OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 4 April 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 4 April 2019

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PUBLIC PETITIONS COMMITTEE

7th Meeting 2019, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con)
*David Torrance (Kirkcaldy) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rhoda Grant (Highlands and Islands) (Lab)
Monica Lennon (Central Scotland) (Lab)
Karen McKeown

CLERK TO THE COMMITTEE

Sarah Robertson

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Public Petitions Committee

Thursday 4 April 2019

[The Convener opened the meeting at 09:30]

Continued Petitions

Countryside Ranger Services (National Strategic Framework) (PE1678)

The Convener (Johann Lamont): I welcome everyone to the seventh meeting in 2019 of the Public Petitions Committee. There are two items on this morning's agenda: first, consideration of one new petition and secondly, consideration of three continued petitions. I intend to begin with agenda item 2, which is consideration of the continued petitions, and then go back to the new petition once we have dealt with them.

PE1678, on a national strategic framework for countryside ranger services in Scotland, has been lodged by Ranger Robert Reid on behalf of the Scottish Countryside Rangers Association. The clerk's note provides a summary of the submissions that we have received since our consideration of the petition in October 2018. The Scottish Government repeats its acknowledgement of the services that Scotland's rangers provide, but its position has not changed in so far as it still believes that it is a matter for local authorities to decide how to distribute funds. Moreover, in response to the committee's specific question on the use of returns and reports from local authorities to provide an overall picture of the level of ranger services throughout Scotland, the Government says that, although such reports can be "useful", local authorities are under no obligation to gather and collate such information.

In its submission, Scottish Natural Heritage provides a full note of the meeting of the ranger development partnership held in January 2019. It refers to that meeting as

"positive ... with much lively discussion",

and it adds that, at a subsequent meeting with the Convention of Scottish Local Authorities, there was agreement on

"the need to raise awareness ... of the profile of ranger services in local authorities".

It considers that, rather than focusing on

"the impact of individual budget decisions",

the profile of ranger services can be improved by looking at the benefits of those services

"across a range of local authority activity".

Scottish Natural Heritage also refers to a positive meeting held between its chair and the Scottish Countryside Rangers Association that concentrated on ways to move rangering forward. That includes a "2030 vision" to look

"beyond the current period of significant change/budget uncertainty"

with a further meeting to be held early next year to review progress. SNH states that, during the next 12 months, it will work with the SCRA and the ranger development partnership to refresh

"the policy framework for rangering in Scotland";

review

"options for reporting on ... ranger services and the benefits they provide";

co-ordinate

"the development of a training and development programme";

and support

"the establishment of new junior ranger programmes."

The petitioner, on behalf of the Scottish Countryside Rangers Association, has provided a further submission that, as the clerk's note identifies, sets out the SCRA's aspirational outcomes from the petition, including setting up a working group to identify any reasons for what it refers to as

"the significant decline in Ranger Service posts";

updating the strategic framework, which is at the core of the petition; and securing

"the future funding of Ranger Services".

The submission makes it clear that the SCRA does not consider SNH to be

"a suitable agency to lead"

any working group, and adds that it believes that the ranger development partnership

"does not carry sufficient authority and lacks the clear leadership required to look objectively at the various issues."

Paragraph 12 of the clerk's note identifies other issues of concern highlighted by the SCRA. Do members have any comments or suggestions for action?

Angus MacDonald (Falkirk East) (SNP): It is a matter of concern that the SCRA does not have a lot of confidence in SNH, although it is perhaps understandable, given the history of the issue. It is also a bit concerning that COSLA did not manage to get along to one of the meetings that was arranged, although it seems to be engaging now with regard to preparing a paper with SNH on the future of ranger services.

A wider issue that has been captured by the rangers in the past is preventative spend. It is something that the Parliament and the Government should look at, because, in that respect, the demise of the ranger service certainly seems to be counterproductive. I am keen that we organise a round-table discussion on the way forward, to which we could invite all stakeholders, at some point in the not-too-distant future.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): I agree with Angus MacDonald. Given that the SCRA has said that it does not believe that SNH would be a suitable agency to run the working group, we ought to give SNH the opportunity to respond. We should also seek responses from other stakeholders, particularly COSLA, on the issue of funding, the postcode lottery and the fact that there are ranger posts that have still not been filled. Many questions have been raised. We have received highly informative submissions from a number of people, but we need to bring these people together so that we can drill down into the issues.

The Convener: Although it has been acknowledged that there has been a significant decline, the Scottish Government is still saying that the ranger service should be a matter for local authorities. That is problematic. Another small point that was made was that there used to be jobs that served as an introduction to becoming a ranger, but the fact that there is no longer a career path must lead to further decline in the longer term.

Do members agree that we should consider holding a round-table discussion? That would afford an opportunity to explore what the job is, why it is important, why there are challenges with sustainability and, if there is to be a group to bring folk together, which body should play the lead role, if SNH is not considered suitable. Is that agreed?

Angus MacDonald: It is certainly agreed. I hope that COSLA will be invited to the round-table session. We should also try to identify a local authority that still provides support for rangers and invite it to the discussion to give us a positive spin on the job.

Brian Whittle (South Scotland) (Con): I totally understand the Government saying that it is local authorities' responsibility to provide rangers, but surely it must still have an interest in understanding what is going on at that level. The ranger service cannot just be pushed to one side and allowed to decline in that way. I am sure that the Scottish Government must have an interest in the issue.

The Convener: In its submission, the Government has made it clear that it values the ranger service, but it still says that, as it has handed responsibility for the service to local government, it wants the situation to be resolved at local government level. There is a logic to that, but there is also a problem if the consequence is that the service is not sustainable in the longer term.

If we can agree to take evidence in a round-table format and allow such dialogue to happen, that would be very useful.

Rachael Hamilton: Do we need to agree on who we want to invite to that session? I note, for example, that our paper mentions the rebranding exercises of the National Trust for Scotland and Historic Environment Scotland, which are an important part of the inconsistency that there is concern about.

The Convener: With the committee's permission, I will take the authority to work with the clerks on a list of organisations to invite. We will make sure that we hear from a broad range of people who are available and willing to participate.

Medical Care (Rural Areas) (PE1698)

The Convener: PE1698, on medical care in rural areas, was lodged by Karen Murphy, Jane Rentoul, David Wilkie, Louisa Rogers and Jennifer Jane Lee. I welcome to the meeting Rhoda Grant, who is attending for our consideration of the petition.

At our previous consideration of the petition on 22 November 2018, we agreed to write to the Scottish Government and the Scottish rural parliament. As members will be aware, submissions from those organisations, as well as a response from Karen Murphy, have been received.

Issues have been raised about the transparency of the remote and rural general practice working group and the scope of its work. We have also recently received correspondence about a troubling development. The vice-chair of the Rural GP Association of Scotland has resigned from the working group, saying:

> "it is a committee decision that I should resign from the SLWG (Working Group), and for RGPAS to withdraw from further SLWG work ... We need to see more tangible and convincing commitment to addressing the issues affecting our members and our rural communities in Scotland."

Despite the questions that have been asked and the submissions that have been received, further scrutiny is required of the calculation of the Scottish workload allocation formula and the implications of the new GP contract. The most recent submission from the Scottish Government states the background to and the intentions behind the new formula, but the specific issues that the petitioners have raised are not addressed sufficiently. That lack of clarity appears to exist

both on this issue and on the other issues that the petitioners have raised.

Members will also note that two questions on the topic will be asked at general question time today. Gail Ross's question is:

"To ask the Scottish Government what steps it plans to take to re-engage the Rural GP Association with its Remote and Rural General Practice Working Group",

while Donald Cameron's question is:

"To ask the Scottish Government what action it is taking to support GP practices in rural areas."

Do members have any comments or suggestions for action?

Brian Whittle: At the moment, the Health and Sport Committee is doing a piece of work on the GP contract. It just so happened that we had a rural national health service board in last week, and when I asked how the contract had been accepted by its GPs, the board was not as candid as I would have liked it to be, but it did say that, although 70 per cent of respondents were positive about it, it was 70 per cent of 30 per cent, as only 30 per cent of GPs replied. The inference seems to be that there is an issue with the GP contract in that rural area.

It would be good to invite the Cabinet Secretary for Health and Sport to the committee and ask for her opinion, and cross-referencing with the work that is being done in the Health and Sport Committee would certainly help.

The Convener: Okay. I invite Rhoda Grant to come in at this point, as she has been working with the campaigners.

Rhoda Grant (Highlands and Islands) (Lab): As members know, I cover the Highlands and Islands, and this is a really big issue in my area, given the number of rural GPs. I do not have the figures with me, but I understand that when rural GPs were polled, most were against the contract, with only a very low number supporting it.

The new contract does not recognise the differences in how people operate in rural areas. For example, there can be higher numbers of home visits, because people are being kept out of hospital. Instead of elderly people being sent away, they get more hands-on care. Moreover, GPs are responsible for local hospitals in places such as Campbeltown and Golspie, so they have additional—and specialist—work that is not recognised in the contract. The way in which the contract was drawn up has really impacted on the morale of rural GPs, who often work above and beyond and do not feel that they are valued.

The contract also flies in the face of the work on tackling the health inequalities that we all recognise. It is working neither for rural areas, nor for deprived urban areas. Because it looks at the number of appointments that are available and at the age profile of patients in a practice, the 10-year life expectancy gap that we all know can exist in deprived areas means that those practices are getting less, given that their patients do not live as long as patients in other areas. The contract seems to have moved funding in a direction opposite to the one that it was understood that funding needed to move in.

To that extent, the whole contract needs to be looked at, but it certainly needs to be looked at with regard to rural GPs, given our struggle to fill posts. If the contract goes unchanged or there are no additional deals for rural practices, the situation will get worse, and the cost of locums is already extremely high for rural health boards.

Rachael Hamilton: There seems to be some disagreement here. The Scottish Government's submission of October 2018 states:

"The new ... Formula gives greater weight to older patients and deprivation".

I, too, represent a rural constituency, and I am concerned by the number of GPs who have fed into the Health and Sport Committee's inquiry, as well as the high number of people who are dissatisfied with the Scottish workload allocation formula. The petitioners and the Scottish Government seem to disagree in what they are saying, and we need to tease that out somehow.

09:45

The Convener: As I recollect from our previous discussion of the petition, more money is coming into the system, but money is also being taken out of poor communities and rural areas, which seems counterintuitive. I do not know whether the system takes account of the number of appointments; after all, as we know, people in deprived areas bring with them more problems than just the problem with which they present—there can be comorbidities and other issues.

I was struck by how, in one of their submissions, the petitioners expressed a frustration that the significant questions that they had flagged up had simply not been answered in the Scottish Government's submission. There seems to be a process issue here. I do not pretend to understand it properly, but the issue seems to be that the technical advisory group on resource allocation was not consulted, which would have been the normal process. We will want to explore why that was the case, and it might be useful to bring in the Cabinet Secretary for Health and Sport so that we can do that.

I hear what Brian Whittle has said about looking at the contract, but there seems to be a specific issue about the subset of rural GPs. In a big city

practice, other staff can do various things for GPs so that they do not need to do them, but, in a rural practice, there is not necessarily the range of people to do those other jobs, which increases the pressure on GPs.

Interestingly, the petitioners have flagged up the issue of rural proofing and how that feeds into the Government's thinking to ensure that it understands what rural or island proofing means in practical terms when such decisions are made. When the Government makes provision for a service right across Scotland, how does it ensure that it considers deprived urban areas, such as those in my region, and rural, remote and fragile areas?

There are two things that I am getting a strong sense of. First, because the short-life working group was not allowed to visit the contract, the Government did not respond to the question that the petitioners raised. Secondly, the petitioners feel that their questions are not being answered, which is quite a big issue.

Brian Whittle: Following on from what the convener and Rhoda Grant have said, one thing that has come out early in our investigation is that it is much less likely for a rural GP to have a team that includes a physiotherapist, a mental health expert and a pharmacy. There is without question a big disparity in that regard, and it is an issue that is not being addressed in the contract.

The Convener: Obviously, people will make their case during the negotiations, but even with special pleading, we will have a major problem if we do not attract GPs to rural areas. Some of the submissions make that point very strongly, because there will be consequences for the sustainability of rural communities.

Rachael Hamilton: The petitioners say that reassurance has been limited and that there could be knock-on effects for the recruitment and retention of GPs. Rural practices are already experiencing those difficulties. After all, GP's patient lists are increasing, simply because the number of GPs being attracted to such areas is, in some cases, non-existent.

The Convener: If the philosophy is to focus on primary care to ensure that people do not need to jump immediately to acute services, it is important that GP provision is sustainable.

Angus MacDonald: We should not forget that rural GPs had significant concerns even before the contracts were introduced. Given the concerns that have been raised not only by the petitioners, who have expressed frustration in this respect, but also by RGPAS, which stated in its submission that there are serious concerns that the GP contract is not fit for purpose in rural communities, the Government needs to answer a number of questions, and we should consider inviting the Cabinet Secretary for Health and Sport to give evidence on the issue.

The Convener: Do members have any final points?

Rhoda Grant: I just want to emphasise your point about the working group, convener. It was set up to sort the matter out, but if the people on it have no confidence about what is going to happen, it is important that that fact is brought to the cabinet secretary's attention and that we can see where we can go to ensure that the problem is solved.

The Convener: Do members agree to invite the cabinet secretary to provide evidence on matters raised in the submissions that we have received? We would hope to do that speedily, as we realise that this is an on-going issue that, if not resolved, will have consequences for broader health provision in rural areas.

Members *indicated agreement.*

The Convener: I thank Rhoda Grant for her attendance.

Wildlife Crime (Penalties and Investigation) (PE1705)

The Convener: Our final continued petition is PE1705, lodged by Alex Milne, which calls for a review of legislation relating to the investigation of, and penalties applicable to, wildlife crime in Scotland.

The clerk's note refers to the Scottish Government's submission, which states that it intends to bring forward legislation to increase penalties relating to wildlife crime. The petitioner has welcomed that intention and has indicated that he will respond to any consultation that the Government brings forward to inform any primary or secondary legislation.

The petitioner has also provided what he considers to be potential solutions to the current difficulties in presenting video evidence in the context of wildlife crime, and he notes that the challenges were recently discussed as part of the Environment, Climate Change and Land Reform Committee's consideration of the "Wildlife Crime in Scotland: 2017 Annual Report".

Do members have any comments or suggestions for action?

Angus MacDonald: The petitioner has rightly highlighted the issue of video evidence. The ECCLR Committee, of which I am a member, has been looking at this issue for some time, and it has heard that video evidence has, for various reasons, not been used, which is a matter of concern. Given that the ECCLR Committee

recently took evidence on the wildlife crime annual report for 2017—we are always a year or sometimes two behind with the annual reports—given that the issue of wildlife crime has been very much on that committee's radar since it was formed, and given that its predecessor, the Rural Affairs, Climate Change and Environment Committee, took the issue extremely seriously, too, there is a good argument for referring the petition to that committee so that it can be given the time and concentration that it deserves.

The Convener: As there appear to be no other views, I thank the petitioner for his substantial response to help with our consideration of the petition. Do we agree to refer the petition to the ECCLR Committee for its consideration as part of its on-going work on wildlife crime and for any potential scrutiny of relevant legislation in this session?

Members *indicated agreement.*

The Convener: I again thank the petitioner. I think that significant progress has been made as a consequence of this petition, and the petitioner himself will be able to follow the ECCLR Committee's continuing consideration of this issue.

I suspend the meeting briefly.

09:54

Meeting suspended.

09:55

On resuming—

New Petition

Mental Health Services (Review) (PE1716)

The Convener: We turn to consideration of a new petition. PE1716 calls for a full review of mental health service provision across the national health service in Scotland to ensure that policy and practice are delivered consistently across the country. I welcome Monica Lennon to the meeting for this item.

The petition was lodged by Karen McKeown and Gillian Murray. The background papers explain the circumstances that led to the petition. Members will be aware that those circumstances have been addressed in the Parliament at First Minister's question time, and that they have received significant media coverage. The note that has been prepared by the Scottish Parliament information centre and the clerks provides data and statistics and outlines the range of strategies and action plans that the Scottish Government is taking forward. Members will recall that, at our previous meeting, we took evidence from the Minister for Mental Health. At that meeting, the minister restated her announcement of the independent overarching review of mental health and incapacity legislation.

For our consideration of the petition, we will take evidence from one of the petitioners, Karen McKeown. Welcome, Karen, and thank you for attending. Would you like to make an opening statement?

Karen McKeown: I thank members for considering our petition and for giving me the opportunity to be here today. I also thank the Public Petitions Committee clerks for their sympathetic care and support during the process.

Luke was my best friend. He was my partner. He was my rock and soul mate. He was a devoted father to our two wonderful children. Luke was a hard-working, kind and generous person. Tragically, he took his own life, and I feel it was a preventable death.

During December 2017, Luke began to act totally out of character. I started to notice that he had become mentally unwell, and I was desperately concerned for his safety. He began to have visual and audio hallucinations, and he was unable to sleep. That lasted for over three weeks. I became more and more concerned that I was unable to keep him safe and he was unable to keep himself safe.

One day, Luke left the house and, when he returned, he was acting very odd. He told me that the voices in his head were going to kill him, like murder, and it would be put down to suicide. My concerns grew, and Luke agreed that I could call NHS 24. They advised me that, if I was concerned for my own safety, I should call the police or take Luke to accident and emergency. The first time that I took him to accident and emergency was on 29 December 2017. Between 23 December and 29 December, we tried in vain to get help from the hospital on two occasions—the community psychiatric nurses and addiction services. I begged every service to help us or point us in the right direction to get support, or even just to give him medication to ease his symptoms but, every time, we were turned away and abandoned. I also called NHS 24 on a further three occasions.

We had the added issue that Luke had been removed from his GP practice earlier that year. I phoned every GP surgery in our area and asked them to help us and begged for appointments. I even begged my own GP surgery to take Luke on as a temporary patient but, as it was the Christmas holidays, no practice was taking on new patients. With every professional I spoke to, I made very clear my concerns that Luke was planning to end his life. Time after time, I pleaded for help—I was begging. I knew from his odd behaviour that Luke was unable to keep himself safe any longer and my concerns grew, but every time that we sought help we were dismissed and turned away.

On 29 December 2017, I woke up at 2 am to find Luke hanging from my stairs, feet away from where our children were sleeping. The events of that night have shattered my world. I will relive that memory for the rest of my life; it will never leave me. My children have been left without a father to care for them and guide them throughout their lives. My children and I, our wider family and the local community have felt the loss.

10:00

After Luke's tragic death, I made a formal complaint. I was shocked to read that the findings said that Luke had shown no signs of mental illness and was not suicidal. The report concluded that staff had followed the correct procedures, even though, on every occasion that I dealt with a professional, I voiced serious concerns about Luke being suicidal. Once again, I was told that correct procedure was followed in relation to not admitting Luke to hospital. If that is the case, are current procedures fit for purpose? Why is a fatal accident inquiry not automatically carried out to ensure that lessons are learned?

I want the mental health service to be reviewed, to ensure consistency and quality in our NHS. Luke's case is not unique—far from it. The same failures are happening up and down the country. Lessons must be learned. Crisis support needs to be available 24 hours a day, 365 days a year. Most important, family concerns must be listened to and not dismissed. We understand those who we live with; we know when something is just not right.

Nothing that I can do will ever bring back Luke. As his partner and mother to his children, it is my duty to continue to campaign for change. We urgently need a mental health service that is fit for purpose. I need to look my children in the eye and tell them that their dad did not die in vain.

Luke's legacy will prevent other families going through the horrendous pain and distress that we have gone through and will continue to go through. We need action now, for everyone who has lost their lives to suicide, including Luke.

The Convener: Thank you—your statement is very much appreciated. Gillian Murray, Karen McKeown's co-petitioner, is not able to attend today's meeting, but has provided a statement, which has been circulated to members. I have her permission to read it out:

"Most of us are aware of David Ramsay's story; David Ramsay, my uncle, was failed by NHS Tayside and took his own life following a breakdown which resulted in psychosis. Despite 3 suicide attempts in 4 days, David was sent home after his second emergency assessment at Carseview Centre and consequently took his own life.

Thankfully, the Scottish parliament listened to me last year and an inquiry is under way into NHS Tayside mental health services due to the sheer volume of similar cases to David's.

What has struck me from my campaigning is that these mental health failures—whilst they seem to be more concentrated at NHS Tayside—are not unique to Tayside, the same failures are repeated throughout Scotland and most concernedly, no lessons ever seem to be learnt.

I do not want another family to go through this pain. I do not want to become another statistic myself.

I cannot be there in person today because I am now unwell, due to the NHS failures which cost my uncle his life. I have been diagnosed with Post Traumatic Stress Disorder. The impact on my life has been enormous.

I have had zero help from the NHS (despite working and paying into the system) other than a repeat prescription of medication. How can it be acceptable that my uncle was failed and now I am being failed?

Why are no lessons being learnt? Why is the ripple effect allowed to continue? Why is it a postcode lottery whether you have access to a mental health service that is fit for purpose? Why are bereaved families having to campaign and fight for parity of esteem and for justice?

It cannot be right that a prisoner who takes their life in jail receives an automatic Fatal Accident Inquiry, yet patients, under the 'care' of the NHS are taking their lives in a 'secure' psychiatrist ward yet no Fatal Accident Inquiry takes place."

We thank Gillian Murray for her statement.

We will now move to questions, to explore some of the issues that Karen McKeown has highlighted. We will then consider what we want to do with the petition. We appreciate just how difficult and personal this is for you, Karen.

You have highlighted some of the things that have been done in relation to your partner's case, including the fact that Monica Lennon raised your concerns at First Minister's questions. Some of what has happened has been reported in the media, and I know that people will be familiar with the background to your petition. You indicated that you had a meeting with the Minister for Mental Health. Will you say a little bit about that? When was it? Has there been any follow-up to the meeting?

Karen McKeown: I met the minister early in October last year. She listened to what I have just told the committee, but that was all that she did. There was no follow-up or action. Nothing else came out of the meeting apart from the fact that the minister listened to me. That is all that I can really say about it.

The Convener: Okay. Thank you.

Brian Whittle: Good morning, and thanks for giving evidence to us.

In your petition, you and Gillian Murray state that your loved ones

"asked for help a number of times"

and that your families "expressed concerns", but those concerns

"were dismissed and no help or support was offered".

The word "dismissed" has strong connotations. How did the NHS staff—

Karen McKeown: They dismissed us. They did not even give us medication. When I asked them whether they could give medication to ease Luke's symptoms, they dismissed the fact that he was mentally unwell altogether. According to them, he was not suicidal or mentally unwell, and there was nothing wrong with him—he was a healthy man. That is why I feel that I was dismissed. I feel very strongly that Luke's concerns, my concerns and the whole matter were dismissed.

Brian Whittle: For clarification, the NHS staff you saw did not recognise any issues.

Karen McKeown: No. They became quite confrontational when I told them about my concerns. I came to the situation from a nursing background. I have some understanding of mental illness, I have done the applied suicide intervention skills training, and I have safeTALK training. Everything that I learned in that training told me that there were severe warning signs. When I tried to explain that to the staff, they just dismissed it. According to them, Luke and I did not know what we were talking about, and he was not mentally unwell.

Brian Whittle: Outside the healthcare service, there are third sector organisations that can potentially help. Did you seek help or get any feedback from them?

Karen McKeown: When I was researching and trying to find people to help us at that point, I could not find anything that was available. Since Luke's death, I have found some amazing organisations, such as FAMS—Families and Friends Affected by Murder and Suicide—and Chris's House. There are amazing organisations out there, but I did not know about them at the time.

I brought up that issue at the suicide review. I said that, if the NHS staff could not help us, why did they not point us in the direction of Chris's House? It is not even a mile away from Wishaw general hospital. How could they not point us in that direction? I was told that they do not endorse charities—that they cannot advocate them.

Brian Whittle: That is a point.

Karen McKeown: I was disappointed myself.

Brian Whittle: I asked that question because I have a constituency case that is exactly the same as this case, and it has been difficult to find services. There are fantastic local services, but it has been difficult to point people in their direction.

Rachael Hamilton: Good morning, Karen, and thank you for telling us your story. In your petition, you say that the assessment tools are inadequate. Will you expand on that a little? You have spoken to Chris's House and FAMS. Do you believe that they share the same views?

Karen McKeown: I feel that the assessment tools are lacking. In the investigation, it was found that all the risk assessments were apparently carried out and they were all in place for Luke, according to the NHS. However, the assessment tools should have recognised that he was suicidal, just as I recognised that he was, so they miss key aspects. Some of the questions that the assessment tools ask do not get to the root of the problem. They skim about the issues, and the most serious questions are missed and are not highlighted. That is where the problem falls.

There needs to be a generalised system so that social workers, the health organisation and the justice team all put their risk assessments into one central system. Currently, they all have their own systems. Risk assessments that were carried out on Luke in previous years said that he was at high risk of self-harming, but they were missed when we went to the accident and emergency

department. All the assessment tools need to be looked at in a holistic approach.

Rachael Hamilton: You are talking about quite a long timeframe from when Luke was first assessed. If staff in A and E had seen the risk assessment, they could perhaps have had more information, so that is what you are asking for.

Karen McKeown: Yes. I have his medical records and, having gone over the risk assessment that was done for Luke at the time, I do not agree with the answers that were given. They said on the risk assessment that he had not suffered a recent loss or bereavement, which was not true. He lost someone very close to him 13 weeks before he died, which obviously had a massive impact, yet that was missed on his risk assessment.

The risk assessments need to be addressed. They need to be more robust. When we were in the accident and emergency room, there was no way that the person Luke saw did a risk assessment in the time that Luke was in with him, because he was in for maybe 10 or 15 minutes. There was no way that he did a risk assessment, a safety plan or any of those kind of things. Nurses do those things after the patients leave, which is not good enough. They need to be done there and then. The timings on Luke's records show that his risk assessments were done a long time after we left accident and emergency.

Rachael Hamilton: Karen, you talked about Chris's House, which you found after Luke sadly died. When you speak to people in such circumstances, do they say similar things about the assessments and how they are not joined up?

Karen McKeown: A lot of organisations feel that the mental health system is failing. A lot of them try to get help for patients, even by contacting patients' services, and they feel as if they are up against it, too. It is not just me who feels like this; all the organisations feel the same.

The assessment tools need to be looked at and made more robust and patient centred. They are still running off the nursing model and they need to get away from that. It does not work and it has not worked for years. We need to change it. Those organisations feel the same way about that.

Angus MacDonald: You have also said that you want to see a review of crisis support services outside office hours. Who would you want to carry out or be involved in such a review? What are the main issues that should be looked at?

Karen McKeown: Mental health services need to be available 24 hours a day. At the present time, the majority of hospitals in Lanarkshire—certainly Hairmyres and Monklands hospitals—do not have psychiatrists in hospital after office hours, and they have a skeleton staff over Christmas or other holiday periods, so psychiatrists are not as available as they are during normal office hours.

I would like a central hub to be set up, so that not everybody goes to accident and emergency for mental health crises. Going to accident and emergency in itself can be quite distressing for the person in crisis because they are experiencing all that torment. Sitting in a busy environment is not the place for them. There needs to be a central hub away from the hospital; somewhere with mental health nurses where you can go in a crisis. All crises need to be brought into that, including drug crises, such as drug psychosis. The issue of mental health is so wide and, for all aspects of mental health, the crisis is getting worse.

Angus MacDonald: Your suggestion of a central hub certainly seems to be an ideal solution. We will make sure that that is fed in.

Do you know whether your concerns are shared by others such as the mental health support groups that you mentioned earlier? Have you discussed your concerns with them?

Karen McKeown: Chris's House was the first non-medical 24-hour help service out there and, if there was no need or market for that service, it would not be there. Chris's House is there 24 hours a day; you can call any time and get support. It has already started to go that way—a central hub is needed and that support needs to be spread more widely throughout Scotland, including in Lanarkshire.

10:15

There needs to be consistency across different health board areas because a lot of things that other health boards do, NHS Lanarkshire does not do, and there is no consistency from one health board to another—it can be night and day. There is a massive difference between the child and adolescent mental health services in Motherwell and Bellshill, for example. Some CAMH services do not even take over-16s. They shut you off, but the adult services do not take people on until they are 18, so there is a gap around crisis help that needs to be addressed.

Angus MacDonald: And of course there is the signposting issue that you mentioned—you were not aware of those services.

Karen McKeown: I feel that if we had been signposted to places such as Chris's House and FAMS and the other amazing organisations that are out there, that could have made a bit of a difference. There might have been somebody for Luke to talk to and maybe if they told the hospital that he was genuinely unwell, the people there would have listened better to somebody like that

than they listened to me. They did not listen to me and they did not listen to Luke. Luke told them that he was not well, he told them that he was hearing voices and he told them that he was not sleeping. Luke told them that he needed something to help him but they did not listen to him or to me. Maybe they would have listened to someone from one of those organisations.

David Torrance (Kirkcaldy) (SNP): Good morning, Karen. You have suggested that a fatal accident inquiry should be conducted if a person who dies by suicide has been in contact with mental health services in the previous three months. Can you expand on that suggestion, please?

Karen McKeown: The suicide review that NHS Lanarkshire carried out, and then the complaint investigation, gathered information but did not investigate what went wrong. They did not ask where Luke was failed. Was it the assessment tools? Was it the staff attitude? Where do the lessons need to be learned in this case?

I feel that the only way to gather that information is through a fatal accident inquiry. I also feel that if somebody has been in contact with mental health services so close to their death, there should definitely be a fatal accident inquiry. If somebody dies in prison, it is automatic to have an inquiry, so there should be consistency, and there should be an inquiry if somebody has been in the care of the NHS and has gone on to take their own life.

If there are inquiries into Luke's case and David's case, maybe lessons will be learned. Maybe if health boards start to learn lessons from previous suicides, it would save more people's lives. The idea of having a fatal accident inquiry is definitely a big one for me; I really want an inquiry for Luke so that lessons are learned.

David Torrance: Can the three-month timescale that you suggested be shorter or longer? What is your opinion?

Karen McKeown: I suggested three months because I knew that suggesting one year was unrealistic. I think that three months is perhaps more realistic, or even a month. Luke was in contact with mental health services the day before he died. We were at the addiction services on Thursday 28 December and he took his life at 2 am the next morning. Before that, on 27 December, we were up at accident and emergency. I do not know why an inquiry has not happened, when he was in contact with mental health services so close to his death and then went on to take his life. It baffles me. I feel that it should have been done automatically. That is why I am here today.

Monica Lennon (Central Scotland) (Lab): I feel privileged to be here today in support of Karen McKeown and Gilly Murray, their petition and their campaigning. They are both so courageous and I am full of admiration for them. Karen is not just a constituent now; she is a friend. I wish I did not know her so well—I am not as brave as her. Karen emailed me—we had been in touch about another issue, so it was not the first time I had heard from her—during Christmas recess in 2017. My office was technically closed—my staff were on holiday and I was the person monitoring the inbox. You joke that it will be a quiet time and, unless there is a flood or something locally, not much will be happening.

I checked my inbox early on the morning of 30 December, which was a Saturday morning, and found that Karen had emailed me at 7.42 am to inform me that Luke had died at home by suicide. That was really the start of my journey of working with Karen and her family. I am grateful to Karen's sister, who is in the public gallery today. I do not know how people can continue without immediate family support. It is such an injustice that Gillian Murray cannot be here today—she is struggling with her own mental health and is experiencing post-traumatic stress disorder.

In my office, we have spent a lot of time with Karen. We have been in touch with NHS Lanarkshire, and have progressed a formal complaint and gone to the ombudsman and so on. I am aware that nationally, in Parliament and in Government, lots of work is being done on different reviews and strategies. However, what Karen is talking about is not so much legislative change; partly, it is about culture change and attitudes. I know that Karen will not mind me saying that, having studied all the information about Luke's case and Karen's experience, I think that part of the reason why Karen was dismissed by professionals is perhaps because she is a young working-class woman—she was seen as just a mother and a partner who did not have the right insight and knowledge. As Karen has shown very powerfully today, if you love someone and live with a family member, you know that person inside out. She was able to see the changes in Luke's behaviour and she knew his medical history. The fact that we do not have integrated health and care information means that there are gaps, and people can fall through them.

Karen has touched on some of the points that I wanted to make. I am grateful to members for your considered questions. As a Central Scotland MSP, I know that there are inconsistencies in the service, even within Lanarkshire. However, as we know from Gillian Murray's testimony about Tayside, and as I am sure members will know from their areas, there is inconsistency right across the country.

I have a question for Karen, who has worked closely with Gillian Murray and organisations such as Chris's House, which brought her into contact with other families. At a national level, we say that people should ask once and they will get help. Are there areas in the country that we can look to for good practice because they have learned lessons and are doing this well? Alternatively, do we need a wholesale national approach through guidelines and providing the out-of-hours services that you have mentioned?

Karen McKeown: From the people who have contacted me through my campaign, I have not heard any positive feedback on the mental health service. My experience with my son is with CAMHS, but he went from a service that said that he did not fit the criteria to a new service, and I honestly cannot fault the CAMHS worker that he has now. She goes above and beyond. She is really helping Luke and she is there for me. That is the only good experience that I have had.

From what I have heard from the people who have spoken to me, I do not think that there are any services that are actually getting it right, apart from the charities. There are some amazing charities out there, such as Chris's House and FAMS. In our local area, a new one has just opened in a local high school. I would say that charities are the best way to go forward, because they are out there pushing and campaigning and they actually understand people. I do not feel that the NHS gets it.

Monica Lennon: I want to pick up on the ministerial meeting that we had. I was with Karen at that meeting, and we had high hopes. It is great that Scotland has a dedicated mental health minister and that the current minister is a mental health nurse with lots of experience in the health service. However, it is fair to say that Karen did not ask for that meeting to have a cup of tea and more sympathy, because there is plenty of sympathy around; she was looking for action.

In the meeting, we discussed the fact that there are additional barriers when it is perceived that someone has a substance misuse or addiction problem, or when they actually do. People are sent to different doors, and it is sometimes the case that people have to have their addiction resolved before they can access mental health treatment.

Could you say a bit more about that, Karen? When we have discussed the issue, you have said that there is a disconnect there. When we asked the Minister for Mental Health about it, she told us that she was working on the mental health and suicide prevention side of it and that the Minister for Public Health, Sport and Wellbeing was working on the addiction side of it. How do you feel about that?

Karen McKeown: The addiction side of things caused a lot of problems with Luke's case in particular, and I know that it causes a lot of problems for other people because, as you said, the addiction has to be addressed before their mental health will be dealt with.

In my opinion, addiction is a mental health issue. A person who is addicted uses a substance—whatever it might be—to black out what is going on in their head. It just adds fuel to the fire. Luke had stopped using substances three to four weeks before he died. He had addressed his addiction issues, although not fully. He was not taking substances when he died—his toxicology report showed that there was nothing in his system.

The addiction side of things is causing a lot of hassle. People are repeatedly told that they have to get treatment for their addiction, but where is the crisis centre for addictions? Where is the pathway programme for people who are coming off cocaine? Where is the recognition of the fact that there are psychological effects of the withdrawal process? It can lead to drug-induced psychosis, which is a mental health condition. Although the addiction needs to be addressed, it is a mental health issue that leads to mental health problems. That needs to be addressed more widely, so the committee will probably see me again in a couple of months.

Monica Lennon: You have talked about some of the attitudes that you have encountered. The majority of people who work in our health services are undoubtedly very compassionate and share the values of the NHS. However, there is still a lot of stigma around mental health, and particularly around addiction. Do you feel that that stigma is still a barrier for people who try to access services?

Karen McKeown: It certainly is. When you say that you are addicted to something, people automatically assume that it is heroin or alcohol. There is a wider range of addiction issues out there. The fact that the use of legal highs is on the up is going to lead to a phenomenal crisis in the coming years. There is the cocaine epidemic. If you throw a stone, you will probably find somebody who has taken it or who still takes it. The effects of addiction and the stigma surrounding it need to end, because it could happen to anybody. Mental health shows no discrimination; addiction shows no discrimination. People in any walk of life can be affected. The stigma needs to be broken. It is coming from the top. Clare Haughey's view was, "That's not my issue—that's somebody else's," but that is not the case. Addiction is a mental health issue; it is everybody's issue. It is our country, and if we want to make our country better, we need to start

putting money into mental health, addiction, education and all the other things that need more attention, rather than the petty things that it is getting spent on.

Monica Lennon: There is another point that I would like to bring up. As I said, Karen emailed me on 30 December 2017. Just before new year's eve 2018, I received an email from another constituent in Lanarkshire—the father of a young man in his 20s. I am still haunted by Karen's email, so when I got that other email, there were echoes of Karen's; the situation seemed very similar. I mention that because the committee has touched on the fact that there are times in the year when people are more at risk. Christmas can be a difficult time. When services are winding down for the Christmas holidays, it can be more difficult to get support.

10:30

I had to doorstep NHS Lanarkshire on new year's eve, down at its headquarters in Bothwell. The young constituent I mentioned had been discharged from hospital—Wishaw general hospital, again—in early December after a suicide attempt. Before his discharge, he had completed a psychiatric assessment, which I think takes five to 10 minutes; you just tick some boxes. On, I think, 29 December, his father got in touch with me. He was very concerned about his son and thought that he was at high risk of suicide. He told me that the family was having difficulty getting access to the community substance misuse team.

When I went to NHS Lanarkshire's headquarters, the people there were reluctant to give me the mobile phone number for that team because the service is overstretched and they were worried that the team would be inundated with calls. I promised that I would not advertise the phone number. I was genuinely afraid that this man, whom I cannot name because his family are going through hell—there is alcohol addiction, drug addiction and he is now going through the justice process—was going to be another Luke Henderson.

The Christmas and new year period is particularly difficult for people. Karen, from your experience with the network of people you know across the country who have, sadly, been affected by suicide, do you find that it is common for people to experience difficulties with getting help at that time of year?

Karen McKeown: It is definitely common, because there is only a skeleton staff over Christmas and new year. The services are not running at full capacity for nearly two weeks or perhaps longer, depending on when the holidays fall. The experience echoes throughout the country. I know what I am like at Christmas now—this past Christmas was horrendous. My mental health deteriorates at times, but I am lucky in that I have family and good support. Not everybody has that, however. There needs to be more support specifically around Christmas and the holiday period.

Monica Lennon: I have just one more point to make—thank you for your patience, convener. It relates to Karen's mental health and that of Gillian Murray and others who have gone through similar experiences. I know that the Scottish Government is doing good work nationally to ensure that all services across the NHS are trauma-informed. It can be difficult to go back to a GP practice or an accident and emergency department because of the memories that are associated with those places, and because you feel that you are having to answer all the same questions and perhaps be subject to a bit of judgment. Would you like to make any last point about how widespread training needs to be beyond just the mental health specialists? Is it the case that everyone across the NHS needs to up their game in the area?

Karen McKeown: I would definitely say that that is true for all aspects of healthcare, but specifically for GPs. There is an issue with the attitude of some GPs. I once found myself in the middle of a full-blown debate with a GP, who told me that I had to go and grow up. At that point, I was not mentally too well, and I needed somebody to say to me, "Look, this is what you need," and try to calm me down a bit. That is what a GP should do. GPs and other healthcare workers have to be better advised on suicide and mental health issues. That needs to be widespread, but GPs in particular need to be aware of how to handle patients and how to recognise that someone is in a state of mental distress.

The Convener: Do you think that the problems were compounded by the fact that you had to go to A and E, where—not to make excuses for your treatment—the staff are under pressure and are not specialists in mental health? Should there perhaps be a specialist accident and emergency department for people who are in crisis?

Karen McKeown: I would like there to be a specialist NHS place for people who are in a state of mental health crisis. I feel that mental health is more important than physical health, and making someone who is in torment sit by the door in a jam-packed accident and emergency department on a Friday or Saturday night is not a good idea. They need somewhere quiet and secluded where they can feel safe and secure, not somewhere where there is too much going on around them.

The Convener: Given your experience, it is obviously important that, even if such places were

provided, information is also provided about how people can get the help that they need.

You will know that the committee gets a lot of petitions on mental health and, sadly, they very often come out of tragic experiences. You are showing amazing courage, as other petitioners have done. We know that mental health-related problems are happening across our communities.

I mentioned that the Minister for Mental Health was here a couple of weeks ago and that she has announced an independent overarching review of the Mental Health (Care and Treatment) (Scotland) Act 2003 and associated legislation. I know that you have been sent information on that, but you might not have been able to look at it all yet. Do you have a view on the review? How should the issues that you have highlighted today be played into the review? Can they be played into it?

Karen McKeown: It is good that the minister is reviewing the legislation, but I do not know how changing the legislation would help in Luke's case, unless it was to make a fatal accident inquiry automatic. I have not looked into it too much, although I have read wee bits. I will need to look into it a bit more. However, from what I have read, the review needs to be more about the policies and procedures that are in place, rather than about the legislation surrounding them. It is good to talk, but we can talk until we are blue in the face and, unless there is action, nothing will change.

The Convener: I was struck by the point about how addiction and mental health are seen separately. Those elements feel intertwined. Anyone who has known anyone with an addiction knows—I do not pretend to understand—that addiction may come first and then mental health issues, but sometimes the addiction is a consequence of trouble in somebody's life. I am not sure how those aspects can be divided off in the way that has been mentioned. Perhaps we can pursue that issue with the Scottish Government.

Do members have any final questions?

Brian Whittle: I have a point to make. Karen's story about the difficulty of getting her voice heard really resonates with me, because I once went to a GP with somebody quite close to me who had attempted suicide three times and their partner. It seemed likely that we would leave the surgery without getting any help whatsoever. As a last roll of the dice, I told the GP that, if the person succeeded in taking their own life, I would make sure that everybody knew that I had been to his surgery and raised the matter with him. I am by no means advocating that approach, but it was only when I said that that the GP agreed to take positive action. I am absolutely convinced that, if I had not said it, the person would not be with me today.

I know the impact that that experience has had on me over a number of years, and that person is still here. It is very brave of you, Karen, to come and give us your evidence. People should not need to go to the lengths that I had to go to in order to keep their loved ones safe.

We know that there are huge pressures on the NHS and that assessments by GPs are subjective, but it strikes me that the systems that we have in place are not adequate to deal with the continuing mental health problems that we have. We see those problems at this committee almost every month, and it is the same in the Health and Sport Committee. We have a system that is under huge pressure; it is broken. Somehow or other, we have to find a solution.

The Convener: Thanks for that, Brian. I guess that, for my generation, this issue has come to the fore in a way that it did not in the past—it just would not have been talked about. Although there are lots of people in the system who are doing their best, something is preventing people from getting help when they need it. It might be down to how those in the health service read someone, whether they are under pressure themselves, whether they are simply not trained in that field or whatever, but it is a massive issue.

It is significant that the Scottish Government is reviewing the legislation, but we must ensure that what you see, Karen, coming out of that review is not just legislation that we can all be happy with but policies being put in place behind it. Do you want to make any final comments before we finish our consideration?

Karen McKeown: Coming back to what Brian Whittle said, one of the last things that I said to every person when I left that hospital was, "If anything happens to him, you will hear from me"—and, by God, they are hearing me now. I do not want to hear about another case of families trying to find and begging for help. We are talking about a man who has lost his life and children who are growing up without a father, and I am going to grow old without him beside me. I do not want anybody else to feel that pain. I just want to thank you for giving me this opportunity and for listening to me, and I hope that something comes of this and that people's lives can be saved.

The Convener: We want to thank you, too, because there is no doubt that, in the way that you have spoken out about your circumstances and formulated the petition, you are not only speaking powerfully for yourselves and your loved ones but speaking for a broader community that also needs help. We really appreciate that.

We should also thank your co-petitioner Gillian Murray, and we hope that she can make a recovery with the support of her family. We understand the pressures on her and how difficult they are.

With regard to how we should take forward the petition, I think that we will want to write to the Scottish Government and some of the other key organisations that have been identified to seek their views on the actions called for in the petition. After all, the petitioner has not only set out what happened but highlighted what needs to change, and there is quite a lot that different organisations, perhaps some of those involved in mental health, might want to respond to. For example, I am interested in the division that there seems to be between public health and mental health, which I think is not helpful.

I do not know whether members can think of other organisations that we could usefully contact, but certainly we should write to the Scottish Government, charities and groups operating in the field and perhaps professional bodies. It might be interesting to find out whether psychiatrists and so on think it feasible to have a kind of hub that would almost be the equivalent of an A and E department but would direct people out of what is often the chaos of A and E.

Rachael Hamilton: I would also like to ask about the points that Karen McKeown has made about risk assessments and the need for collaboration between all the people who make them. It is probably a software and data-sharing issue, and it would be good to look at how best we can achieve something in that respect.

The Convener: I think that we are agreeing to take forward the petition in the terms that I have set out by writing to the Scottish Government and other key people. Once we get those responses, Karen, you and Gillian Murray will get a chance to respond and make a further submission before we consider your petition again, and that will allow us to look at the extent to which you think people have responded to the asks in your petition.

I again thank Karen McKeown very much for coming, and I also thank her fellow petitioner Gillian Murray. You have given us lots to think about.

Meeting closed at 10:43.

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