to dealing with mental health and suicide prevention strategies, and appropriate mechanisms for monitoring and evaluation, as, in our case, we feel very badly let down by NHS Tayside being able to decide autonomously whether to produce an appropriate SCEA report or not and being able to delay matters and withhold reports and information from us, despite even requests from my then MSP, Christian Allard.

My family and I wish to offer our thanks to the Scottish Parliament for the time and consideration afforded to this issue, and we will be extremely grateful if more lives can be saved and families can be spared from enduring these horrific losses of loved ones to suicide.