NHS Resolution

A summary of: Learning from suicide-related claims

A thematic review of NHS Resolution data

September 2018

Advise / Resolve / Learn

Our report, ***Learning from suicide-related claims: a thematic review of NHS Resolution data***, provides an in-depth examination of the causes of these tragic incidents and the investigations that follow them.

This study focused on 101 deaths that occurred between 2010 and 2017, and where the trusts involved were supported by NHS Resolution's inquest scheme.

This leaflet highlights the:

- aims of the review;
- key findings; and
- the nine recommendations in the report.

We would encourage you to the read the full report which can be found online at www.resolution.nhs.uk/mentalhealthreport

Working in partnership with other organisations, including the Royal College of Psychiatrists, The Care Quality Commission, NHS Improvement and NHS England, we have highlighted areas for improvement and made clear recommendations to help trusts prevent further incidents.

Aims of the review

1 Identify the clinical and non-clinical themes in care from completed suicide that resulted in a claim for compensation

2 Identify the clinical and non-clinical themes in care from attempted suicide that resulted in a claim for compensation

3 Disseminate the shared learning and use this as a driver for change and quality improvement

4 Highlight evidence of good practice that could address areas for improvement, signpost potential solutions and make recommendations for change

Key findings

- There were 101 claims between 2015 and 2017 suitable for review. Admissions of liability were made in 46% of the claims reviewed.
- There were some examples of good practice in relation to a number of trusts that had a proactive approach to engaging families, staff and patients in improvement work.

However,

- Those with an active diagnosis of substance misuse were referred to specialist services less than 10% of the time.
- Risk assessments were often inaccurate, poorly documented and not updated regularly enough. There was little account taken of historical risk.
- Observation processes were inconsistent.
- Communication with families was poor.
- Support offered to families and staff following a serious incident (SI) was variable.
- Evidence of poor quality SI investigations at a local level:
  - The family were involved in only 20% of investigations
  - Only 2% of investigations had an external reviewer and 32% of incidents were investigated by a single investigator
  - The recommendations were unlikely to stop similar events happening in the future
- Although this review analyses a small number of specific claims, the findings resonate with other reports with similar findings[1,2]

References

1 Care Quality Commission. *The state of care in mental health services in the UK* 2014-2017. Care Quality Commission, 2017.

2 *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.* S.l. : University of Manchester, October 2017

Recommendations

1. A referral to specialist substance misuse services should be considered for all individuals presenting to either mental health or acute services with an active diagnosis of substance misuse. If referral is decided against, reasons for this should be documented clearly.

2. There needs to be a systemic and systematic approach to communication, which ensures that important information regarding an individual is shared with appropriate parties, in order to best support that individual. Trust boards should consider how communication is best enabled within their existing systems and prepare to adapt to new models of care, which should include working models to facilitate communication across services.

3. Risk assessment should not occur in isolation – it should always occur as part of a wider needs assessment of individual wellbeing. Risk assessment training should enable high quality clinical assessments, which include input from the individual being assessed, the wider multi-disciplinary team and any involved families or carers. While acknowledging that risk can be considered as 'high', trusts should move away from stratifying risk assessments into crude 'cut offs' of risk, and encourage more descriptive formulations of risk. In order to ensure that professionals are performing to a high level, this training should be repeated every three years and risk assessment should be reviewed regularly during clinical supervision.

4

The head of nursing in every mental health trust should ensure that all staff including:

- mental health nursing staff (including bank staff and student nurses who may be attached to the ward);
- health care assistants who may be required to complete observations; and
- medical staff who may 'prescribe' observation levels

undergo specific training in therapeutic observation when they are inducted into a trust or changing wards. Staff should not be assigned the job of conducting observations on a ward or as an escort until they have been assessed on that ward as being competent in this skill. Agency staff should not be expected to complete observations unless they have completed this training.

5

NHS Resolution should continue to support both local and national strategies for learning from deaths in custody. In particular, there should be ongoing work to review learning from litigation in cases involving prison healthcare, which will continue to inform the Prison Safety Programme and National Partnership Agreement action plan. External bodies such as Her Majesty's Inspectorate of Prisons and the Care Quality Commission (CQC) have a role to play in sharing good practice nationally, and will ensure that the aforementioned programmes are effective in delivering their objectives.

6 The Department of Health and Social Care should discuss work with the Healthcare Safety Investigation Branch, NHS Improvement, Health Education England and others to consider creating a standardised and accredited training programme for all staff conducting SI investigations. This should focus on improving the competency of investigators and reduce variation in how investigations are conducted.

7 Family members and carers offer invaluable insight into the care their loved ones have received. Commissioners should take responsibility for ensuring that this is included in all SI investigations by not 'closing' any SI investigations unless the family or carers have been actively involved throughout the investigation process.

8 Trust boards should ensure that those involved in arranging inquests for staff have an awareness of the impact inquests and investigations can have on individuals and teams. Every trust should provide written information to staff at the outset of an investigation following a death, including information about the inquest process.

In addition we recommend that the following mechanisms to support staff are considered:

- The SI investigator should keep staff members up to date with the SI process, and the trust legal team should inform them of whether they will be called to coroner's court as soon as this information is known.

- There should be formal follow-up points to 'check in' with staff that have been involved in an SI. For example, there could be a follow-up meeting with managers three months, six months, and one year after the SI to ensure staff are supported both throughout the process and when it has finished.
- Introduce a system for monitoring and alerting managers when staff have been involved in more than one SI in close succession in order to highlight the potential need for additional pastoral support.

9

NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies in the report to prevent future death (PFD) process nationally. We recommend that this should include training for all coroners around the PFD process. Monitoring of the PFDs given, both in terms number and content should lie with both the CQC and other external bodies, with this information being shared nationally to drive improvement in health care systems.

Where these recommendations explicitly reference actions to be undertaken by bodies external to NHS Resolution, we have worked in partnership with them to agree the relevant recommendation and are grateful for their support and commitment to action them.

NHS Resolution

Emotional support for those affected by suicide

Samaritans
You can call Samaritans for free from any phone on 116 123
email them at jo@samaritans.org or visit www.samaritans.org

Survivors of Bereavement by Suicide (SOBS)
https://uksobs.org

Cruse Bereavement Care
www.cruse.org.uk 0808 808 1677

Support after Suicide Partnership
www.supportaftersuicide.org.uk

If you or somebody you know is struggling with thoughts of suicide, please seek help. You could consider contacting your GP or the Samaritans.

Suicide is not inevitable and things can get better.

To see more of our resources please visit:
http://bit.ly/NHSResolutionResources

To read the full report: www.resolution.nhs.uk/mentalhealthreport

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