NHS
Resolution

Learning from suicide-related claims
A thematic review of NHS Resolution data
September 2018

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Foreword

Foreword

From the outset, the author would like to express their sincere gratitude to the families that have offered their time and shared their experiences in the production of this report. Listening to you has been a humbling experience. Thank you. In a similar manner, the input of staff from member organisations has been both appreciated and heartening – there are so many individuals who are passionate about improving the services we can offer to those who may be approaching or in crisis. I hope this report goes some way towards supporting those aims.

The NHS is one of the safest healthcare systems in the world and ranks highly compared to health services in similar countries.[1] In England in 2016 there were 4,575 suicides registered, continuing a year-on-year decreasing trend.[2] The decrease in suicide occurred in spite of an increase in the number of people coming into contact with the health service[3] and in population.[4]

Approximately 25% of people who go on to take their lives are in contact with mental health services in the year before their death. While it is important to review where services could better support these people, it must be acknowledged that suicide is also a societal issue. We all have a collective responsibility to better support those for whom suicide is an option.[5]

Unfortunately, services occasionally fail to prevent suicide attempts and death for those in contact with them. This can result in claims against the NHS, contributing to the £2.2 billion current cost for clinical negligence in 2017/18.[6] While not necessarily the most expensive claims, each claim that relates to suicide represents a devastating individual story and immeasurable pain and suffering for those left behind.

The ambitions of the former Secretary of State for Health and Social Care to 'aim for nothing less than zero inpatient suicides'[7], coupled with the desire for the NHS to become the world's 'largest learning organisation'[8] will act as drivers to reduce avoidable harm. To achieve these ambitions, the learning that occurs when things go wrong must be shared to identify areas and strategies for both local and national improvements.

NHS Resolution is in a unique position in that it holds information about every personal injury claim made against NHS trusts in England over the past 23 years. This information, when correctly distilled, can be used to identify national themes about potential problems associated with NHS care. These themes can then be used to focus improvement work to reduce the likelihood of similar problems in the future. The learning generated from reviewing claims could then be used to improve care, improve safety, reduce avoidable harm and decrease future litigation costs.

Aims

This thematic review presents a detailed analysis of claims made after an individual has attempted to take their life. Claims relating to completed suicide and attempted suicide are reviewed, regardless of whether the claim resulted in financial compensation. It identifies common problems with care and provides recommendations for improvement to support service delivery.

Some readers may feel upset or uncomfortable due to the subject matter of this report. If you or somebody you know is struggling with thoughts of suicide, please seek help either via your GP or the Samaritans. Suicide is not inevitable and things can get better.

Dr Alice Oates
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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.

Executive summary

Purpose

This thematic review analyses in depth the data held by NHS Resolution on compensation claims that relate to suicide between 2015 and 2017. The claims that are reviewed are those where member organisations received funding to provide legal representation at inquest via NHS Resolution's inquest scheme. In addition, there is a review of non-fatal suicide attempts following which a claim was pursued. The purpose of this review is to identify the clinical and non-clinical issues in care that arose in those claims, share this learning with the wider system to act as a driver for improvement, and make recommendations to reduce further harm.

Background

Suicide has a devastating, lifelong impact on the family, carers and staff bereaved when a person takes their life. While compensation claims relating to suicide are a small, highly specific group of incidents which may involve potentially avoidable harm, this may not reflect the entirety of care across the NHS. This review looks at cases both where liability has been admitted – which by definition means that there were errors that should have been prevented – and where liability was denied. In both instances claims will contain learning that should be shared.

Methodology

NHS Resolution's claim management system (CMS) was searched for all claims relating to suicide that were accepted for funding under NHS Resolution's inquest scheme between 2015 and 2017. The CMS holds a wealth of information, which can include the original hospital serious incident (SI) investigation, statements from clinicians, expert reports, and records of inquest, among other documents. An in-depth review of the documents was conducted using thematic analysis methodology.

NHS Resolution Clinical Fellow Programme

NHS Resolution invites clinicians, with a track record of both academic and clinical excellence, to compete for a year-long secondment. Fellows review claims data through a clinical lens, culminating in a report to share this learning and as a starting point for quality improvement. During the year they also receive specialist training in leadership, media engagement and presentation skills. The fellows then return to clinical work, armed with their newly developed skills and knowledge, to drive change in the organisations that they subsequently work for.

Results

The results are split into two parts. The first part analyses the problems identified from the clinical details of each claim and the second part analyses the quality of the serious incident reports.

Part one identifies recurring clinical themes and areas for improvement. Five areas where there were common issues in clinical care are discussed in depth:

- Substance misuse

- Communication, particularly failures in intra-agency working

- Risk assessment

- Observations

- Prison healthcare

Part two identifies four main areas of concern, where:

- There was a lack of family involvement and staff support through the investigation and inquest process.

- The quality of root cause analysis undertaken as part of the Serious Incident (SI) investigation was generally poor and did not focus on systemic issues.

- Due to the poor SI report quality, the recommendations arising from SI investigations were unlikely to reduce the incidence of future harm.

- Reports to prevent future deaths (PFDs) were issued to trusts by the coroner with little consistency and there were poor mechanisms to ensure that changes in response to the PFDs had been made or addressed the issues highlighted.

Key findings:

- There were 101 claims between 2015 and 2017 included 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 an SI was variable

- There was 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 investigator 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.[3, 9]

This review, especially when making recommendations, has taken into account the work currently ongoing within the wider system. This includes implementation of *The Five Year Forward View for Mental Health*[10], *Learning from Deaths*[11] and the forthcoming review of the serious incident framework by NHS Improvement due later this year. Trusts should consider the findings of this report and will need to work with commissioners who will have an important role in implementing many of the recommendations within this review. National support from the organisations responsible for oversight, safety, training and improvement will also be required to ensure changes are embedded and sustained.

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.

*including principles around positive engagement with patients, when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this and actions to take if the patent absconds.

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 (HMIP) 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 (HSIB), 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 of the 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.

Background

Suicide

Suicide is the leading cause of death for adults between the ages of 20 and 34 years in the UK (24% men and 12% women).[12] For statistical purposes, general population suicides are defined as 'all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over.'[2] Rates of suicide vary across the UK with the highest rate of suicide in Cornwall and the Isles of Scilly, at 14.4 per 100,000 population, and the lowest in Hertfordshire and West Essex, at 7.4 per 100,000 population.[9]

Suicide occurs in those with a history of mental illness and contact with mental health services, as well as those who have no previous history. Risk factors for suicide can be considered as being either static, non-modifiable risk factors – gender; age; personal suicide attempt and family history of suicide – or dynamic, modifiable risk factors including mental health diagnoses, emotional turmoil, substance misuse and suicidal thoughts.

Suicides occur in a range of environments including inpatient settings, public places and in the home. Similarly, those taking their lives have varying degrees of involvement with mental health services: those who attempt to take their own lives can be psychiatric inpatients, under the care of what is commonly termed the crisis or home treatment service or community mental health teams, be seen by their GP or have no contact with mental health services. A feature shared by nearly all suicides is the devastation that follows for families, carers and others connected to the individual.

NHS Resolution

In April 2017, the NHS Litigation Authority (NHS LA) evolved to become NHS Resolution. The NHS LA was originally established in 1995 as a special health authority, providing not-for profit indemnity cover for compensation claims against the NHS. It continues with this role today in addition to sharing learning, with the aim of preventing future harm occurring and advising on practitioner performance.

A suicide is a tragedy for everyone involved – the costs to the family, carers and staff supporting the individual are immeasurable and could never be fully compensated with money alone. However, the financial costs of litigation are also significant. Learning lessons to prevent similar tragedies where they are avoidable and to reduce this cost burden across the NHS is essential.

NHS Resolution has taken the approach that learning throughout the life of a claim is more effective, more appropriate and offers more opportunity to support member organisations to improve their care. Figure 1 illustrates how an incident may become a claim, the failures that may arise and why learning throughout the process can be disjointed.

Figure 1: The previous 'worst case' model of incident-to-resolution

Incident **Complaint** **Claim**

Might be a failure to be open

Potential loss of trust

Search for an explanation

Sometimes blame takes hold

Lawyers to get answers

Money to recognise that something went wrong

Learning fragmented
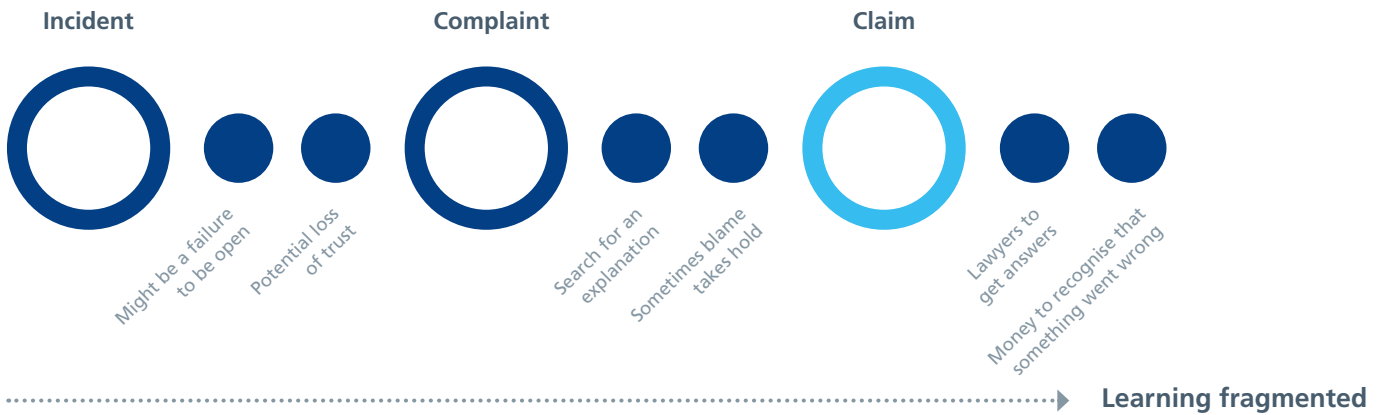
(Source: NHS Resolution April 2017)

The new strategy, demonstrated in Figure 2, involves earlier intervention and support, with the aim of resolving the incident quickly and fairly, while having a more joined up process for learning along the way.

Figure 2: The new 'best case' model of incident-to-resolution

Incident **Complaint (not needed)** **Claim**

Candour

Peer support

Investigation

Learning for prevention

Improved handling

Mediation

Fixed costs

Resolution

Learning throughout
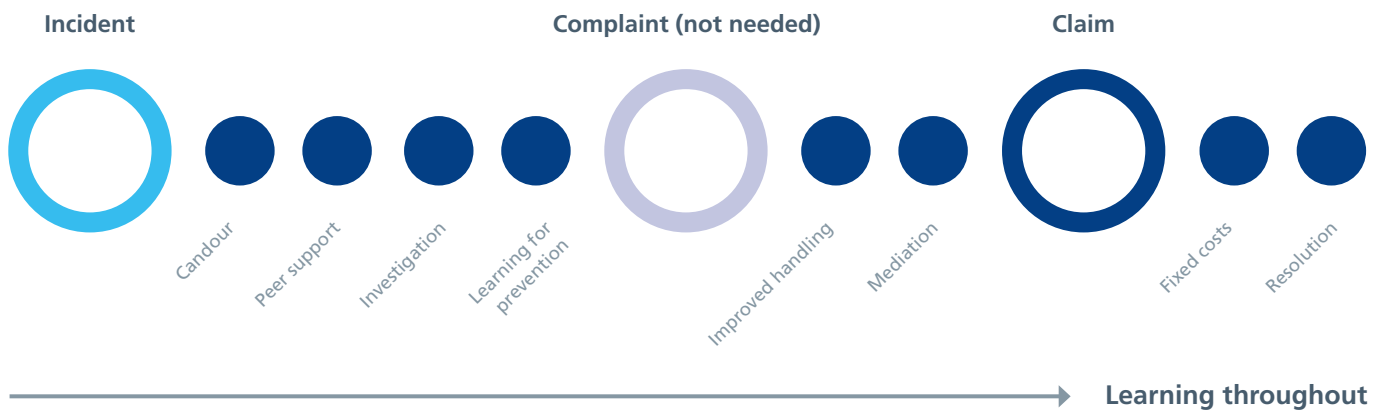
(Source: NHS Resolution April 2017)

The Inquest Scheme

Since 1 April 2013, NHS Resolution has offered discretionary funding under its Clinical Negligence Scheme for Trusts (CNST), to provide legal representation for member trusts at inquests. If an application for funding is successful, the trust is then supported by one of ten legal 'panel' firms. Panel firms are law firms that have high quality legal health clinical negligence teams that are contracted by NHS Resolution to provide legal advice for healthcare claims.

NHS Resolution welcomes the guidance relating to exceptional funding for inquests recently released by the Lord Chancellor. The changes mean that from June 2018, legal aid is likely to be awarded for representation of the bereaved at an inquest following the non-natural death or suicide of a person detained by police, in prison or in a mental health unit.[13]

The NHS Resolution inquest scheme seeks to:

– facilitate a difficult process for the family by making appropriate admissions; offering an apology and/or settlement where indicated

– support staff during both the inquest and any subsequent claim

– assist members in taking proactive steps to resolve issues which might form the basis of a civil claim

– minimise the overall cost to the public purse with the inquest and civil claim running in tandem

NHS Resolution has funded the following number of inquests in the past five years:

Table 1: Funded inquests since the inquest scheme began in 2013 to 2018

Year of funding	Funding requests and approval rates
2013/14	653 requests; 443 approved (68%)
2014/15	480 requests; 327 approved (68%)
2015/16	377 requests; 261 approved (69%)
2016/17	652 requests; 419 approved (64%)
2017/18	658 requests; 464 approved (71%)

Table 2 shows the specialties which are most frequently funded at inquest. Preliminary work conducted by NHS Resolution's panel firms suggested that the leading cause of death across all cases funded by the inquest scheme was suicide, with 23% of funding awarded relating to this.

Table 2: Inquest scheme funding approved from 1 April 2013 to 31 March 2018 based on speciality

Specialty	Number of claims
Psychiatry / mental health	282
Emergency department (previously referred to as casualty or A&E)	230
Obstetrics	200
General medicine	183
General surgery	168

Coronial process and reports to prevent future deaths

Coroner's inquest

If the cause of a person's death is unknown, violent, occurs in state custody or is unnatural it is referred to the coroner who will conduct an investigation to determine the cause of the death, which may then result in an inquest to establish who the deceased individual was, and when, where and how they came to their death. This process is known as 'coroner's inquest' and is held in public, with or without a jury. The coroner's role is not to apportion blame or the civil or criminal liability of another individual. Coroners are required to complete an inquest within six months of the date that the coroner is made aware of the death, or as soon as it is reasonably practicable.[14]

Inquest conclusions

There is no definitive list of conclusions available to a coroner. The following are most commonly used and are commonly referred to as 'short form' conclusions:

Natural causes: the death was caused by the normal development of a natural illness which was not significantly contributed to by human intervention.

Accidental death: the cause of death was unnatural but not unlawful.

Misadventure: this is similar to 'accidental death' and may be the right conclusion when a death arises from some deliberate human act which unexpectedly and unintentionally goes wrong.

Suicide: it is decided that the person took his/her own life and intended to do so.

Unlawful killing: the death was caused by murder, manslaughter, infanticide or through a serious driving offence.

Open conclusion: there is simply not enough evidence to return any other conclusion.[15]

In cases where there is a suspicion that an individual may have intentionally taken their own life, a conclusion of 'suicide' may be reached by the coroner. Until July 2018, the threshold for reaching this conclusion was high, and the criminal standard of 'beyond all reasonable doubt' applied.[16] A new ruling by the High Court has determined that the conclusion of suicide is now to be determined on the civil standard of proof – 'the balance of probablities' as opposed to 'beyond all reasonable doubt'.[17]
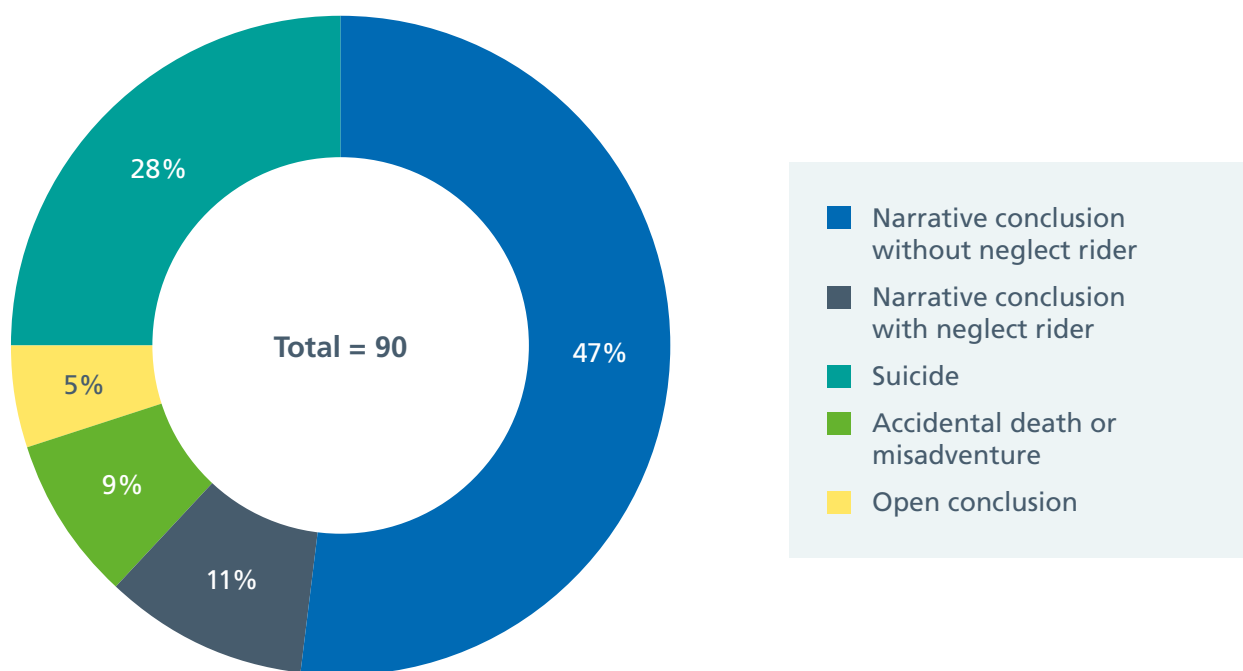
Coroners or a jury may also deliver a **'narrative'** conclusion which sets out how the deceased individual came to their death. This longer explanation will include the coroner's or jury's conclusions on the main issues surrounding the death.

Neglect is not a conclusion in itself; it is best described as a finding. A coroner can report a finding of 'neglect' in addition to a short form conclusion or as part of a narrative conclusion. In cases where neglect is a finding, it is deemed that there has been a gross failure to provide the deceased individual with his or her basic needs. There must be a clear causal link between this gross failure and the death of the dependent person. This finding is commonly associated with the failure to provide even basic medical attention. The coroner would generally consider neglect as a contributing factor rather than the sole cause of death, and as such will add the term as a 'rider' to another conclusion.

Inquest conclusions in our cohort

The conclusion of the inquest was available in 90 of the 101 claims. In two cases the trust was approached and the coroner's report was uploaded to the CMS. The range of conclusions is described in Figure 3.

Figure 3: The inquest conclusions recorded by the coroner in this cohort

Total = 90

47%

11%

9%

5%

28%

- Narrative conclusion without neglect rider
- Narrative conclusion with neglect rider
- Suicide
- Accidental death or misadventure
- Open conclusion

The average duration from death to the conclusion of the inquest was one year and 20 days (range = 23 days to three years, three months and 20 days) This falls outside the coronial guidelines, with inquests that take longer than a year to reach conclusion being reported to the Chief Coroner.[18] The Chief Coroner has highlighted the variation in 'backlogged' inquests across different jurisdictions. Reasons for delays in holding inquests may include:

- The type of inquest being held. Inquests involving prisons or inquests with a jury (Article 2 inquests) can often take up to two to three weeks to reach a conclusion.

- Any form of concurrent statutory investigation may delay when the inquest can be held, for example criminal proceedings or Police Prison Ombudsman investigations.

- The jurisdiction of the coroner – varying population characteristics, population size, differing proportions of institutions likely to invoke an Article 2 inquest.

Reports to prevent future deaths

At any point during the investigation and subsequent inquest, if it becomes apparent to the coroner or jury that there are clear steps that could be taken by care providers that would reduce the risk of future deaths in similar circumstances, there is a legal duty for them to make a Report to Prevent Future Deaths (PFD). If a PFD is issued, the care provider has 56 days to offer a written response outlining the action or proposed action to be taken, or an explanation as to why no action will be taken to prevent future similar deaths.

The PFD and the response are then sent to the Care Quality Commission (CQC) and the Chief Coroner, who may publish a summary of it which is open to public scrutiny.[19]

One area coroner has confirmed that a thorough investigation with robust recommendations would reduce the likelihood of a PFD report being issued.[20] Trusts want to deliver safe and efficient care for the benefit of both patients and staff – they also need to be proactive and able to evidence their learning to demonstrate that they are trying to achieve this.

If the coroner identifies areas for learning at inquest that have not been highlighted in the trust's SI report there will also be additional work for the trust to comply with any recommendation made – work that could have been achieved at an earlier stage and that could have been incorporated into the trust's initial action plan. PFDs are often a source of interest for the CQC during their inspections, particularly if a PFD is made and actions and learning from this have not been embedded by the trust. This can cause reputational damage, which trusts are keen to avoid.
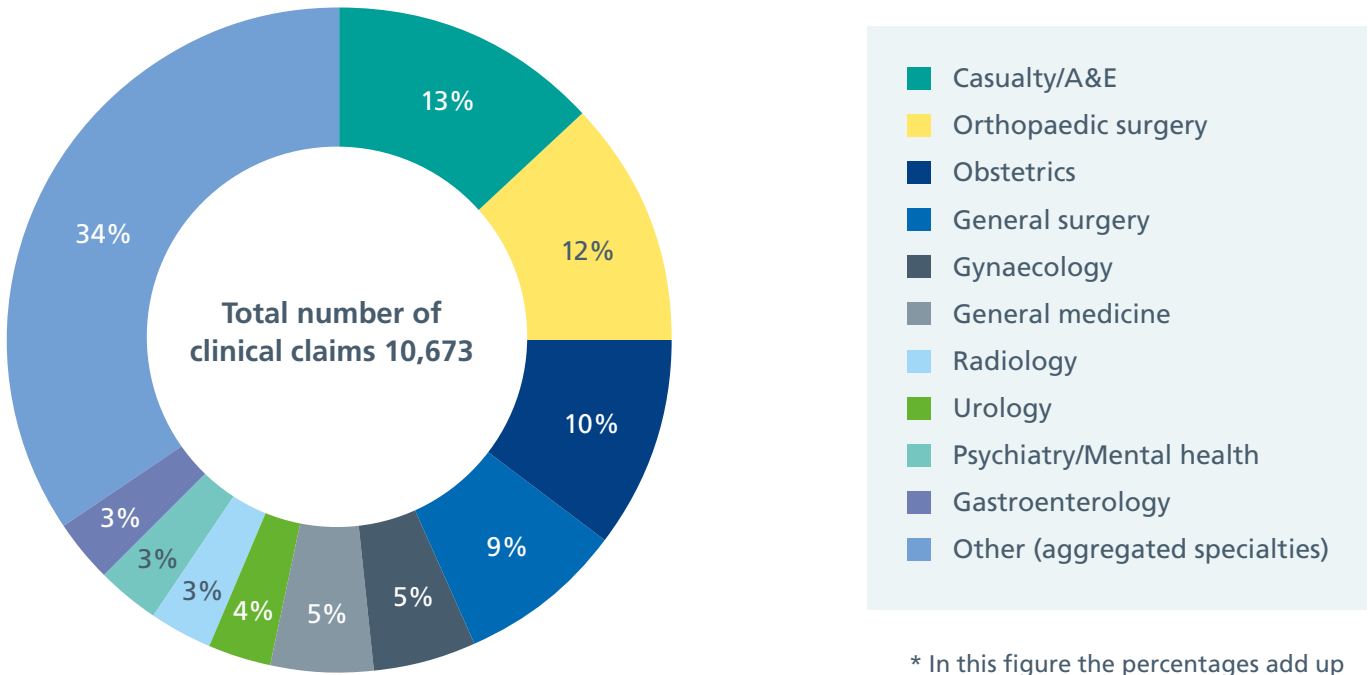
Financial perspective

The total payments made for clinical negligence in 2017/18 were £2.2 billion. This is expected to increase as both the number of claims and the cost of settling them continues to rise.[6] Changes to the personal injury discount rate, from 2.5% to minus 0.75%[21] announced in February 2017 have contributed to the recent increase and will continue to do so, with the biggest increases seen in the lump sum payments for the highest value claims.

In relation to the claims referred to in this report, these claims are likely to relate to the need for ongoing care, for example following an attempted suicide, or where dependants are left following completed suicide. There is currently a review of the methodology for calculating the discount rate.

It is difficult to predict how changes in the discount rate will affect different types of claim, but by looking at claims with ongoing payments (PPOs) that have been subject to the change in discount rate already, we know that a claim which may have settled at a certain value at a 2.5% discount rate is likely to be valued much higher in the future should the discount rate remain at minus 0.75%.
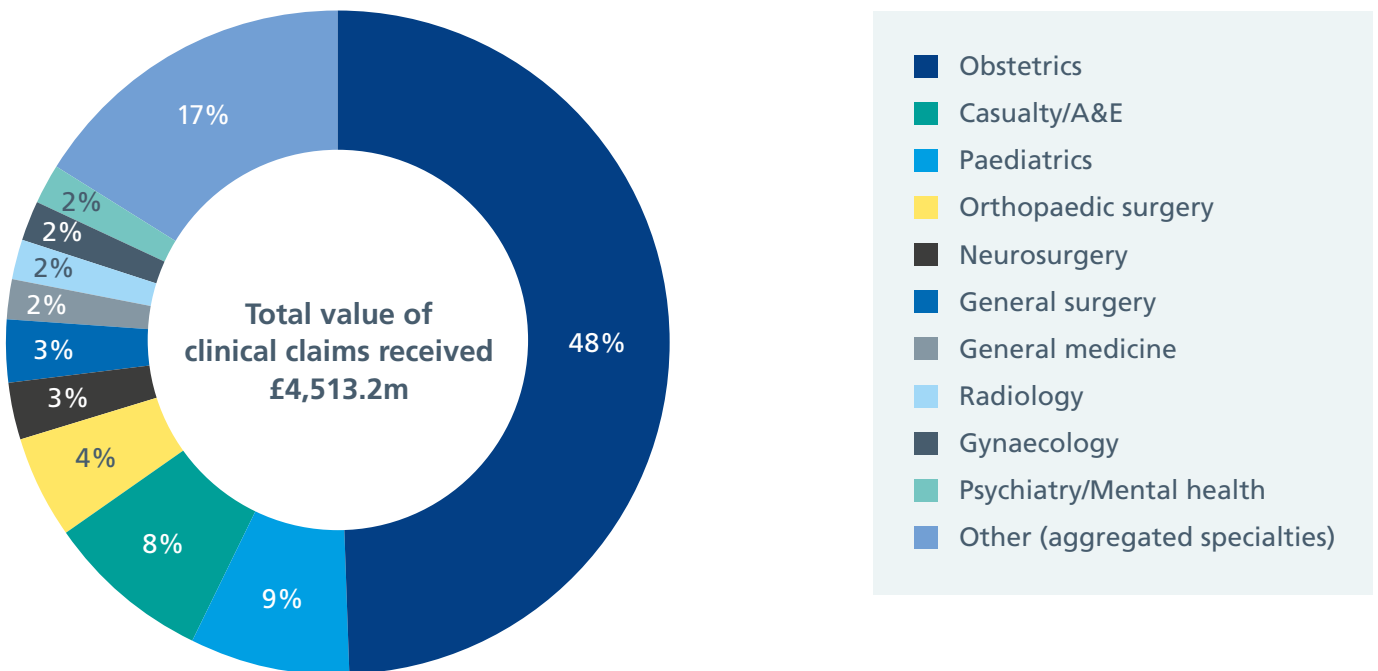
Figure 4: The number of clinical negligence claims received in 2017/18 by specialty across all clinical negligence schemes*

Total number of clinical claims 10,673

13%
12%
10%
9%
5%
5%
4%
3%
3%
3%
34%

- Casualty/A&E
- Orthopaedic surgery
- Obstetrics
- General surgery
- Gynaecology
- General medicine
- Radiology
- Urology
- Psychiatry/Mental health
- Gastroenterology
- Other (aggregated specialties)

(Source: NHS Resolution annual report and accounts 2017/18)

* In this figure the percentages add up to 101% due to rounding 2017/18 by specialty across all clinical by looking at emergency medicine specialty.

Figure 5: The value of clinical negligence claims received in 2017/18 by specialty across all clinical negligence schemes

Total value of clinical claims received £4,513.2m

17%
2%
2%
2%
2%
3%
3%
4%
8%
9%
48%

- Obstetrics
- Casualty/A&E
- Paediatrics
- Orthopaedic surgery
- Neurosurgery
- General surgery
- General medicine
- Radiology
- Gynaecology
- Psychiatry/Mental health
- Other (aggregated specialties)

(Source: NHS Resolution annual report and accounts 2017/18)

Figure 6: A comparison of the number and total value of claims made against mental health trusts for clinical negligence over time
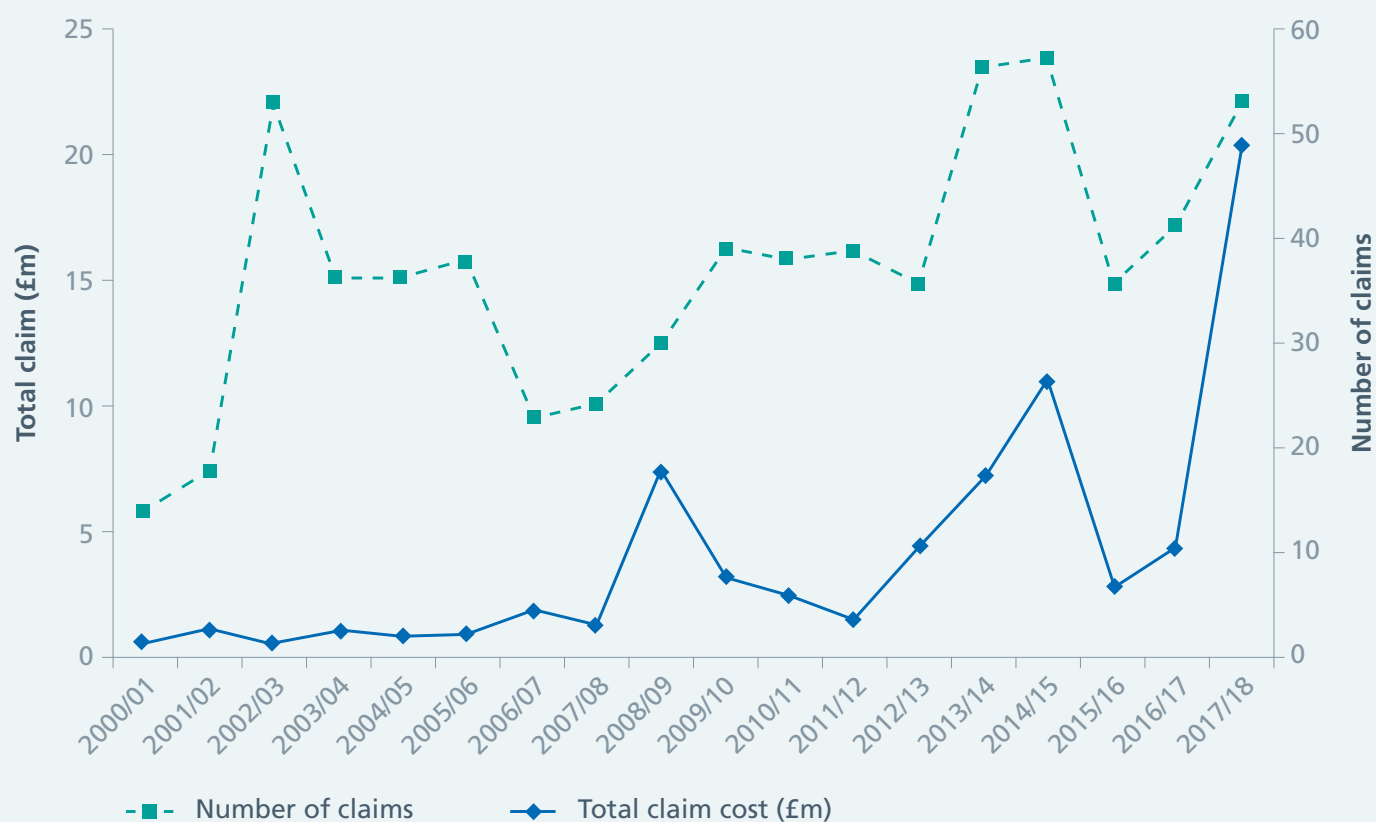
(Source: NHS Resolution data)

Compensation

Compensation is designed to place individuals, at least financially, in the same position they would have been in had the incident not occurred. In cases where a patient has died, compensation is offered to the estate, for the bereavement of close relatives and to support dependants of those left behind following a death.

This may include payments to dependants of the deceased individual which would match the contributions that they would have provided them. For example, children of a deceased parent working and providing for them prior to their death may be entitled to a certain proportion of these earnings.

Equally, the value of services provided by a deceased parent or partner can also be recovered. In cases where the injured party is still alive, compensation is offered to cover damages for pain, suffering and the loss of the amenities of life, as well as for past and future monetary losses. For claims relating to non-fatal suicide attempts, this can include the loss of future earnings, the cost of ongoing care (domiciliary care, physiotherapy, and pain management), equipment and adaptations required to the home as a result of the injury. Given advances in medical science, despite significant injury, there may be little impact on life expectancy.

No amount of compensation can ever substitute the presence of a loved one for a family. It is not considered that by paying damages NHS Resolution or the member trust have by any means 'undone' the damage caused by any failings in care. However, paying damages is the only way that the law is able to compensate for failings in the care given to individuals. Where compensation is due it should be given willingly and in a timely manner to prevent further distress and suffering to distraught families.

The human cost

The costs and emotional strain to families, friends and those caring for an individual when they take their lives are immeasurable. Grief will be felt in a number of ways, and there is no 'right' or 'normal' way to feel when a person acts to end their life.

As well as the costs to families and carers, staff can also be deeply affected by the loss of a patient. There is increasing evidence about the impact on staff of being involved in an adverse event[22] and the limited support that is available.[23][24] The term 'second victim' has become common to describe the family, carer or staff member who are also traumatised following a serious incident.[22]

> *'It's like a bit of me has died along with him.'*
>
> **Bereaved parent**

> *'I can vividly remember each patient that I have cared for that has gone on to take their life. They haunt you, flashing into your thoughts when you are having breakfast or watching a film. They fade with time, but they are still there, an ever present reminder of the part of our job nobody likes to talk about.'*
>
> **Consultant psychiatrist**

A note on terminology

In this report the aim was to review 'claims relating to suicide'. A cause of death of suicide can only be confirmed by the coroner, and the margin between a conclusion of suicide and a narrative conclusion can be narrow. A large source of potential learning would be lost if this report only focused on claims that had a conclusion of suicide at coroner's court.

The pragmatic decision was taken to review all cases where it was considered likely that an individual had acted in some way to take their own life, while reporting the variety of coroners' conclusions in these deaths.

Throughout this report the term 'individual' or 'patient' will refer to those in our cohort or who have been accessing health services. It is noted that there is not a clear consensus on terms to describe those receiving support, and some people prefer 'service user'.

The terms 'serious incident requiring investigation (SIRI)', 'serious incident (SI)' and 'serious untoward incident (SUI)' are often used interchangeably. For ease, this document will refer to 'SIs' and 'serious incidents'.

Methodology

The claims management system (CMS)

The CMS is a large database which holds the details of every clinical negligence claim notified to NHS Resolution since 1995.

As such, it contains large amounts of highly sensitive personal and legally privileged data not held in any other place or available to those without access to the system.
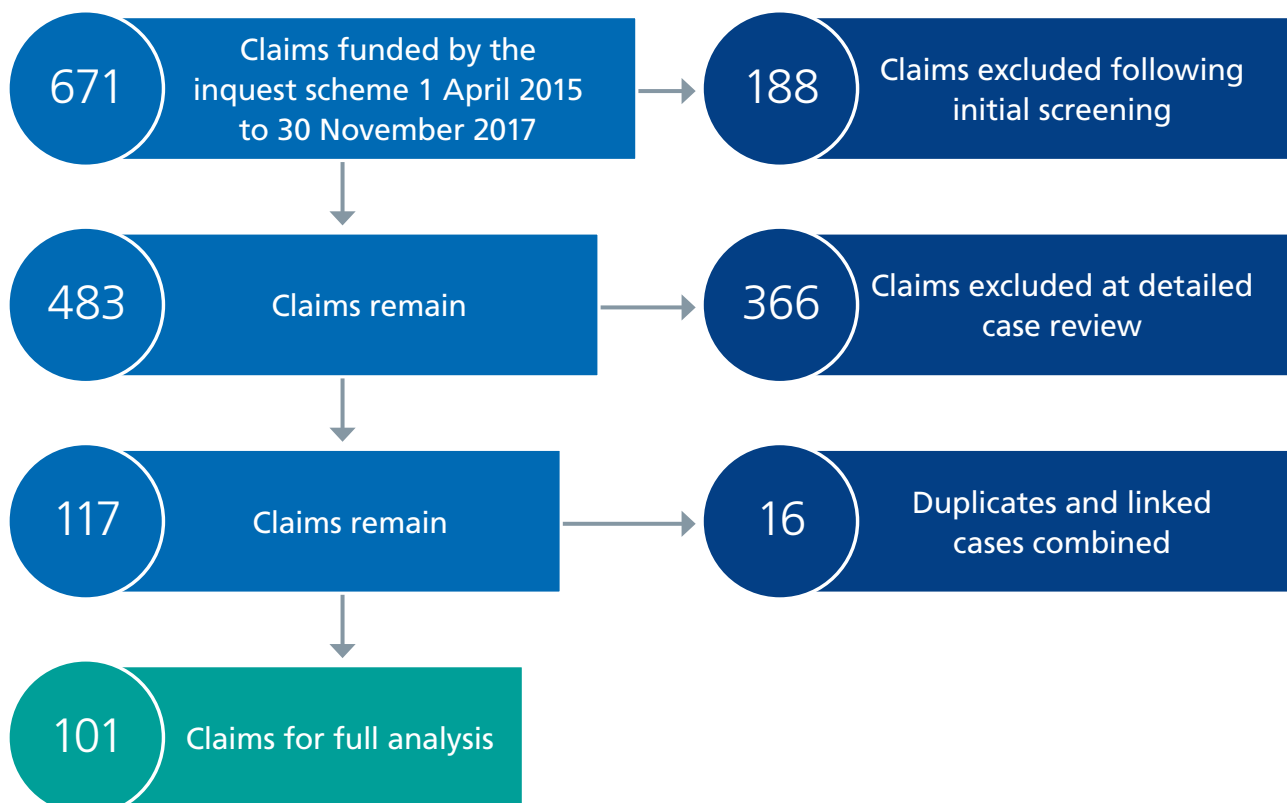
Information within the CMS is coded to allow quick navigation of the data and some crude analysis.

Search criteria

A search was conducted to capture all of the cases that were funded by the inquest scheme between 1 April 2015 and 30 November 2017.

Each claim was then reviewed to verify whether it was suitable for inclusion or related to a different type of injury. Figure 7 outlines the process for searching and screening claims.

Figure 7: The process of reviewing claims for inclusion

| 671 | Claims funded by the inquest scheme 1 April 2015 to 30 November 2017 | → | 188 | Claims excluded following initial screening |

| 483 | Claims remain | → | 366 | Claims excluded at detailed case review |

| 117 | Claims remain | → | 16 | Duplicates and linked cases combined |

| 101 | Claims for full analysis |

Data collection and analysis

It was decided that a thematic analysis would facilitate an inductive approach to best capture the intricacies and relationships within the data.[25] Thematic analysis is a commonly used methodology when reviewing qualitative data such as the serious incident report.[25] Descriptive analysis was conducted on elements of the data not suited to thematic review: time periods, financial data, etc.

A data collection tool was designed by the author, a senior psychiatric registrar working as a Clinical Fellow at NHS Resolution. The tool was carefully considered and summarised the following information: claim details, patient demographics, relevant aspects of clinical care that could have contributed to the suicide attempt, and the SI report. Also available for review were all of the documents held within the CMS for each claim.

Once the data was collected and anonymised a thematic analysis[26] was conducted.

To ensure that the themes generated were robust, they were reviewed independently by both clinical and legal experts, a mental health clinician with over 20 years' experience and a select group of panel firm experts who have a particular interest and wealth of experience in mental health inquests and claims.

Once drafted, the report was peer reviewed by a number of consultants and senior mental health nurses currently working in the NHS.

Information governance

In undertaking this work NHS Resolution has been mindful of the confidential and sensitive nature of the information which forms part of this investigation. To this end, only the minimum necessary information has been processed in an identifiable format during the research phase, and is not presented in an identifiable format in this report.

The author has been contracted to work for NHS Resolution for the purposes of this project, and is bound by professional obligations of confidence as a doctor, as well as contractual obligations through their work.

An integral part of NHS Resolution's functions is the promotion of safety and learning to improve the safety and quality of services provided by the NHS, to which this report directly contributes, and this encompasses the proportionate use of information held by NHS Resolution about claims involving living and deceased individuals for those purposes where necessary and in the public interest.

Limitations of this study

Limitations of the CMS

Coding: as with any research involving coded systems, there can be inconsistencies in the way that claims are coded. This means that potentially some cases that should have been included are overlooked. There are consultations currently underway about how best to redesign the CMS to make it more suitable for analysing claims.

Consistency of information gathered: there were differences in the information included in the correspondence section of the CMS. For example, different levels of detail in solicitor reports relating to the inquest.

Lack of original clinical information: the CMS does not contain a full copy of the healthcare records, hence occasionally inferences about clinical care have to be made based on the information available.

Limitations of the search

As with any search, claims may have been wrongly excluded that would otherwise provide an opportunity for learning. This has hopefully been minimised by reviewing individual claims rather than relying on coding.

The sample examined represents but a fraction of those who have taken their lives in the UK over the same time period. While the claims arise from trusts throughout the country, as only trusts in England are included in the inquest scheme it may be more difficult to generalise the findings nationally. Similarly, any recommendations made need to be viewed in the context of the wider healthcare system as it is acknowledged that if the only learning reviewed is that present in claims, other important learning may be overlooked. Claims only represent the tip of the iceberg, and there is an opportunity for learning from complaints and incident reports relating to mental health.

Few trusts would claim that just because a claim against them was not awarded compensation, there are not important lessons to be learned. Therefore both compensated and defended claims have been included to maximise the learning.

Limitations of a thematic review

While thematic analysis is flexible, this flexibility can lead to inconsistencies and a lack of coherence when developing themes derived from the research data.[27] In this study the reliability of our claims was increased by using multiple reviewers to theme the data.

When data is themed the power of individual stories can be lost. By sharing anonymous examples we hope to retain some of this original power. It is also hoped that the themes emerging will have enough weight to influence change.

Limitations when reviewing clinical reports

The author's previous knowledge and experience of patient suicide may have influenced the qualitative data interpretation given the subjective nature of this type of review.

As this report is based on a series of cases and their SI reports, there are no comparison cases where similar treatment did not end in suicide.

Hindsight bias

It is important to acknowledge the phenomenon of 'hindsight bias' when considering SI investigations. This occurs when those investigating or reviewing wrongly believe that an event may have been predictable, without any objective evidence at the time an assessment took place.[28]

In this report efforts have been made to minimise hindsight bias where possible by reviewing decisions in as objective a manner as possible. Despite these efforts there is the possibility that some of the data related to risk assessment may be subject to a degree of hindsight bias.

Breakdown of claims

The data following relates to the claims for completed suicide. Non-fatal suicide attempt related claims are reviewed in a later chapter.

We identified 101 claims as being suitable for thematic analysis. The 101 claims were spread between 55 different trusts, with different types of trust facing litigation. The majority were mental health trusts (69%).

A patient suicide automatically meets the threshold for an SI investigation[29] so it is likely that all of the deaths were investigated internally by the individual trusts. As some of the claims were closed with no liability admitted and no court proceedings, some of the claims did not have the SI report uploaded to the CMS. This was the case in three claims. The individual trusts were approached and we were able to upload those SI reports in two cases.

Table 3 shows which panel firms dealt with the claims. Of the ten panel firms that act on behalf of NHS Resolution to manage clinical negligence claims, nine were involved in the claims in this report, with four of the claims being dealt with 'in house' by NHS Resolution.

Table 3: Panel firms dealing with claims

Panel firm	Number of cases
Bevan Brittan	11
Browne Jacobson	10
Capsticks	7
DAC Beachcroft	15
Hempsons	19
Hill Dickinson	10
Kennedys	15
NHS Resolution	4
Ward Hadaway	6
Weightmans	4
Total	**101**

The incident date ranged from September 2010 to January 2017.

Table 4: Incident year for fatal cases

Incident year	2010	2011	2012	2013	2014	2015	2016	2017
Number of claims	1	0	4	19	30	33	12	2

Table 5: Year NHS Resolution notified of claim

Notification year	2015	2016	2017
Number of claims	37	53	11

The average duration from death to the notification of a claim to NHS Resolution was one year, four months and 19 days (range = six days to four years, nine months and 20 days).

Claimants

Those listed as a claimant were reviewed. Parents were most likely to make a claim following the death of a child, followed by a spouse or partner, and then children of the deceased individual. The 'other' category mainly consisted of siblings (66%) and other family members.

Table 6: Claimants in completed suicide claims

Claimant	Number of claims
Parent	49
Spouse	22
Child	14
Friend	1
Other	12
Unknown	3

Admissions

Admissions for either a breach of the duty of care and/or causation were made in 46% of the claims reviewed.

Financial implications

Completed suicide claims

Forty-two claims had been closed with no damages. The average cost of defending each of these claims was £5,461.97 per claim. In addition there will have been legal costs paid to the claimant's representatives, although these costs were not met by NHS Resolution. Four claims had been discontinued with costs to be confirmed.

Fifty-two claims had either been settled with damages agreed or set by court. The average total value (claimant costs + defence costs + damages) of each of these claims was £90,676.15.

Four claims had been discontinued with costs to be confirmed. The remaining three claims were either at an early stage of the claim (one claim), awaiting a letter of response where the claim would be either repudiated or admissions made (one claim) or awaiting the final defence bill (one claim).

Non-fatal suicide attempt claims

A claim relating to a person who has taken their life is likely to receive a smaller settlement than a claim from a person who had significant ongoing care costs for a number of years.

Of the 26 cases reviewed, the total estimated value (claimant costs + defence costs + damages) averaged £4,138,430 per claim. For the claims reviewed, this represents a total value of £99,322,337.68. A huge amount of money that could potentially be spent on frontline care if these tragic incidents could be avoided.

Historically claims were often paid as a lump sum, even if there were ongoing care needs. It is now increasingly common for ongoing payments to be paid via annual periodical payments. These are annual payments for the life of the individual, linked to an inflationary index, to ensure all the needs of the individual are always met. This provides the claimant with the security of knowing that an annual payment will be made and the individual will never run out of funds.

These costs highlighted previously are solely those associated with compensation claims and do not include the organisational costs to the NHS, the additional costs of investigating what went wrong[30] or the often unreported personal and psychological costs to staff.

To reduce the financial burden on the NHS of the growing costs of claims we must 'learn from things that go wrong, to help reduce harm, improve patient safety and prevent claims from happening in the future'.[31]

The sections in this report

The remainder of this report is divided into two parts. The first reviews the clinical themes that emerged from the data. The second reviews the processes around investigating an SI including reports to prevent future deaths, family and staff support following an SI, and the learning from non-fatal suicide attempts.

The sections are not mutually exclusive, in that the themes that emerge in the first section will be influenced by the issues highlighted in the second and vice versa.

It is hoped, however, that separating the report in this way will allow readers to 'dip in' to areas that particularly pique their interest, while appreciating the wider contributions trusts can make to reduce SI occurrence and improve investigations.

Part 1: Clinical themes

This section of the report reviews the clinical details and the common themes that emerged from an in-depth review of the 101 claims relating to completed suicide.

Demographic features

The basic demographic details are outlined in Table 7, with national data* for comparison.[9]

Table 7: Basic demographic details

	Study cohort n=101	NCISH 2005-2015 n=13,576
Demographic features:		
Age: median (range)	38 (16–75)	46 (10–100)
Aged under 25	17%	7%
Male:Female	55%:45%	66%:34%
Living alone	9%	47%
Unemployed	23%	44%
Black and minority ethnic group	9%	8%
Homeless	1%	3%
Patient groups:		
Inpatients	29%	9%
Recent (<3 months) discharge	12%	17%
Under crisis resolution/home treatment services	21%	16%
Missed last contact in previous month	24%	24%
Non-adherence with medication in previous month	22%	13%

When compared to national data,[9] our study cohort tended to be younger, were more likely to be inpatients and were more likely to have been non-adherent with medication in the past month. They were also more likely to be in employment and less likely to be living alone.

This data is not necessarily surprising given we are reviewing cases that went on to become a claim –those providing support to individuals prior to their death may be more likely to recognise failings in care and seek compensation.

The basic clinical details are outlined in Table 8, again with national data for comparison.[9]

Table 8: Basic clinical details

	Study cohort n=101	NCISH 2005-2015 n=13,576
Clinical features:		
Any secondary diagnosis	66%	51%
Behavioural features:		
History of self-harm	76%	68%
History of violence	34%	22%
History of substance misuse	55%	54%
Contact with services:		
Last contact within seven days of death	67%	49%

*The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) provides findings relating to people who died by suicide, and were in contact with mental health services in the year before their death, between 2005 and 2015 across the UK.

We have used NCISH data as a benchmark in this report as it represents the most comprehensive review of data relating to suicide for those in contact with mental health services in the UK. The data is reported on a country-by-country basis, making it a useful comparison as our cohort only includes deaths in England.

When NCISH data is referred to in this report, it is the inquiry's data from England to which we compare.[9]
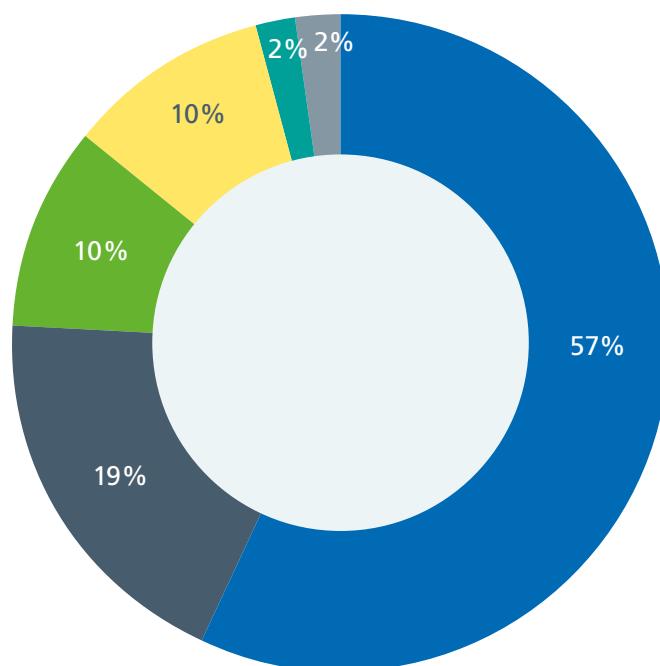
Causes of death

The top three causes of death (albeit with different contributions to the total) were the same as those found in NCISH, namely hanging, jumping/ multiple injuries and self-poisoning. These methods were the most prevalent for both males and females, though in our cohort hanging was more common among males (60% v. 55%) and self-poisoning was more common among females (18% v. 4%).

Prescribed medication was most commonly implicated in self-poisoning, accounting for a third of these kinds of death. In contrast to the NCISH data, opioids were not heavily implicated in our cohort, with only one death noting opioid use in the post mortem report, although this was not considered to have significantly contributed to the death.[9]
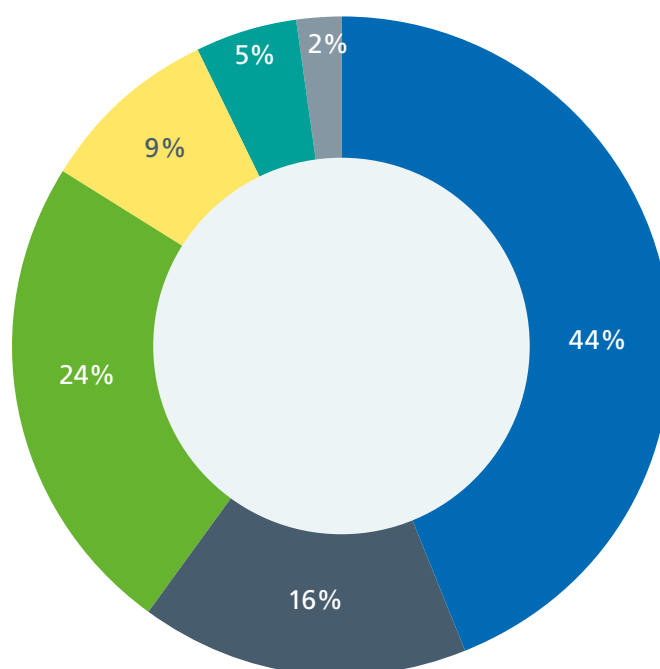
The 'other' category in our cohort is described in Table 9.

Legend:
- Hanging/strangulation
- Jumping/multiple injuries
- Self-poisoning
- Other
- Drowning
- Gas inhalation

Figure 8: A comparison of the study cohort causes of death with NCISH Patient suicide in England: Main causes of death 2005–2015 [9] data.

Study cohort: Main causes of death (n = 101)

NCISH data: Patient suicide in England: Main causes of death 2005–2015 (n = 13,576) [9]

Table 9: 'Other' causes of death

'Other' cause	Number
Wounds causing exsanguination or direct trauma	3
Undetermined at post mortem	3
Self-immolation	2
Firearms	1
Medical complications of suicidal act	1

These findings allow us to be cautiously confident that our study cohort reasonably reflects the national picture of those taking their lives while in contact with mental health services, recognising the relatively small number of claims under review. Consequently, recommendations relating to suicide prevention driven by the data in our cohort are likely to support suicide prevention on a much larger scale.

Similarly, it follows that the themes that emerge from the thematic review are likely to represent those encountered in clinical practice and recommendations to change practice based on these should have a positive impact on the wider system.
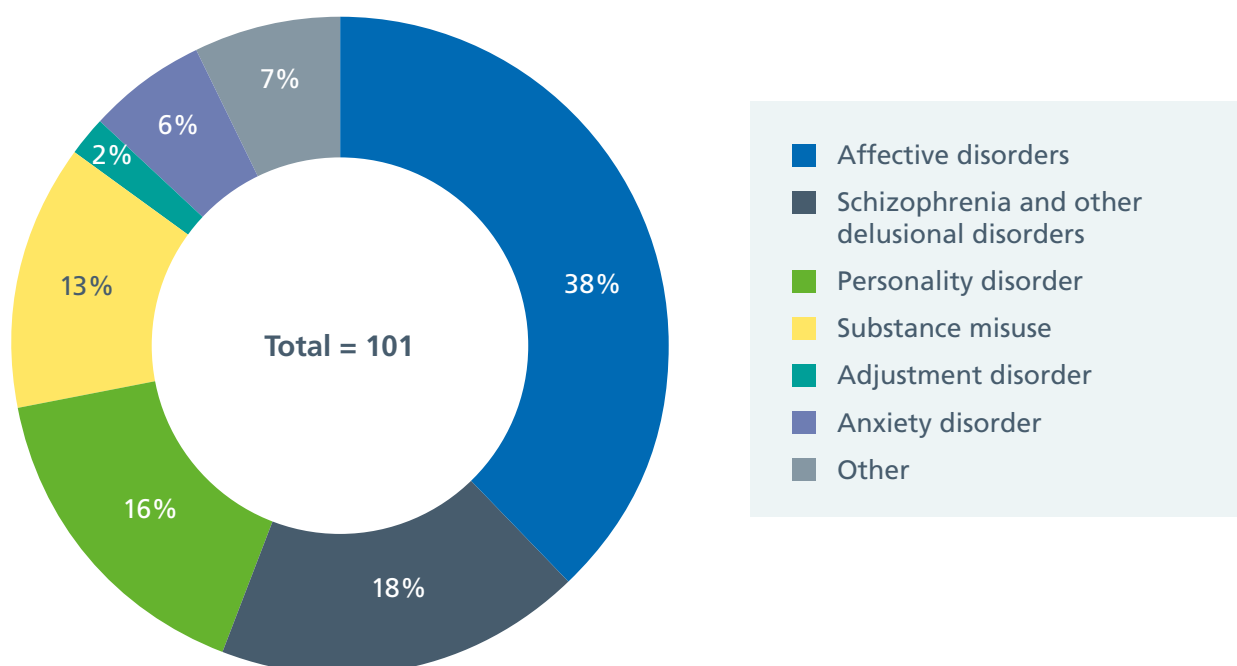
Diagnosis

The primary diagnoses of the cohort are described in Figure 9. They reasonably reflect NCISH data, notwithstanding our cohort showing a higher proportion of diagnoses of personality disorder (16% v. 9%) and lower proportion of affective disorder diagnoses (38% v. 45%).[9]

As shown in Table 8, 66% of individuals in our cohort had a secondary diagnosis. The most common primary diagnosis was depression with 33 individuals having an active diagnosis at the time of death.

Depression was a co-morbid diagnosis in a further 16 individuals, meaning that almost half of our cohort had an active diagnosis of depression at the time of death (49%).

Figure 9: Primary psychiatric diagnoses

Total = 101

- Affective disorders
- Schizophrenia and other delusional disorders
- Personality disorder
- Substance misuse
- Adjustment disorder
- Anxiety disorder
- Other

The perinatal period

There were no suicides in the CMS data by women who were, to the author's knowledge, pregnant or who had died within a year of childbirth. National data suggests that 1% of all female suicides would fit into this category, an average of five deaths per year.[9]

Our small sample means that we cannot attach great significance to this finding and we welcome the plans to increase specialist perinatal psychiatric provision nationally.[32]

Child and adolescent deaths

There was one death when the individual was under the age of 18. There was another which involved an 18-year-old who was transitioning from child and adolescent mental health services (CAMHS) to adult services, a recognised time of increased risk.[33] It is unfortunately beyond the scope of this review to discuss in detail child and adolescent suicide.

The Healthcare Safety Investigation Branch have recently released a full investigation and recommendations relating to this area, which can be reviewed here: https://www.hsib.org.uk/investigations-cases/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/.

Themes identified in clinical care

The 101 claims were clinically varied, but by performing a thematic review it was possible to identify common themes that represent a national picture.

The main themes identified were:

1) Substance misuse

2) Communication

3) Risk assessment

4) Observations

5) Prison healthcare

Theme 1:

Substance misuse

There were 55 claims (54%) where the individual was recorded as having a history of substance misuse. This is consistent with national data[9] and published research into the relationship between substance misuse and suicidality.[34]

A third (n=33) of individuals had an active diagnosis of substance misuse at the time of death, with almost 40% (n=13) of these recorded as having substance misuse as a primary diagnosis.

Figure 10: Active substance misuse diagnosis

- None
- Primary
- Comorbid

20%

13%

67%

Total = 101
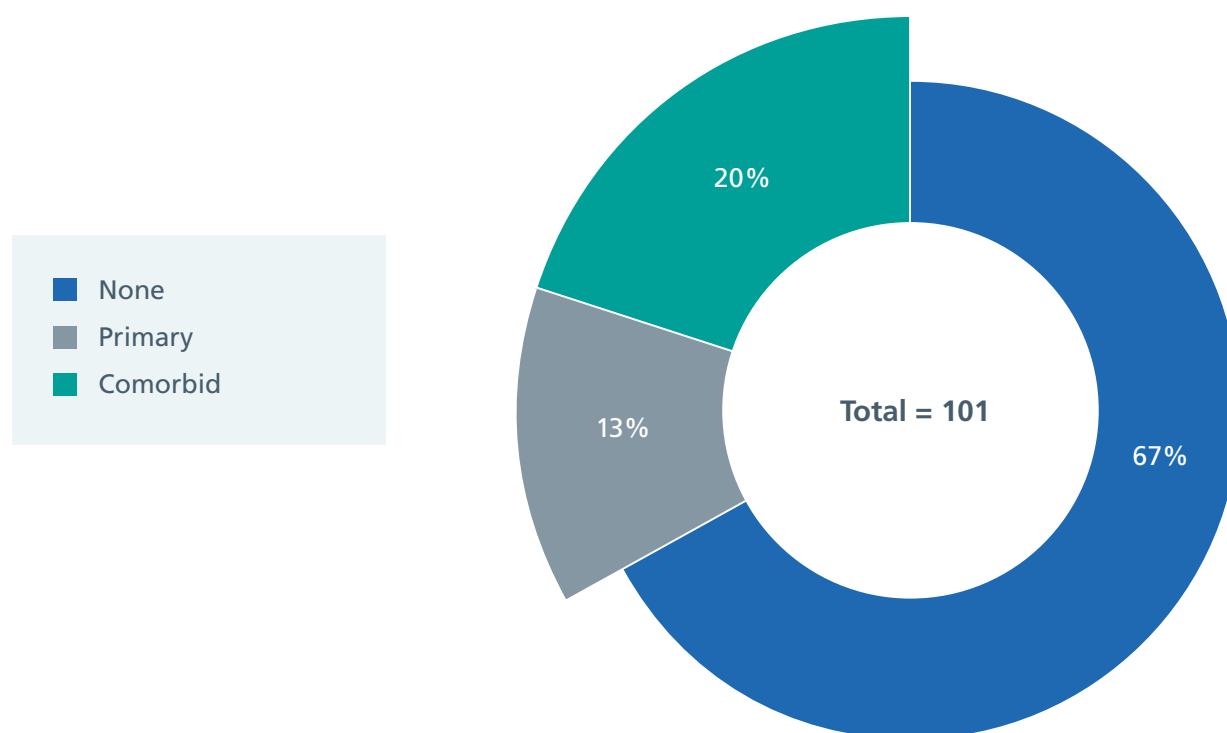
Of the claims reviewed, 10% suggested that the individual was intoxicated with either drugs or alcohol at the time of the suicide attempt. This information was extracted from post mortem reports (n=5), serious investigation reports (n=2) and coroners' reports (n=3).

In spite of these figures, less than 10% of those diagnosed with active substance misuse at the time of death were engaged with a specialist substance misuse service. Two claims involved individuals who were believed to be withdrawing from substances at the time of their death.

One of these cases was a prisoner who, after it was recognised they were in withdrawal, should have had access to pharmacological support for detoxification from drugs.[35]

Evidence from elsewhere

The relationship between substance misuse and suicide is well documented,[9] with up to 40% of patients seeking treatment for alcohol/substance use disorder reporting at least one suicide attempt at some point in their lives.[34] Those who have co-morbid substance misuse and mental health problems feature prominently in hospital admissions data. Of mental health crisis related admissions to acute hospital in 2012/13, 20% were due to alcohol use, the second highest proportion after self-harm and undetermined injury.[36]

The Five Year Forward View for Mental Health highlights the challenges for commissioners who have a responsibility to ensure people with multiple needs do not fall through service gaps.[10] For example, the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units.

Referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care.[10]

Public Health England have recently published work reviewing the barriers to engagement in substance misuse treatment following release from prison.[37] An audit of referrals made from prison to community substance misuse services identified weaknesses in the pathway between custody and the community, for example almost half of the referrals made by prison treatment services were not received by the community treatment services and that there was limited follow-up of individuals who did not attend.

A proportion of medical treatment for alcohol and drug misuse is now delivered by the non-statutory and private sector providers.

While this has the potential to support effective and enhanced services, safe and effective alcohol and drug services need staff with the necessary skills, or at least access to appropriate expertise, to meet all the needs of the population, including those with very complex needs.[36] The Francis Report emphasises the responsibilities of commissioners and providers in relation to service user safety and quality of clinical care.[38]

Clinical guidelines acknowledge the need for collaborative working across multiple agencies, which may require 'traditional' institutional boundaries to be crossed.[39] The guidance highlights the highly specialist nature of substance misuse services, and the varied clinical requirements of individuals with substance misuse problems, emphasising the specific staff skills and competencies required to meet these.[40]

'The reality is, that it is getting harder and harder to get people into and using services.'

Psychiatrist specialising in substance misuse

Recommendation

Clinicians should consider a referral to specialist substance misuse services 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.

How should this be achieved?

At a national level

Compliance with this recommendation is likely to yield an increase in referrals to substance misuse services. Already stretched services may struggle to match demand. In July 2016, the Cabinet Office launched the new Life Chances Fund which, among other aims, offers up to £30 million for outcomes-based interventions to tackle alcoholism and drug addiction.[41] The Life Chances Fund aims to contribute around 20% of the total outcomes payments, with local commissioners paying for the majority of the outcomes payments. Local areas will have to demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems in order to access this additional funding.

There will need to be clarity about the funding contribution required from local commissioners to pay for the outcomes that are being sought,[10, 36] but commissioners should consider ways that they may access this funding over the duration of the scheme (2016–2025) to increase service provision.

Commissioners and providers should work collaboratively to ensure ongoing specialist training posts in alcohol and drug misuse services are available. This will involve engaging with the appropriate deanery, which in most cases would be the role of the provider. The Royal College of Psychiatrists can support this, and should work collaboratively with providers to promote specialising in addiction as an attractive career option for trainee doctors. The Royal College of Psychiatrists' successful Choose Psychiatry campaign could encompass this.[42]

Health Education England also has a responsibility to ensure that there are opportunities for doctors and nurses to develop skills in substance misuse to ensure that service demand can met be met by qualified staff.

At a local level

The national Suicide Prevention Strategy set out the requirements for all local areas to have multi-agency suicide prevention plans in place by 2017.[43] This is supported by guidance[39] which highlights that a key component of risk management in mental health care requires specialist substance misuse and mental health services to work closely together. Trusts should have clear referral guidelines and pathways to support joint working between substance misuse service and both acute and mental health trusts.

Referrals should be regularly audited to ensure that those in need of support are then offered access to services, if appropriate, once a referral has been made. If barriers to engagement are identified, local quality improvement work should aim to minimise these.

From 2018, during CQC inspections, one of the Key Lines of Enquiry will be: *'Are people's physical, mental health and social needs holistically assessed, and is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including National Institute of Clinical Excellence (NICE) and other expert professional bodies, to achieve effective outcomes?'* Given the guidelines around specialist substance misuse involvement, trusts should recognise it as a failure in care if specialist support is not considered.

Time frame for implementation

By the end of 2019 it would be reasonable to expect the recommendation to be implemented and the CQC to review the provision for those with substance misuse issues during their inspections.

Example of good practice

Solihull Integrated Addiction Service (SIAS) is a partnership between four organisations jointly responsible for the delivery of the drug, alcohol and gambling services in the Borough of Solihull. SIAS also delivers support to families and friends affected. The SIAS partnership comprises the following organisations that collaborate to deliver a range of care services:

- **Birmingham and Solihull Mental Health Foundation Trust:** Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care to those people living in Birmingham and Solihull who are experiencing mental health problems.

- **Aquarius:** Aquarius strives to help people overcome the harms caused by alcohol, drugs and gambling. Aquarius works closely with families and friends to lessen the impact caused by a habit of a loved one.

- **Welcome:** Welcome's purpose is to assist individuals and their families overcome drug, alcohol and gambling dependency. Welcome also runs a social enterprise called Welcome Change CIC to assist those in early recovery from addiction.

- **Changes UK:** Changes UK is a social enterprise based on the Community Interest Company (CIC) model that supports people on their recovery journey towards independence.

Theme 2:
Communication

There were 41 SI reports that cited poor communication as a contributory factor (46% of those available for review). This translated into 70 recommendations for change aimed at improving communication.

In spite of these relatively high numbers, only four investigations identified issues in communication as the root cause of the event (Table 10).

Table 10: Communication issues listed as root causes

Communication issues identified as root causes
'The ward staff and multi-disciplinary team did not establish effective communication with the service user and could not therefore undertake a detailed risk assessment.'
'Lack of staff time to effectively communicate, due to the pressure of meeting so many different patient needs.'
'…huge gaps in effective governance arrangements, including communication, and inadequate management and leadership structures for a prolonged period of time.'
'Message from family not communicated in timely manner to care coordinator on the day of the incident.'

The root causes highlight that communication can fail at different points in the system. This was reflected in the range of recommendations that emerged across the 41 reports, with suggestions to improve communication across a range of areas, demonstrated in Table 11.

Table 11: The areas of communication breakdown addressed by recommendations in the SI reports

Area of communication breakdown	Number of recommendations to address
With family or carers	19
IP/OP/3rd party (including chaplaincy)	13
GP	6
Handover	4
Documentation to support verbal communication	3
Healthcare/prison staff	3
Multi-disciplinary team (including ward round processes)	3
Other	19

Communication between services

Breakdowns in communication were apparent between inpatient services and others responsible for the care of the individual. These included poor liaison between community mental health teams (CMHTs)and inpatient units, particularly on admission and nearing discharge (11 cases); accommodation providers who were receiving patients on discharge (two cases); and there were two examples of chaplains visiting the ward and important patient details not being conveyed both to the chaplain by ward staff (leave arrangements) and to the ward staff by the chaplain (a disclosure by the individual to the chaplain that they were feeling suicidal).

There were also examples of poor communication with emergency services when they were involved in care – this was most common with patients arriving to Emergency Departments by ambulance or with the police. Documentation detailing the initial presentation was not available to healthcare staff for subsequent assessments and important pieces of information to further inform care were missed.

Handover

In total, there were ten recommendations made that related to nursing staff handover processes. As well as four recommendations relating to the quality of verbal handover (all suggesting that the 'SBAR – Situation, Background, Assessment, Recommendation'[44] format is used), written communication to support verbal shift handover was recommended in six SI reports. None of the reports suggested how or where the verbal shift handovers should be recorded or offered an example of the 'ideal' nursing handover for psychiatric inpatients on their units.

Communication with general practitioners

The recommendations to improve communication with GPs were split equally between improving referral pathways for GPs to refer patients for urgent review into mental health services, and inpatient and crisis teams communicating with GPs when patients had improved and were being discharged back to community care.

These recommendations highlight the central role GPs play in the care of many patients in the community, that they may be the first professional who identifies a risk of suicide, and are often relied upon to review and monitor individuals when their mental state is deemed to have improved and they are discharged from secondary mental health services.

Documentation

Written communication in the form of documentation attracted 74 recommendations across the cohort. Table 12 lists the top seven issues that prompted recommendations.

The remaining 27 recommendations were not offered more than three times each, but generally included issues around electronic note systems, documenting risk assessments and leave arrangements, and documentation relating to discharge.

Table 12: Number of claims with recommendations relating to documentation

Recommendation themes that related to documentation	Number of claims (Not mutually exclusive)
'Follow documentation policy'	15
'Document clinical discussions'	10
'Document multi-disciplinary team discussions'	6
'Document discussions with carers'	6
'Document medication'	5
'Upload correspondence'	4
'Improve care planning documentation'	4

The recommendation to 'Follow documentation policy' will be addressed in another section of this report. It is interesting that the next three most common recommendations all relate to the documentation of clinical discussions. The ideal of accurate, contemporaneous notes is perhaps more challenging in psychiatric practice compared to other specialties, owing to the depth and length of many of the discussions.

An observation from the reports was that recommendations relating to documentation often did not take into consideration the pressures and constraints of clinical practice.

An example of this would be a recommendation that suggested:

'The multi-disciplinary team meeting clinical discussions and actions should be written up, circulated, agreed by those expected to carry out the action before being uploaded to the system.'

A recommendation relating to documentation from an SI report

This process may have ensured high quality notes, but there would have been a significant delay to updating the system, with potential adverse consequences for the patient.

The *Carter Report* identified the variation in the systems used to record notes across different trusts and even within the same trust between inpatient and outpatient services.

The report showed that many clinical record systems in mental health trusts are time-consuming and difficult for staff to use and recommended that NHS Improvement should support trusts to change this by developing guidance on good operating practices for services delivered in the community, and providing benchmarking metrics for mental health and community health service lines on the Model Hospital by April 2019.[45]

Communication with families is addressed in full in another chapter.

Recommendation

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.

How will this be achieved nationally?

Developing more integrated approaches to mental health should be a key priority given the close links between mental health and physical health outcomes, and the impact these have on the quality and costs of care. (46) The new models of care introduced by the *NHS Five Year Forward View* create an important opportunity to deliver whole-person care that responds to mental health, physical health and social needs together. (10)

Sustainability and transformation partnerships (STPs) are the main mechanism for delivering the *Forward View*. It is essential that all STPs set out ambitious but credible plans for improving mental health and integrating mental health into new models of care. These should include clear guidelines on how services should communicate and suggest systems to implement this.

A small number of the partnerships are now evolving into integrated or 'accountable' care systems (ACSs). In these areas providers and commissioners come together, with a combined budget and fully shared resources, to serve a defined population. (47)

Work is also underway in a number of systems to consider what activities providers could take on from Clinical Commissioning Groups (CCGs) within new forms of integrated care partnership (ICP) or integrated care organisation (ICO). Approaches range from collaborative approaches, in which CCG and provider colleagues both share expertise to inform new service specifications, to an increase in alliance contracts across local provider partners, to the development of more innovative open book and risk share arrangements between providers and CCGs. (48)

Planning for these changes in trusts should be reviewed regularly by trust boards. Trusts should be able to evidence their engagement in consultation about developments to their commissioning arrangements to the CQC, who will confirm this as part of their routine inspection process.

How will this be achieved locally?

At a local level trusts should evaluate their current systems of communication both internally (for example, at medical shift handovers) and externally (for example, discharge letters being sent to a GP). If it is apparent that the systems do not work to offer comprehensive, timely communication to relevant parties, priority should be given to projects to remedy this.

Those with knowledge of the communication systems in place, and those responsible for communicating between relevant parties, should be consulted on what might constitute the most effective way to communicate. This should include stakeholders external to the trust, for example, local GP practices. This work should not remain at board level, with both clinical staff and trainees being encouraged to engage in quality improvement work to improve communication locally. Where there are measurable improvements, the strategies behind this should be shared with other trusts via Quality Improvement networks, such as the Royal College of Psychiatrists' College Centre for Quality Improvement[49] or national conferences.

Digital systems to aid communication

NHS Digital currently have three work streams that are aimed at improving communication between services to support coordinated patient care:

- **The Summary Care Record** is a national system that allows core information from their GP practice to be accessed by NHS care providers via the Spine system. The core information, available for 96% of the population, includes: medication, allergies and adverse reactions. Patients can also opt in to have additional information added to their summary care record, including but not limited to: significant medical history, reason for medication, anticipatory care information, end of life care information and immunisations. Take-up of this option is comparatively low and there is a drive to increase sign-up, working closely with CCGs and GP practices.

- **The National Record Locator Service** is currently being developed and will act as a national index for finding out what records exist for a patient across local and national care record solutions. The initial phase is currently focused on providing an ambulance service with the ability to see whether a patient has a mental health care plan. Again, this system should have national reach, and will enable staff to view where a patient has had contact with services.

- **'Reasonable adjustment flagging'** is currently being developed by NHS Digital. The idea is to provide a capability for national flagging of reasonable adjustments under the Equality Act (2010) with the pilot due later in the year, focusing on patients with a learning disability. One of the key reasonable adjustments for mental health is signposting the mental health crisis care plan and details of the carers to be involved.

NHS England is investing over £30 million between 2016 and 2023 in upgrading the **Healthcare and Justice Information Service (HJIS)**. This upgrade will include improved links between prisoners' healthcare records, including enabling prisoners to be registered to prison services through Spine. This will enable electronic referrals, electronic prescribing and automated data extraction for performance reporting, as well as making it possible for patient records to be shared between GPs in the community and those in prisons. There are also plans to create a workable process that will ensure patients being released will have a GP to go to in the community, to maintain care and support. This will help to improve patient safety on reception and at release, due to greater continuity of care.

Examples of good practice

Since April 2018 the Living Well Network Alliance (LWN Alliance) has been established in Lambeth, South London. The LWN Alliance is a group of seven to eight providers and commissioners who coordinate and deliver support and services for those experiencing mental health issues in Lambeth. This includes providing support across traditionally separate areas including housing, social care, mental and physical health and welfare. There remain a number of significant challenges in Lambeth, including high demand for services, lack of coordination between services and providers, financial pressures and health inequalities. The LWN Alliance have been piloting smaller scale projects with positive results, including formal collaboration, contracting with established mental health support services. As well as supporting a personalised and holistic support service in Lambeth, the LWN Alliance aims to coordinate care and drive improved integration across the system, including managing demand through primary prevention and reducing dependency on services.

It is recognised that the culture of the interaction between services will require constant review and the LWN Alliance plans to promote a positive and respectful culture for staff and service users. More details can be found at: http://lambethcollaborative.org.uk/lwn-alliance.

Tower Hamlets Together, working with East London NHS Foundation Trust as a full partner as well as working with partners from City and Hackney and Newham, has developed a primary care mental health service to support the discharge of people with stable serious mental illness into recovery-oriented primary care services, and provide step-up support to people from primary care. Since the scheme's inception in 2013 more than 5,000 people have received support from the primary care mental health service in East London, helping to create a smaller but more responsive secondary care service and improve patient and practice experience.[46]

Birmingham County Council supports a monthly Strategic Liaison Committee where stakeholders involved in acute care, including but not limited to the police, the ambulance service, mental health liaison services, accommodation providers and social services, collaborate to share current issues in service delivery with the aim of reducing silo working, and identifying and addressing areas where there is potential for communication to break down. By aligning and understanding the differing models of work, there is a proactive approach to continually improving services.

Thrive LDN is a London-wide movement to improve the mental health and wellbeing of all Londoners. Thrive LDN has an aspiration for London to be a zero suicide city and facilitates a number of projects around multi-agency working and increasing knowledge to assist prevention of suicide within London. These are delivered in collaboration with a range of partners across the capital, including the Metropolitan Police Service, British Transport Police, Transport for London, London Ambulance Service, organisations associated with London's railways and the Thames, NHS England and Public Health England (London region), third sector and academic partners, and importantly those with lived experience. Thrive LDN is supported by the Mayor, Sadiq Khan, and led by London Health Board partners. More details can be found at https://thriveldn.co.uk/.

Theme 3:

Risk assessment

> 'If risk assessment becomes the raison d'être of psychiatry, rather than the consequence of good psychiatric practice, much will be lost. Risk assessment is a very valuable tool in modestly helping us predict some aspects of behaviour in psychiatric patients. It will not, cannot, and should not obliterate that risk.'
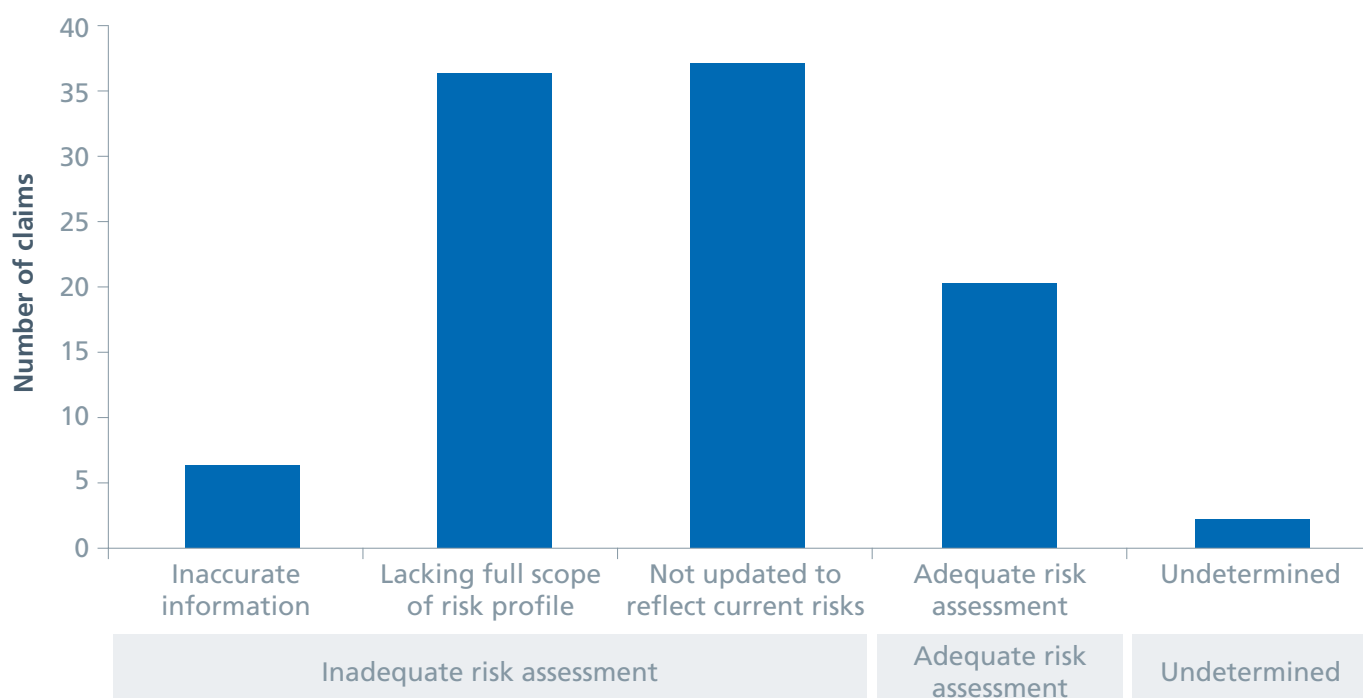
Royal College of Psychiatrists [50]

It is acknowledged that assessing risk is a complex task.[51] Clinicians are regularly faced with patients who have either attempted suicide or are threatening to, and the job of trying to predict their risk of future suicidal acts. These risk assessments often need to be made relatively quickly, for example, when the patient is asking to leave the emergency department after medical management, and can have significant consequences if risk is incorrectly judged as being too low for admission (suicide), or too high for discharge (deprivation of liberty).

While acknowledging the potential for hindsight bias, the quality of risk assessment was reviewed in our cohort. This was done by reviewing risk assessments available in relation to the information available to the clinical team at the time (based on medical notes, SI reports, expert witness reports and coroners' reports).

Risk assessments were considered to be inadequate in the majority of the cases reviewed (78%).

The risk assessments were themed based on why they fell below a reasonable standard (Figure 11). The majority of inadequate risk assessments were deemed inadequate either because they had not been updated following new risk information coming to light – for example, a considerable change in presentation or stated suicidal plan, or the assessment had failed to consider anything other than the most basic features of risk (risk to self or risk to others), ignoring other important features such as risk of absconding and risk of neglect. In a number of cases, the risk assessment had not been completed before a change in observation levels (one case) or before allowing the patient to leave the ward, either for leave (three cases) or on discharge (three cases).

Some of the risk assessments contained inaccurate information – in these cases this generally related to false information about previous self-harm or suicide attempts (66% of risk assessments containing inaccurate information). It was generally not clear from the SIs if accurate information was available to the staff member at the time of the risk assessment, for example documented in previous historical notes. Three SI reports identified that risk assessments had not been updated in a timely manner to reflect current risks due to staff shortages. Otherwise, the SIs did not explore the reasons for inaccurate information, delay in updating risk assessments or lack of consideration of the full scope of risk.

Figure 11: Adequacy of risk assessment

Y-axis: Number of claims (0–40)

Categories: Inaccurate information | Lacking full scope of risk profile | Not updated to reflect current risks | Adequate risk assessment | Undetermined

Grouping: Inadequate risk assessment | Adequate risk assessment | Undetermined

SI report recommendations regarding risk assessment

The SI reports also identified that risk assessment procedures were inadequate in many areas and a number made recommendations and action plans to try to address some of these inadequacies.

Table 13 demonstrates the recommendations made relating to risk in the SI reports.

Table 13: Recommendations relating to risk assessment from SI reports

Recommendation to improve risk assessment	Number of reports recommending this (not mutually exclusive)
Staff training	12
Use of risk assessment tool	11
Acknowledge 'historical risk' in risk assessment	11
Staff should follow the risk assessment policy	11
Risk assessments to be completed at transfers in care (for example ward transfer/discharge)	6
Other	28

The evidence from elsewhere

There is growing clinical consensus that risk assessments are generally poor at predicting which patients will go on to take their lives.[52, 53] The poor predictive value of risk assessment has been acknowledged[52] and some have highlighted the detrimental effect repeat risk assessments can have on the therapeutic relationship.[54] Guidelines issued by NICE go some way to support a change in approach, stating that "assessment tools and scales designed to give a crude indication of the level of risk (for example, high or low) of suicide" should not be used,[55] yet the second most common recommendation for trusts in our cohort was to use such a tool.

The consensus from panel firms was that coroners may criticise a trust for not using a risk assessment tool, particularly if using a tool is described in the risk assessment policy. So why are trusts so wedded to the notion of using a tool to 'calculate' risk in patient groups? A meta-analysis of suicide risk assessment concluded that risk assessment can offer "false reassurance and is, therefore potentially dangerous"[56] may go some way to understanding the problem, supporting the notion that there should be a complete review of how clinicians access suicidal risk.[53]

Example of good practice

Maudsley Simulation, a specialist mental health simulation centre as part of South London and Maudsley NHS Foundation Trust, has developed a course *Making the Challenging Clinical Decision*. In simulated scenarios with professional actors, participants are asked to take a targeted history and complete a risk assessment. Each scenario is followed by a clinical decision pathway, which is then made by the group. There is then a debrief discussion around fact gathering, processing of information, and thinking about treatment decisions, especially to admit or not admit, as well as a review of the biases that can affect decisions and clinical actions. This training allows clinicians a rarely afforded opportunity to examine and develop decision making and risk assessment with peers and trained facilitators, creating a valuable learning experience. Feedback from the course has been hugely positive, with a high demand for more sessions to increase knowledge and skills in clinical decision making. More information can be found at www.maudsleysimulation.com.

Recommendation

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 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.

How should this be achieved?

At a national level

The document *Giving up the Blame Culture: Risk assessment and risk management in psychiatric practice* [50] outlines the complexities of risk assessment, while acknowledging that there are limits to even the most robust and comprehensive of assessments.

NICE guidelines which advise against using risk assessment tools should engender confidence in those seeking to formulate risk without their use.[55] It would encourage trusts to move away from promoting 'tick box' risk assessments if those who are in the position to criticise risk assessments, often with the benefit of hindsight bias, are sighted on these guidelines, and promote best practice in their feedback on clinical care.

At a local level

Trusts should include risk assessment training as part of their mandatory training requirements, including refreshing this training every three years. Training should include both practical clinical skills and a theoretical approach to embed with staff the risk factors to consider when assessing risk.

Provider boards should ensure that they have sufficiently robust policies in relation to risk assessment. These policies should be subject to regular scrutiny, including audit.

Timeframe for implementation

Trusts should ensure that they have developed a strategy to train their staff, and have begun staff training by 2020.

Theme 4:
Observations

Observations are defined by the Royal College of Psychiatrists as:

> *a therapeutic nursing intervention which aims to reduce the factors which contribute to an individual patient's risk (to themselves and/or others) and to promote recovery. There are different levels of observation such as general (minimum acceptable level for all inpatients) and continuous (one-to-one nursing).[49]*

The use of increased levels of observation (Level 2 or above) by healthcare practitioners is routine in mental health environments. The introduction of such observations is seen as a means of reducing risks related to a variety of situations such as suicide, self-harming, aggression and violence.[57, 58]

All patients on an inpatient unit should be assigned a level of observation. The level of observation is generally determined based on their perceived risk, either to themselves or others. Table 14 shows the different levels of observation used on mental health wards in England and Wales.

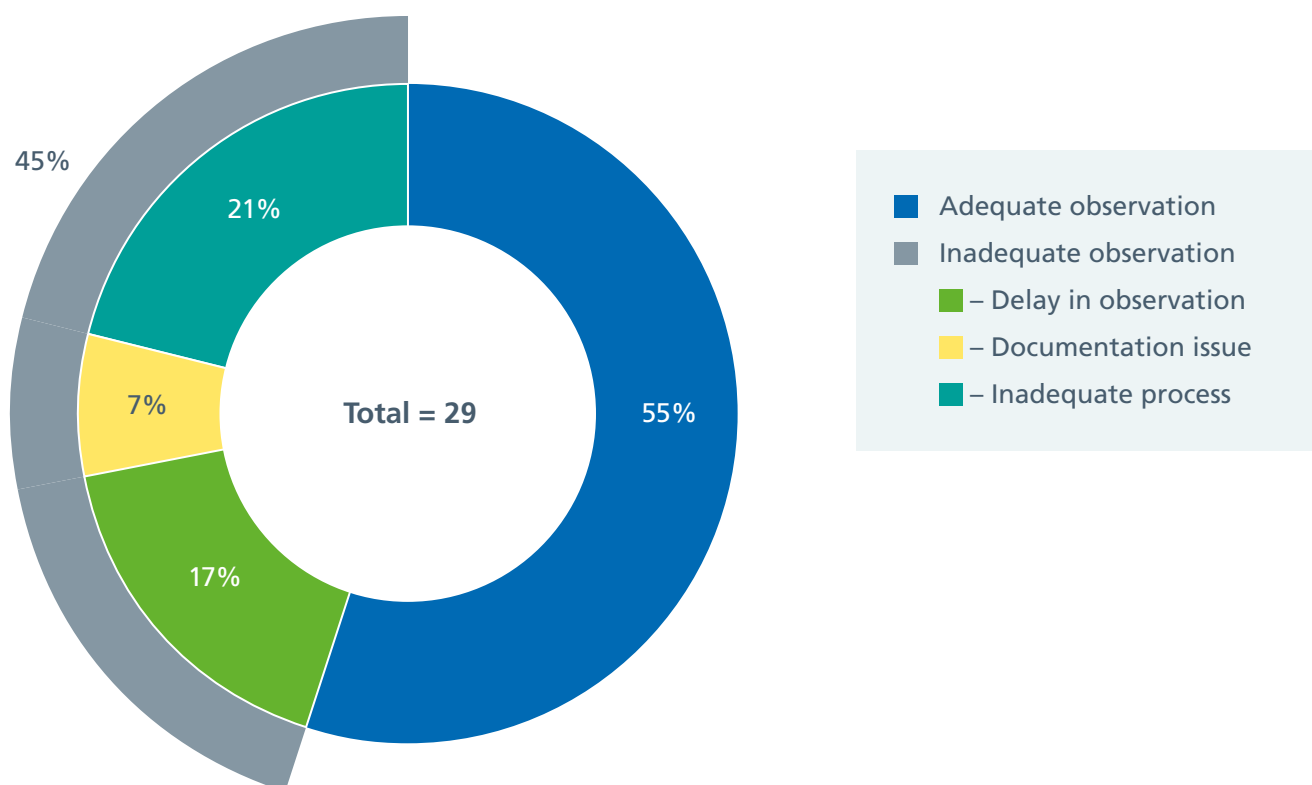## Table 14: The different levels of observation in England and Wales[58]

Observation level	Observations required
Level 1	General observation (observed once every 60 minutes)
Level 2	Intermittent observation (15–30 minute checks)
Level 3	Within eyesight (constant observation at all times, day and night)
Level 4	Within arm's length (constant observation at close proximity)

Observations on mental health wards

Of the 29 patients admitted to the inpatient mental health unit, almost half were subject to inadequate observation processes (13 claims equating to 44.8% of the inpatients in our cohort).

Figure 12 shows the proportion of patients subject to inadequate observations and the failings in the observation process.

Figure 12: The proportion of mental health inpatients subject to inadequate observation

Total = 29

45%

21%

7%

17%

55%

Legend:
- Adequate observation
- Inadequate observation
- – Delay in observation
- – Documentation issue
- – Inadequate process

Inadequate observation process

In six (21%) claims, the SI reports highlighted issues around the manner in which observations were conducted. These were reflected in observations by the coroner at a number of inquests, including being cited in one PFD report as being of grave concern.

> *"I was concerned that there is a risk of future deaths because staff remain unclear about what amounts to an effective observation, and more specifically whether there are circumstances which may allow them to refrain from verbally engaging with a patient, or from physically entering a patient's room to check the environment, and that should that lack of consistency and clarity prevail, other patients may be placed at risk as a result of inadequate observations."*

Coroner's PFD report

Delays in observation

In five (17%) claims the observation was not carried out within the prescribed time interval.

> *"…was found ligatured in her bedroom… She was on 10 minute observations at the time and should have been checked at 7pm. She was not found in her bedroom until approximately 7.12pm, which was 20 minutes approximately from the previous check; this resulted in a lost opportunity to render medical care, attention or treatment."*

Coroner's narrative conclusion

In the case above, it became apparent that one member of agency staff was responsible for recording observations on all of the patients on the ward on general observations, as well as completing checks for patients who were on observations every ten minutes.

Documentation of observations

Observations were not recorded adequately in two cases (7%). In these cases the timings of the observations had been written prior to the observation taking place, and then ticked erroneously.

In one of the claims, the patient had absconded from the ward at the time the observation was signed as being completed.

> *"Pressure of work meant that observations and completion of observation documentation was not done on time and not all observations were signed."*
>
> **Contributing factor from an SI report**

There were no inpatient deaths on the ward under inpatients who were subject to level 3 or 4 (continuous) observations in our cohort.

Observations in physical health wards

Observation processes operate differently in acute hospitals, and there is often confusion as to what level of observation is required for patients with psychiatric problems. This can be particularly apparent when patients are admitted to medical wards where the staff may have limited mental health training. Medical nursing staff report that they are sometimes asked to 'keep an eye on' certain patients – an impossible task when also juggling conflicting clinical responsibilities.[59]

In our cohort, three patients absconded from emergency departments or medical wards and immediately acted to end their lives. All three patients were in the hospital either awaiting further psychiatric assessment (two patients) or an inpatient psychiatric bed (one patient). None of the patients had been highlighted by the accessing clinical teams as being in need of observation, or that steps should be taken to prevent them leaving the department. Coroners tended to take a poor view of this. Examples of excerpts from their narrative conclusions are offered as examples:

"… although it was known at the time he had continuing suicidal ideation and was at risk of absconding from the hospital, no effective measures were put in place to prevent him from doing so."

"…his death was contributed to by significant failures of the senior clinical staff … to prevent the patient leaving the Department that night…"

Determining the appropriate level of observation

When the SI reports were reviewed it was apparent that patients were often on an inappropriate level of observation when this was evaluated in relation to their documented level of risk and reported clinical presentation. This was the case in nine of the 29 inpatient observation levels reviewed (31%). In all cases, the level of observation was lower than what might have been reasonably expected.

Of the nine SI reports reviewing the observation levels, six confirmed that there was no obvious rationale for having patients on general or intermittent observations, among which were four cases where the observation level had been reduced without any involvement or discussion with the wider multi-disciplinary team.

Investigation into the reasons behind these failings suggests that staff often do not see the purpose of observing the patient or how it links to the overall plan of risk management. The decision to start or stop observation can also, quite wrongly, be influenced by staffing levels and resources rather than dictated by the patient.[60]

Evidence from elsewhere

While there are a number of studies that support the use of observation in reducing self-harm and suicide,[57, 58] there is some debate as to whether observation is an effective tool to mitigate risk for suicidal patients.[61, 62]

Difficulties in observing patients in the psychiatric environment have been highlighted in a number of studies. A recent case study concluded that patient deaths were linked with the use of less experienced staff or staff unfamiliar with the patient, deviation from procedures and absconding.[60]

This reflects the patterns in our data, and further supports the work of others who acknowledge the level of skill required in carrying out effective nursing observations.[61]

It is important to recognise that observation can be a restrictive intervention; therefore every effort should be made to use the least intrusive level of observation necessary, balancing the patient's safety, dignity and privacy with the need to maintain the safety of those around them.[63, 64]

It should also be recognised that there is an impact on staff when they are responsible for carrying out observations, especially if these are level 3 or 4 continuous investigations.[65]

Recommendation

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.

How should this be achieved?

At a national level

The Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) have published *Standards for inpatient mental health services*, which state that there should be a policy on patient safety and the use of therapeutic interventions and observation, which includes a number of considerations that could be incorporated into local training.[66]

The next edition of the Standards are due in spring 2019 and, in line with our recommendation, the CCQI will consider the inclusion of a standard that staff are, as a minimum, locally trained in observation processes on a ward before being expected to take responsibility for observing patients. Participating mental health services will need to comply with this in order to be accredited by the College. The CQC expects trusts to be able to produce records of training, and this should include evidence of specific training in observation.

This recommendation can also be applied in the prison setting, where prison officers should be specifically trained in assessing the risk of suicide or self-harm. There should be local collaboration from healthcare teams within prisons to support this training. HMIP assess the support given to prisoners at risk of suicide and self-harm and, within this, consider the training needs of staff, including in relation to observations.

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*including principles around positive engagement with patients, when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this and actions to take if the patent absconds.

At a local level

All mental health trusts should identify a psychiatrist and a nurse who have a responsibility for championing the observation policy in their hospital. One of their roles will be to promote multi-disciplinary working, ensuring in particular that clinicians are aware of the observation policy and the rationale behind commencing enhanced observations or stopping them.

Patient observation levels must be handed over at each nursing handover and nursing staff responsible for individual patients should document the level of observation in the notes for each shift.

Staff should be supported, particularly if they have been assigned one-to-one observations, and ideally should not be expected to carry out this type of observation for an entire shift, while acknowledging that continuity of care is important in developing the therapeutic aspect of observation. This can be considered on a case by case basis.

Timeframe for implementation

Given the next CCQI standards are due in early 2019, by the end of that year it would be reasonable to expect all of those working towards accreditation to be implementing the recommendation and able to demonstrate this.

Examples of good practice

Nursing staff at Birmingham and Solihull Mental Health NHS Foundation Trust highlighted that there were issues around the therapeutic observation process. The Trust used its development team to consider the issues raised and develop solutions to support staff. The team have developed a web-based 'digital ward' platform which can be accessed from a range of devices including phones, tablets and PCs.

The platform links with their electronic notes system to record when patient observations are completed. The app automatically updates if there are changes to the observation levels on the electronic notes system and prompts staff to complete observations by listing which patient should be reviewed next according to the observation schedule. The system was piloted, initially for 24 hours, then with an extended trial. As the app had been co-designed with staff, only minor adaptions were required to maximise its potential for use in clinical practice. It is now being used across all wards in the Trust, and staff have quickly and willingly adapted to the new system. The facility to accurately time and date 'stamp' observations electronically means that the completion of observations can be quickly audited both internally and externally.

As well as supporting a timely observation process, staff also report that the additional information automatically available on the tablet, for example, the rationale for observation level and key clinical details, etc., allows them to have more informed and therapeutic interactions with the patients, encouraging real engagement with patients rather than merely observing and ticking that an observation has been completed. Future work for the Trust includes the plan to link physical observations into the same device, and to continue to share their work with other trusts to demonstrate their practices.

The Mental Health Nurse Leaders & Directors Forum have developed a national policy template to support trusts in developing or updating their supportive observation and engagement policies. The document has been developed based upon recent literature, and feedback from service users, carers and mental health trust employees. Use of the template is voluntary, and trusts will need to use discretion in adapting or making use of this template to fit their specific needs and local circumstances. It can be found at: http://mhforum.org. uk/public-documents

NHS Improvement developed and run a Mental Health Observation and Engagement Collaborative. The Collaborative involved 20 mental health trusts, keen to improve their processes around therapeutic observations. Over a period of 90 days, trusts were invited to undertake quality improvement projects to target areas they identified could be improved within their services. The areas for improvement were broad, with observation policy, documentation processes, staff training and clarity around who could initiate or reduce observation levels being most frequently targeted. This focused review brought about a number of improvements, with many trusts rolling out successful changes across their services. The success of the collaborative has led to a similar project being carried out across acute trusts, with similarly successful outputs anticipated. More information about the Collaborative, including examples of improved practice can be found via the NHS Improvement website: https:// improvement.nhs.uk/
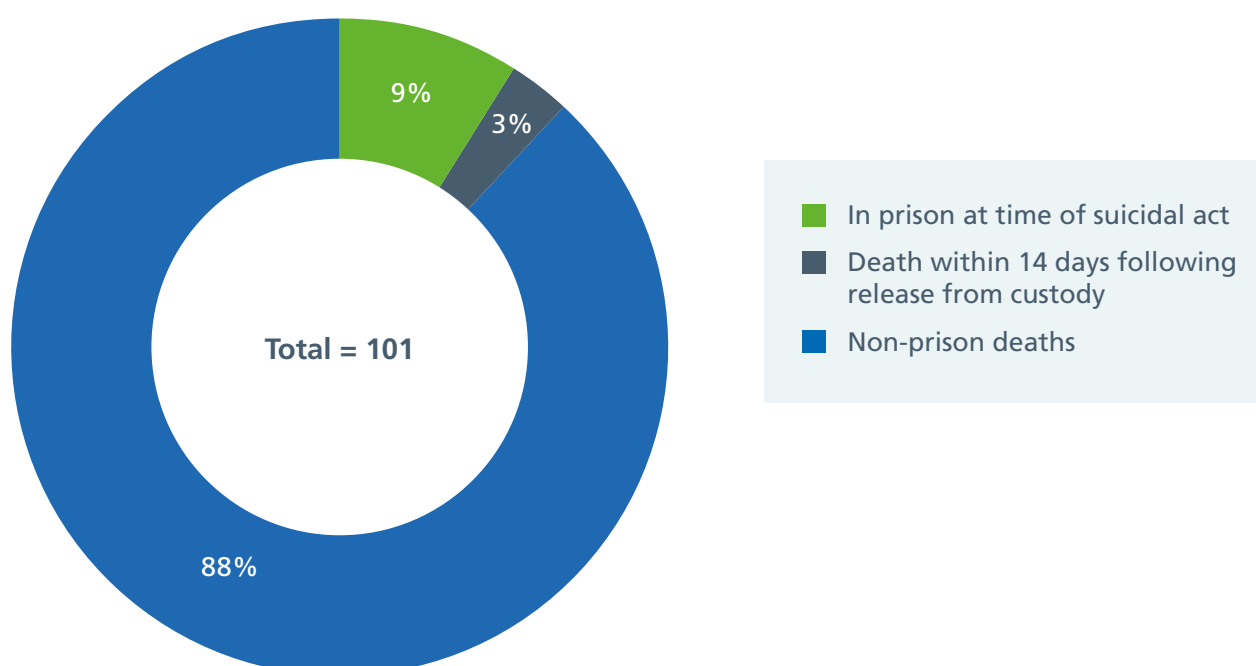
Theme 5:

Prison healthcare

People detained in prison may have particularly complex co-occurring needs. The care that they receive should be equivalent to that which exists in the community and of a standard that they could expect to receive if not incarcerated.[67] It is concerning that in our cohort the coroner was more than twice as likely to issue a PFD during the inquest of a person who acted to end their life while in prison than during the inquest of someone not in prison (78% vs. 30%).

Also of concern is the proportion of deaths within prisons that are classified as 'self-inflicted'. However, in recent years the proportion of deaths that are self-inflicted appears to be following a decreasing trend - self-inflicted deaths went from 90 (35% of all deaths in prison) in 2015 to 122 (34% of all deaths in prison) in 2016, to 70 (24% of all deaths in prison) in 2017.

Nine of the 101 claims reviewed related to deaths occurring in custody (9%) – Figure 13. All were male, reflecting the known increase in suicide for male prisoners compared to female.[69]

Two individuals took their lives within the first two weeks of detention – this is recognised as a high risk period for suicide attempt.[69] There were also three cases in our cohort who died within 14 days of release from custody, another recognised risk period for suicide.[70]

Figure 13: The proportion of deaths in custody in our cohort

Total = 101

9%
3%
88%

- In prison at time of suicidal act
- Death within 14 days following release from custody
- Non-prison deaths

Themes emerging from the prison data

This section is based on a very small number of cases, which constitute a very low proportion of the total number of self-inflicted deaths in prison during the period under discussion.

However, the findings do echo broader findings from PPO investigations and while not being completely representative, do offer some insights into the types of challenges faced when providing mental health care in prison.

Assessment, care in custody and teamwork (ACCT)

Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures.[71]

Healthcare input to ACCT

Despite requiring a multi-disciplinary approach, ACCT case reviews often fail to include the appropriate staff required to support the prisoner's individual needs.[72] Healthcare providers need to be informed by prison staff that an ACCT has been initiated and that reviews are due, unless it is the healthcare provider that has initiated the ACCT.

In three PFD reports from this cohort, the coroner commented that there should have been a member of the healthcare team at the first ACCT assessment. This echoes the guidance on the ACCT process from the Ministry of Justice which states that the healthcare team must take part in at least the first case review.[71]

As a prisoner progresses through their care plan, it may be appropriate to reduce or increase the number of people attending ACCT reviews based on the multi-disciplinary team assessment of the individual's risk and care needs.

Prisoners report that relationships between staff and prisoners are important: they need to feel supported, cared for and able to confide in and trust staff.[73] As for any other patient group, continuity of care is important.

Documentation where there are shared responsibilities

The ACCT document is the central hub of information contributed to from a range of sources, when dealing with prisoners who are deemed to be at risk of suicide or self-harm.

It was emphasised in two PFD reports that the healthcare team should have reviewed the prisoner and then documented clearly any outcomes or assessments relating to the ACCT in the prison electronic notes system, P-NOMIS, rather than remaining only in the paper ACCT document or the prison healthcare electronic notes system, System One.

Sharing concerns between staff is vital to providing effective risk management, and continuity of care and accurate record keeping should support appropriate care giving and decision making.

Prisoner transfers

There is clear guidance around the documentation that should accompany all patients during a prison transfer.[71] This includes hard copies of any open or recently closed ACCT documentation that may contain important information for the next care givers. Although available in prisons nationally on System One, it was apparent that when transferred to a new prison, the System One and ACCT notes were frequently not thoroughly reviewed, and that the prisoner's reassurance regarding their safety was often taken at face value.

This is significant when an individual's self-reported risk is incongruent with their recently documented experiences. Current working practices suggest that the job of transferring the ACCT document sits with the prison staff. There are often not robust mechanisms to make sure that the ACCT is then shared with healthcare

teams at reception, requiring healthcare teams to request a copy when the prisoner arrives in the new prison. Additionally, factors relating to prison culture and the prison environment can mean that even if an individual needs help, they feel unsafe in expressing vulnerability:

> *"You can't be too open, you can't open up and let your soul out… you're in prison for f**** sake…"*
>
> **Prisoner**

In two cases, prisoners missed receiving medication as there was no individual available to check their medical notes and prescribe following transfer out of hours. This alone should have triggered a local incident report; there was no mention as to whether this had happened in either of the PPO reports. It is also important that notes are available when individuals leave prison and return to community psychiatric services.

Prior to the prisoner leaving prison, there should be a plan for them to engage with community mental health services if required, including having a named contact and a booked initial face-to-face appointment.

Communication between acute hospitals treating prisoners who then return to prison was also mentioned in three of the eight reviewed PPO reports.

Issues highlighted included a lack of safety netting (the acute hospital advising in what circumstances the prisoner should be returned for further medical treatment) and subsequent limited understanding by the prison officer of when to return with a prisoner to hospital in case of deterioration. This is an issue, particularly out of hours, when other medical support within the prison may be reduced. There was also a lack of understanding from the acute hospital about the degree of medical treatment that may be available to a prisoner when they returned to prison.

DANGER
STRICTLY
NO ADMITTANCE

The quality of prison SI investigations

All deaths in custody are reviewed and investigated by the Police Prisons Ombudsman (PPO). These investigations are then published following the conclusion of the inquest and are available to the public. In our cohort, the PPO reports were reviewed as they offered the best insight into the care of the prisoners before their death. If the prisoner has been in contact with healthcare services within the prison prior to their death, NHS England commission a Clinical Review report to contribute to and be included in the PPO report. It has been highlighted by panel that these investigations are independent; however the Clinical Review should also be shared with the healthcare provider (who should be conducting their own separate SI investigation) for factual accuracy and for any response to the recommendations made. This process should run parallel to the trust's SI process. If the reports are not shared, this is can represent a missed opportunity to learn for trusts, particularly as anecdotally there have been incidents where the PPO report and Clinical Review have not been directly shared with all of the health providers working within a prison.

Eight of the nine deaths within custody were available for review with a PPO report. The healthcare reports in particular were reviewed for both information and quality. Only two of the eight healthcare investigations were written by staff with clear professional psychiatric experience, despite the prisoner's main contact with healthcare being with the mental health team. Although clinical information was considered in the reports, it is possible that important details relating to psychiatric care were overlooked, resulting in a basic appraisal of care which may not be nuanced enough to highlight failings and areas for improvement, or good practice.

In 2014, the PPO recognised significant variation in the quality of reports and revised their guidance for clinical reviewers in order to increase consistency.[74] NHS England are due to release further revised guidance in September 2018, which will emphasise the requirement for the Clinical Reviewer to be within two years of clinical practice and have clinical experience relative to the care received prior to the death. The majority of deaths (eight of nine) occurred before the guidance was published and therefore improvements to the clinical reports may have been made. It is the responsibility of the PPO, working with NHS England, to ensure that the clinical reports are of a high quality: as well as reviewing the care prior to death, the standard of investigation following a death in custody should be equivalent to that which would be expected in the community.

Anecdotal evidence – the impact of psychoactive substances

Although not a major clinical theme in this report (where the dates of death in custody were between 2012 and 2015), our panel firms report that in recent years the number of cases where prison deaths have been related to the use of psychoactive substances (PS, previously referred to as 'novel psychoactive substances' and 'legal highs') has increased dramatically, supporting wider recognition of this issue.[75, 76] In November 2016 the Prisons and Probation Ombudsman reported that they identified 64 deaths in prison that occurred between June 2013 and April 2016 where the prisoner was known, or strongly suspected, to have been using PS before their death. While the PPO was careful not to make a causal link between PS use and these deaths, it is striking that 44 of these deaths were self-inflicted, in some cases involving psychotic episodes potentially linked to PS use.[77]

Public Health England (PHE), in consultation with colleagues from Her Majesty's Prison and Probation Services (HMPPS), published a toolkit for prison staff supported by a national training programme.[78] Feedback from this training was overwhelmingly positive, with high levels of satisfaction. Reservations focused on implementation. Few thought that they would have access to the resources or have the capacity to implement the training fully (28%) due to space and budget (25%) and a lack of time (43%).[78] The example of PS use and its consequences reminds us that we are working in dynamic environments and that the need to learn, adapt and improve is constant.

Evidence from elsewhere

In 1999 HM Chief Inspector of Prisons published a thematic review *Suicide is Everyone's Concern.*[79] Despite the change in prison landscape in the past two decades, many of the themes that were raised in that report, such as the importance of effective induction and reception processes when prisoners arrive at a prison, disseminating lessons learned, and the need for local accountability, were also raised in more recent reports, including *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?*[80] published jointly by INQUEST and the Prison Reform Trust in 2012, and the Prisons and Probation Ombudsman 2015 report Learning from PPO Investigations: *Self-inflicted deaths of prisoners.*[77]

The Justice Secretary commissioned an independent review into *Self-inflicted Deaths in Custody of 18–24 year olds (the Harris Review)* which was published in 2015.[81] The purpose of the review was to make recommendations to reduce the risk of future self-inflicted deaths in custody. The review focused on a variety of issues including vulnerability, information sharing, safety, staff/prisoner relationships, family contact and staff training.[81]

Recommendation

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 HMIP and the CQC have a role to play in sharing good practice nationally, and will ensure that the aforementioned programmes are effective in delivering their objectives.

How should this be achieved?

Reducing the number of self-inflicted deaths will be a particular priority under the new partnership agreement setting out the arrangements for the commissioning and delivery of healthcare in English prisons. *The National Partnership Agreement for Prison Healthcare in England 2018-2021* explains how NHS England, Public Health England, Her Majesty's Prison and Probation Service, the Ministry of Justice and the Department of Health and Social Care work together to deliver three core objectives, which include *"improving the health and well-being of people in prison and to reduce health inequalities".*[89]

The first of the ten priorities set out in the document is to:

'Continue to work collaboratively to improve practice to reduce incidents of self-harm and self-inflicted deaths in the adult secure estate, by strengthening multi-agency approaches to managing prisoners at serious risk of harm and further embedding shared learning.'

A detailed action plan setting out how this specific priority is due to be published in autumn 2018. The Prison Safety Project Board chaired by MoJ/HMPPS, and with representation from Public Health England, NHS England and DHSC, will oversee the work programme related to this priority, reporting to the Prison Healthcare Board for England which oversees delivery of the overall partnership agreement.

Activities within the action plan will be drawn from evidence collated by Public Health England's Health and Justice Team, drawing on discussions with experts, current research evidence, the updated National Suicide Prevention Strategy (2017)[90] and the draft NICE guidance on Preventing Suicides in Community and Custodial Settings, and the draft findings of an exploration of the key issues and statistics surrounding self-inflicted deaths in custody undertaken by NHS England's Deaths in Custody working group.

The Ministry of Justice (MoJ) and HM Prison and Probation Service (HMPPS) jointly lead a Prison Safety Programme, focused on preventing suicide and self-harm and reducing violence. Key developments during 2017-18 included: recruitment of more than 3,100 new prison officers, securing ongoing funding to the Samaritans to support the Listener scheme, now guaranteed until 2021, and the development and roll out of improved training for prison staff – a revised modular introduction to suicide and self-harm prevention course, including a mental health awareness element, has reached over 17,000 staff, and improved training is being provided for those taking on the more specialist roles of case manager and assessor in the ACCT process. There has also been extensive work on the design of new prisons. All elements, from the layout of house blocks to the features of individual cells, have been designed to improve wellbeing and to reduce the opportunities for self-harm and suicide.

For 2018-19 a new Prison Safety Framework has been introduced, and each prison and prison group is devising a local safety strategy based on this framework.[91] It structures work around five areas - people, physical environment, population, partnerships and procedures. Activity at national level has also been structured around the framework, and is being taken forward in seven key areas:

- Direct support for prisons, including those facing particular safety challenges (e.g. multiple self-inflicted deaths);

- Continuing the roll out of the Offender Management in Custody model and the deployment of key workers;

- Improving the management of risk, including during the early days and transition, and through improvements to the Assessment, Care in Custody and Teamwork (ACCT) case management process for prisoners identified at risk of self-harm or suicide;

- Developing targeted work with groups at high risk, such as those in segregation and individuals who prolifically self-harm;

- Understanding the illicit economy and introducing measures to reduce the impact of debt;

- Building staff capability and wellbeing; and

- Continuing to build rehabilitative cultures in prisons.

Her Majesty's Inspectorate of Prisons (HMIP) reports on conditions for and treatment of those in prison, young offender institutions, secure training centres, immigration detention facilities, police and court custody suites, customs custody facilities and military detention. The role of HMIP is to provide independent scrutiny of the conditions for and treatment of prisoners and other detainees, promoting the concept of 'healthy establishments' in which staff work effectively to support prisoners and detainees to reduce reoffending and achieve positive outcomes for those detained and for the public.[82]

HMIP inspect establishments in partnership with the CQC and carry out inspections against published inspection criteria. These are called Expectations.[83] They are grounded in Human Rights standards and include:

– Safety: Prisoners, particularly the most vulnerable, are held safely.

– Respect: Prisoners are treated with respect for their human dignity.

– Purposeful activity: Prisoners are able, and expected, to engage in activity that is likely to benefit them.

– Resettlement: Prisoners are prepared for their release back into the community and effectively helped to reduce the likelihood of reoffending.

The publication of these inspection reports can act as a driver to improve care and, by sharing examples of good practice, as an example of how to improve services. The HMIP website has a section dedicated to sharing good practice and can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/.

Examples of good practice

The Royal College of Psychiatrists has developed a set of ten standards that, once achieved, lead to an Enabling Environments Award.[84] The standards are designed to be applicable to a wide range of settings, including prisons. The Enabling Environments ethos promotes making changes to the environment so that it is one that promotes wellbeing, rather than exacerbates vulnerability. Although some of these standards are challenging to implement in a prison setting, there are examples of working towards them in prison, and in approved premises with people with personality disorder.

In 2016 HMP Drake Hall became the first full prison in England and Wales to receive the Enabling Environments Award for an outstanding level of best practice in creating a positive social environment.

A HMIP inspection shortly after the award was received noted the positive and respectful interactions between staff and prisoners, with staff showing a caring approach when dealing with challenging issues and providing a generally supportive environment. This included encouraging women to progress through their sentence. It was felt that the Enabling Environments initiative had enhanced relationships within the prison.

Timeframe for implementation

As the recommendations in the report relate to existing frameworks and serve to support their implementation further, these should be adopted with immediate effect.

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[1] Recent good practice can be seen in each indicator of the four healthy prisons tests in the sidebar menu.

Other topics explored

Although not identified as themes in this report, the following findings are worthy of discussion as:

1) They impacted on patient care and should be acknowledged as doing so.

2) Patients at risk of suicide who are engaged with services are likely to be affected by at least one of these topics on a daily basis.

3) They reflect many of the challenges that our members reported in focus groups.

Staffing levels

A third of the SI reports reported staffing levels. Of these, 70% determined that staffing levels were lower than required for optimum working. While reduced staffing levels were not listed as a root cause in any of the SIs, the cohort had a higher absentee level in comparison to other reports discussing the adverse impact of staffing levels on suicide.[92]

One SI investigation advised that following an inpatient suicide the ward in question had immediately closed beds in order to make staffing levels safe.

There were also concerns about the availability of consultant reviews, particularly in community mental health teams, with four reports recommending that the availability of medical appointments needed to be increased. The recently published *Carter Report* highlighted the variability in medical staff job planning, and suggested that this was an area that required review.[45] *Stepping Forward to 2020/21* sets out a range of measures that Health Education England and the other national arm's length bodies will take to bring about a net 19,000 increase in the specialist mental health workforce in the next three years.[93]

Recruitment and retention of high quality, compassionate staff is a challenge for most trusts. The difficulty can be exacerbated in more rural areas when the employable population is reduced, but trusts in cities also struggle, due to a more fluid population. Ten per cent of all the SI reports included recommendations to either recruit more staff or address the high staff turnover within their trust. Evidence suggests that staff turnover has an impact on inpatient suicide rate, particularly when this turnover is in non-medical staff.[94] NHS Employers 'Improving staff retention – a guide for employers' was developed following work with 100 NHS providers (including 12 mental health trusts) to support them to retain staff.[95] The report includes examining why staff choose to leave or stay in their organisations and then helps them to develop, deliver and evaluate plans for improved retention.

Continuity of care

Generally, relationship continuity is highly valued by patients and clinicians, and the balance of evidence suggests that it leads to more satisfied patients and staff, reduced costs and better health outcomes.[96] In teams with high turnover, it can be difficult to ensure continuity of care. Eleven SI reports made recommendations that highlighted need for continuity of care across both inpatient (three claims) and outpatient (five claims) services, as well as in prisons (three claims).

Recommendations to increase continuity of care recognised the benefits of a consistent therapeutic relationship, and included recruiting permanent rather than locum medical staff, ensuring staff providing crisis reviews were as consistent as possible (for both ACCT reviews and home treatment team visits) and making recommendations to reduce staff turnover, with the stated aim of increasing continuity of care as a by-product. Continuity of care and staffing are inextricably linked – the initiatives relating to staffing,[95, 93] if successful, should help to increase continuity of care.

Joint working

Difficulties in joint working were highlighted in 14 SI reports. The difficulties and their frequency follow.

Table 15: Issues identified in joint working

Issue identified in joint working	Number of claims (not mutually exclusive)
Unclear boundaries of responsibility between teams	3
Lack of/inadequate joint working policy	3
Issues joint working with third sector	3
Dual diagnosis	2
Lack of awareness of other services and how they operate	2
Engagement of CMHT in joint working	2
Issues joint working with Eating Disorders service	1

The issue around a lack of awareness of other services was also apparent, with 11 SI reports citing problems in referral processes between services. There was a lack of understanding about what particular services could offer, as well as uncertainty about referral criteria for different services.

The governance around accepting or rejecting referrals was highlighted in three reports (two from deaths in custody), focusing on the regularity with which referrals were screened and accepted or rejected and the feedback mechanism surrounding this process.

Joint working occurs within specialties as well as with external agencies, be they in health, employment, or social care. A consultation by the Mental Health Confederation reported that participants wanted mental health services to find new ways to meet individuals' needs, for example through coproduced services outside conventional settings, and through focusing on people's practical needs such as housing and employment.[97]

It is hoped that the recent expansion of the role of the Secretary of State for Health and Social Care to include responsibility for social care will enable and support improvements in joint working across disciplines.

Clinical environment

Inadequacies in the physical clinical environment were recorded as contributing to the SI in ten claims. The most regularly identified three issues were:

1) ligature risk due to environmental design (five claims)

2) ineffective security on locked doors (four claims)

3) substandard estates and facilities (three claims).

NHS Improvement have listed a failure to install functional collapsible shower or curtain rails as a never event in a bid to avoid suicide attempts by ligature.[98] Although there have been reductions in inpatient suicides, possibly as a result of this guideline, the most common ligature points on inpatient wards are 'low lying'.[9]

Member trusts have voiced frustration at the seemingly conflicting demands of providing an environment that maintains dignity and privacy, prevents ligature and is achievable with minimal budgetary spend. There was also a consensus that there are no guidelines as to what best practice looks like when adapting a ward, and while there has been welcome development in the design of new mental health units, to include safety features such as full lines of sight and anti-ligature facilities, there is no specific guidance as to how existing mental health inpatient units should be adapted to make them as safe as possible.

In all four claims that mentioned physical door security, patients had broken through apparently locked doors and escaped the ward. In one case the patient was not discovered as missing for a considerable time as the alarm systems used to alert staff that a door has been opened were also ineffective. While there are health building notes published by the Department of Health and Social Care (best practice guidance on the design and planning of new healthcare buildings and on the adaption of existing facilities) that suggest that windows "should be tested to ensure that they maintain their integrity against escape"[99] there is interestingly not similar guidance relating to locked doors on inpatient units.

The layout, design, decoration and ambience provided by the physical surroundings all play a role in fostering a therapeutic environment for both patients and staff.[100] In three SIs, the physical surroundings that patients were expected to receive treatment in (two outpatient, one inpatient) were criticised, with one SI recommending a complete relocation of the service to alternate premises.

The Royal College of Psychiatrists have produced guidance including a number of suggestions, of limited cost, about what can be done to improve the ward environment for both patients and staff.[100]

Example of good practice

One trust reported that they hold annual risk assessments of all the clinical environments within the trust. There are additional assessments following an SI where any particular features of the environment are reviewed in relation to the incident. The assessments follow a multi-disciplinary team approach, with clinicians, those from the risk management team and the estates and facilities team collaborating to holistically evaluate the clinical environment. These assessments are then reported back to the trust board with recommendations to address particular areas of risk if necessary.

The same trust reported that they were currently piloting anti-ligature doors, with alarms triggered on the application of unusual pressure to the door handle or the top of the door.

The trust recognised that should the trial be successful, a decision would have to be made about how best to protect patients on the ward with limited financial resources.

Conversations with a number of member trusts centred on the uncomfortable nature of a cost/benefits realisation in relation to human life and safer estates management: this example highlights the difficult decisions trusts are faced with each day with regard to resource allocation.

Section 135 and Section 136 (S.136)

National data reports that in 2012–2015 there were 155 patients who had been conveyed to a hospital (n=133) or custody (n=43) based place of safety under Section 136 of the MHA in the three months prior to suicide. This represents 4% of all suicides in this time period, an average of 39 per year.[9] Our data did not allow for direct comparison (as there was not enough background information in most cases) but the relationship to S.136 detention was explored. Table 16 shows the number of claims that were associated with the individual being detained on a S.136 prior to their death.

Table 16: Claims associated with Section 136 detention

Relationship of death to S.136	Number of claims
Death on ward from admission following detention on S.136	5
Discharged directly from S.136 and went on to take their lives	4
Within seven days of being detained on S.136	1

All of the deaths relating to patients under S.136 detention occurred before the changes in December 2017 which saw the initial 72 hour period of assessment reduce to 24 hours.[101] The impact of this change is yet to be reviewed, but continuing to collect data will be essential in maintaining and improving services for those in crisis.

There were no patients who came into healthcare services under a Section 135 in this cohort.

Detained patient suicide

There were 13 suicides in detained inpatients, representing 45% of all inpatient suicides in our cohort. This is higher than the rate reported in national data, which reports a rate of almost 1:2 detained to non-detained inpatient suicides.[9] This may be explained by the theory that those instigating a claim, whether liability is accepted or not, may feel that there is more likely to have been a breach in a duty of care if the individual was a detained patient. This is not necessarily the case, as was highlighted in Rabone vs. Pennine Care NHS Foundation Trust.[102]

Part 2: The quality of member trusts' serious incident investigation reports

Background to incident investigation

The framework for SI investigations during the period covered by the review spans three documents.[103, 104, 29] There is another iteration of the framework due for publication later this year to which NHS Resolution has contributed.

In order that there was consistency as to which incidents should be investigated the Serious Incidents Framework, 2010, defined SIs as:

> *An incident that occurred in relation to NHS-funded services and care resulting in one of the following;*
>
> *1) unexpected or avoidable death,*
>
> *2) serious harm (where the outcome results in permanent harm or will shorten life expectancy).*

An incident was defined as "an event or circumstance that could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient."[103]

The 2015 framework states that there is "no definitive list of events that constitute a serious incident" but they include "acts and or omissions that result in 1) unexpected or avoidable death 2) unexpected or avoidable injury…that has resulted in serious harm".[29]

In September 2017 the National Quality Board published *Learning from Deaths*.[11] This guidance is designed to help standardise and improve the way acute, mental health and community trusts identify, report, review, investigate and learn from deaths, as well as how they engage with bereaved families and carers.

A key feature of the *Learning from Deaths* strategy is the requirement that trusts now publish details about the deaths they have been investigating to a dashboard, including reporting the total number of deaths considered more likely than not to have been due to problems in care.[11] The guidance also suggests that trusts should reconsider an SI report following the issue of a PFD in order to examine the effectiveness of their review processes.[11]

Breakdown of claims

Of the 101 claims analysed in this review 89 had SI reports uploaded to the CMS. As referenced earlier in this review, all of the deaths would have triggered a robust investigation which should have adhered to the standards outlined in the frameworks, producing an SI report, in most cases, prior to a claim being made against the trust.

In 84 claims the SI was performed before a claim for compensation was made. In five claims the claim was made before the completion of the SI report. The shortest length of time between the death of an individual and a claim being made was six days.

It was unclear if there had been complaints to the trusts that predated a claim. NHS Resolution data suggests that as many as a third of claims start as a complaint, and advocate that complaints management should be triangulated against claims in trusts to understand the reasons people make a formal claim.

Similarly, there was not enough consistently documented evidence of a formal apology from the trust in the CMS to draw any meaningful conclusions from this. The Duty of Candour[105] made an apology mandatory in 2014, aligning with the stance of NHS Resolution that healthcare professionals should always offer a meaningful apology, regardless of any ongoing legal processes.[106]

> *"We just want an apology, from the Trust, about what happened. We need it to show that we did everything we could."*
>
> **Parent who agreed to settle a claim provided that a formal apology was made by the Trust**

Serious incident investigation themes

The main themes identified relating directly to the quality of the SI reports and their failure to adhere to the key features of the SI frameworks:

- Low quality investigations, which were generally based on a root cause analysis model, which did not lead to an understanding of 'why' incidents occurred.

- Recommendations were made that are unlikely to prevent recurrence due to a lack of focus on systemic changes.

- Little reference to the sharing of learning across organisations and the wider sphere to promote systemic improvement.

- A lack of family involvement and support (addressed elsewhere).

Low quality investigations

Over its iterations the SI framework has continued to endorse the application of the recognised system-based method for conducting investigations, commonly known as root cause analysis (RCA), and its potential as a powerful mechanism for driving improvement.[29]

RCA is not a single technique – it describes a range of approaches and tools drawn from fields including human factors and safety science[107, 108] to enable organisations to understand how and why incidents occur, so that changes can be made to prevent recurrence.[29] If the RCA is unsatisfactory and does not manage to truly understand 'why' an incident occurred, the opportunity to learn and progress to enhance patient care is limited. RCAs should be open, fair and logical and adopt a 'just culture' which aims to balance the disparity between individual blame and organisational accountability.[109, 110]

In this review 68 claims used a RCA methodology, with 21 using alternative methodology or offering no stated methodology.

In reviewing the reports there appeared to be a focus on compliance with policy, rather than a focus on systems, and there was generally a lack of detail and depth in the RCA.

Some things were done well. There was usually a very clear and detailed timeline of events in all types of investigation, with only one investigation reviewed omitting this description.

Contributory factors

When SIs attempted to evaluate the issues that had contributed to the incident, there was often a focus on patient factors. Although it is right to consider how patient factors may contribute to an incident, in the cases where individuals have acted to end their lives, investigating teams must be especially careful to present a balanced view of the care the individual received, highlighting areas for improvement rather than allowing the focus to be on the individual, and in doing so be open to the accusation that they may be apportioning blame to the individual. An example of such a contributory factor follows:

"X was troubled by the re-emergence of his mental health problems after a long period without any symptoms. He was aware that he was having a relapse of his psychotic disorder, however he struggled to accept this."

Contributory factor from an SI report

Root causes

Of the 89 reports reviewed, 76 commented on whether a root cause had been identified. This in and of itself is interesting as only 68 claims stated or appeared to use RCA methodology, bringing into question the understanding of the term.

Of these, 38 stated that they were unable to identify a root cause. This is not necessarily a significant finding. Identifying a single 'root cause' can be problematic as there will likely be a range of contributory factors which led to the incident, of which it is hard, and could be misleading to select one or more as the root causes.

Six SIs commented that the cause of the death was multi-factorial and referred back to the contributory factors.

Table 17: Examples of the root cause of incidents included in SI reports

Root causes taken from SI reports
Frequency of contacts did not change to reflect deterioration in mental health.
The decision to discharge X was made by a lone practitioner who had limited knowledge of X's presentation.
Had arrangements been in place to identify X's disengagement during December and January it is possible that the crisis could've been averted but it is not possible to establish a clear line of cause-and-effect.
No evidence of the use of the trust capacity assessment tool by the medic.
The service user's mental illness was not treated.
The patient's mental state was not adequately addressed prior to her leaving the ward.
There was a systemic failure to meet key standards from the following policies and procedures and no effective compliance monitoring.
The service user had not been properly assessed and therefore the risk assessment was inadequate.
NICE guidelines on self-harm were not followed.

Table 17 offers some examples of the root causes as written in the SI reports. The root causes tend to offer a description of what has happened, but fail to identify why:

- Why did the frequency of contacts not change?

- Why was a lone practitioner with limited patient knowledge making a decision about discharge?

- Why was the patient's mental state not adequately assessed prior to them leaving the ward?

- Why were guidelines not followed?

If an SI focuses on what happened in detail, but fails to consider or identify why the errors occurred and what lessons should be learned, there is little hope of uncovering the systemic failures that may have led to substandard care. If this is the case, it becomes almost impossible to identify meaningful learning which may support improvements to the service and prevent similar incidents recurring.

Basic mistakes in the SI reports

A number of SIs contained basic mistakes in spelling, grammar and punctuation. In addition, there were significant errors within the reports, including:

- the incorrect gender of the deceased individual being used

- names being spelled incorrectly

- evidence that some sections had been 'copy and pasted' from other SI reports from incidents in the same trust

These errors, if detected by a family, contribute to the impression of a lack of care and respect for the individual and the investigation. These errors are avoidable: trusts and commissioners must do more to protect families from additional distress with such mistakes.

The evidence from elsewhere

There is a variety of evidence that suggests the quality of many SI investigations is poor, and, as demonstrated in our cohort, particularly regarding the correct use of RCA methodology. This may relate to inadequacies in or a lack of training, especially in human factors.[107] Providers of NHS care have a duty to ensure that all staff involved in SI investigations have been trained appropriately, but there is a lack of a national training package to support this, nor are there standardised methods of accessing the quality of an investigation.

The Morecambe Bay Investigation, led by Dr Bill Kirkup CBE, highlighted that even where there are considerable systematic and organisational failures, poor SI investigations may not detect them, as they can be "rudimentary, over protective of staff and failed to identify underlying problems".[111]

The CQC report *The state of care in mental health services in the UK 2014–2017* commented that on some mental health wards "… learning could not take place effectively because investigations were of poor quality or incident reporting and auditing were poor".[3] Another CQC report, focusing on investigations in acute trusts, identified that only 8% of reports demonstrated evidence of using a clearly structured methodology, which would be likely to identify key issues, contributing factors, system issues and causal factors that led to the incident.[112]

The difficulty with effective RCA

In the late 1990s, RCA methodology was adopted from high risk industries such as aviation and nuclear power and it has been widely applied in healthcare,[29] often without sufficient attention paid to what makes it work in its original context, and without adequate customisation for the specifics of healthcare.[113]

Commentators have highlighted that investigators may fall into an 'unhealthy quest' to find a single root cause,[113] a reductionist view that fails to acknowledge the complex and multi-factorial reasons an SI occurred.[114]

This is especially pertinent to SIs involving mental health as there are often a number of different systems supporting a patient, with each capable of contributing in equal measure to an SI. Only one SI report in our cohort sought to involve the emergency department and the individual's GP in their SI investigation. The need for more joined up investigations was highlighted by one of our members:

> "What's the one thing I think would really improve investigations?... Mandatory joint investigations when the patient is under different services. It is almost impossible to achieve at the moment, but so much information is lost when you don't know what's been going on elsewhere."

Experienced trust SI investigator

There is also evidence to suggest that investigating teams may, when faced with strict timelines and political organisational pressures, end their analysis once they have reached a cause of mutual convenience – perhaps one that edits out the causes (and therefore solutions) deemed to be beyond the remit or capacities of the organisation.[115, 116]

There are concerns that, often, inadequate RCAs result in the 'tombstone effect': though the main purpose of an RCA is to guard against a similar incident in the future, it may be used primarily as a procedural ritual, leaving behind little more than a memorial allowing the trust to claim that something has been done.[117, 118]

When investigations are of a poor quality, it is not only the opportunity for learning that is lost. Families who read the investigation reports are affected by their contents. A poor investigation can damage already delicate relationships, and increase the sense of frustration families feel following an incident.

> "When we were told that there was going to be an 'in-depth investigation' we felt quite confident that the trust was going to look at the case and stop similar cases happening again. When we saw the investigation, it was inaccurate, substandard and had not included a review of the crisis team notes, who were giving most of the care...there was no shared responsibility, no sense that somebody was pulling everything together."
>
> "It felt like the trust was taking a position to avoid litigation, rather than holding their hands up and saying 'we did some things poorly here'. All they were bothered about was batting away a claim."

Family member

The independent nature of investigations

The SI framework states that "…those involved in the investigation process must not be involved in the direct care of those patients affected nor should they work directly with those involved in the delivery of that care".[29]

The need for a degree of independence in the investigation process is clear – those involved in delivering care may not easily recognise failings in the care they have given. The guidance above states that there needs to be a degree of independence of investigators from the clinical team they are investigating in Level 1 and 2 investigations (all of those in our report).

It would be difficult to argue that, as was the case in two SIs in our cohort, an investigating team consisting of the consultant and team leader of the team being investigated provided enough independence to take a balanced view.

External investigators

There is evidence from other medical specialities that employing external reviewers to investigate potential failings in care can offer a higher chance of identifying good practice. It can also offer the ability to suggest a range of alternate clinical approaches (including recommending improvements that may have made a difference to the outcome) and can produce wider actions for improvement throughout a care pathway.[119]

However,there is no guarantee that an external investigation will provide a more insightful, useful investigation than one done 'in house'.

If the investigations in our cohort conducted by the PPO are discounted (as the external investigation of a death in custody is mandatory), only two investigations were subject to external review.* If there is not a local reciprocal arrangement for external reviews between trusts, external reviews may need to be paid for from the trust budget.

Each trust will need to determine if the outlay on an external review is justified by the potential for increased insights and learning about the care they offer.

In this review, external reviewer is used to define someone involved in the investigation who is outside the trust's usual investigating or risk management team, for example a psychiatrist or team leader from another hospital, or an independent investigator commissioned by the trust to conduct an investigation.

Recommendation

Building on recommendations in a previous report,[120] it is recommended that:

The Department of Health and Social Care should discuss work with the Healthcare Safety Investigation Branch (HSIB), 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.

How should this be achieved?

At a national level

There are a number of parties currently working to improve the quality of incident investigations:

- The Healthcare Safety Investigation Branch was established in April 2017. It will conduct professional safety investigations that do not apportion liability or blame. Through these exemplar investigations, the Healthcare Safety Investigation Branch intends to raise standards, improve patient safety and support learning across the healthcare system in England. Their investigation into the provision of mental healthcare to adults in the emergency department has focused on risk assessment and risk management and will be published in autumn 2018.

- The Royal College of Psychiatrists recently published principles to support a robust SI investigation process and, through the establishment of a peer group, they are developing standards for SI investigations.[121]

- NHS Improvement, whose national standard quality assessment tool will be used by those trained and experienced in conducting high quality SIs to monitor and improve the quality of investigation reports.

- The National Quality Board published *Learning from Deaths* in April 2017, describing how trusts should investigate unexpected deaths. NHS England has published their guidance for family and carer involvement in the aftermath of a death, including how to best involve families in the SI process.[122]

These organisations should consider a collaborative approach along with Health Education England to explore the creation of a mandatory, standardised national training package, or consider other means by which to improve investigations nationally.

Timeframe for implementation

A previous NHS Resolution report[120] called to action the above parties with a similar aim. There is no reason why the timeframe of implementation to be completed by 2020/21 is unachievable given the ongoing efforts in this field.

Horizon scanning

In September 2017 the then Secretary of State for Health and Social Care, presented a Draft Health Service Safety Investigations Bill to Parliament. The draft Bill provided for the establishment of a new Health Service Safety Investigations Body (HSSIB) as an independent statutory body, with powers to conduct investigations into incidents or accidents within the NHS which appear to evidence risks affecting patient safety.[123] It also included provisions on other areas (for example the concept of 'safe spaces') that are beyond the scope of this report, but have drawn wide comment.[124, 125]

The draft Bill has been reviewed since May 2018 by a Joint Committee. The Joint Committee published their response to the Draft Bill on 2 August 2018.[126] In it, they recommend that the intention should be for HSSIB to be 'a wholly new statutory and independent capability, separate from the rest of the healthcare system, for conducting investigations into patient safety incidents.' As a contributor to the Joint Committee, the current Chief Investigator of HSIB suggested that, HSSIB 'should not act as a regulator or an enforcement agency as either responsibility would compromise its role and independence from the system it is meant to be investigating'.

The Government's response to the Committee's report is expected in autumn 2018, at which point those at HSIB and other arm's length bodies will begin to set out longer term strategies. Regardless of the outcome, NHS Resolution will continue to work closely with other arm's length bodies, including HSIB, to promote improvements in patient safety and learning across the NHS.

Recommendations which will not prevent recurrence

Establishing why an incident happened is only one part of an investigation. Assuming the investigation has been able to identify what has happened, the responsibility then falls to the investigating team to make recommendations and formulate an action plan to address the problems in care, to prevent them from happening again.

Evidence suggests that the key to improving patient safety lies in improving systems, rather than focusing improvements on individuals,[127] yet one of the most prevalent themes emerging from the recommendations in our study was for individuals to 'follow the policy' in some form or another, with 53 recommendations suggesting actions to this effect.

Some examples of recommendations that lack a basis of systemic improvement are:

Recommendations lacking a basis of systemic improvement
All staff will read and sign to say that they have read the record keeping policy
Staff should follow national guidelines on self-harm
That staff are reminded of the standards expected for record keeping
Safeguarding lead to investigate why the staff member failed to follow the policy
To discuss with the emergency department doctor the need to document medication

All of the recommendations above fail to address any reasons the staff made errors or did not follow guidelines.

If we don't understand why the guideline wasn't followed in this instance, how can we be sure it will be followed in similar circumstances in the future?

A deeper understanding of the reasons why the guideline wasn't followed might lead to more effective systemic changes.

Original recommendation	An illustrative example of a recommendation with a more systemic approach
Safeguarding lead to investigate why the staff member failed to follow the policy.	Induction processes for new starters to fully cover the safeguarding policy. Annual mandatory safeguarding training for all staff to incorporate any policy updates.
That staff are reminded of the standards expected for record keeping.	Record keeping policy to be standardised across all sites in the trust. Review of all other policies with aim of standardising operating procedures across all sites.
To discuss with the emergency department doctor the need to document medication.	Psychiatric liaison services to attend medical staff induction to promote understanding of role and communication within the department.

Examples of good practice

There were examples of excellent practice in the SI reports.

- Where there had been issues around ligature points on an inpatient ward the estates department had commissioned an external review focusing on anti-ligature across the whole trust.

- The electronic notes system in the emergency department had been updated to enable psychiatric notes to be reviewed and added from the emergency department after poor communication was identified between the specialties.

- Schwartz Rounds had been introduced in the trust to support staff reflection and offer support following SIs.

Limited sharing of learning

As well as illuminating many of the issues around adequate SI investigation, the Morecambe Bay Investigation report stated that: 'It is vital the lessons are learnt and acted upon not least by other trusts, which must not believe that it couldn't happen here'.[111]

Learning from events does not happen by itself.[128] The evidence suggests that 'purposeful intent' is needed to:

1) Disseminate the findings[113]

2) Ensure that the recommended actions are salient and actionable.[128]

In our cohort of SIs, the evidence that there would be 'purposeful intent'[128] in disseminating the findings of the investigation was poor.

The area most overlooked when it came to sharing learning was on a national scale. Ten SI reports commented on national sharing by either reporting into the National Learning and Reporting System (NRLS)[129] or commenting that the investigation has been uploaded to the Strategic Executive Information System (StEIS).[130] Only one SI suggested that the trust may share the learning directly with other trusts via conferences or learning events.

The picture of poor sharing was similar when considering the sharing of learning with families, where just over a third (38%) of SIs mentioned that the learning would be shared with them.

Sharing the learning was evidenced more frequently when this was to be done at team (63%) or trust level (68%). There was rarely a clearly defined plan as to how or where the learning might be feedback, with 11% of team or local feedback plans with plans for dissemination, still more than was reported at a trust level, where clear plans were available in 7% of SIs reviewed.

Within trusts, there is also an opportunity to aggregate data, rather than steer improvement work on the basis of single incident analysis. This may highlight systemic issues that could be missed or discounted in the study of incidents in isolation, allowing improvement work to address the wider conditions that allowed the event to occur.[131]

How to address this:

At a national level

It is acknowledged that the current national reporting systems require improvement and that there is overlap between systems, which places an unnecessary burden on those having to report into them.[132] To address this, NHS Improvement are currently developing the Patient Safety Incident Management System (PISIMS) which is due to be launched in 2020.[133] PSIMS will support learning from acute care, but also learning offered from the perspectives of patients and other healthcare settings. This aligns with the *Five Year Forward View* principles of patient and family involvement in learning and improvement.[10]

The *Learning from Death's* policy requires trusts to publish, on a quarterly basis, the learning that has emerged from the reviews of deaths in that timeframe. The public nature of this display means that trusts can observe the learning elsewhere and use this as an external driver for improvement.[11]

At a local level

Trusts should regularly review and theme their data in order that patterns and trends which may not be discernible on an individual basis become apparent. They could use their 'mortality meetings' as a forum for discussing these trends. Trust boards and commissioners should take an active interest in the learning that emerges from SIs, acknowledging their responsibility to ensure that any recommendations made in SI action plans are implemented.

Trusts could consider establishing local networks to share good practice and learning. At NHS Resolution member events, there is always interest in how other trusts are improving their services (which often share similar issues). Trusts coming together to share learning and solutions should be encouraged from board level to 'the shop floor'.

Examples of good practice

In Tees, Esk and Wear Valleys NHS Foundation Trust, when it was noticed that a high number of SIs related to informal patients taking time away from the ward, there was an aggregated thematic review of the SIs. This led to the realisation that there were systemic issues relating to the way that staff understood informal patients' rights and managed processes relating to time off the ward on inpatient units across the trust. This enabled work to be implemented that addressed the culture of the trust in how it manages informal patients, improving the quality of care for this patient group and their families and carers, with a reduction in similar SIs following the improvements.

Greater Huddersfield CCG host a Shared Serious Incident Team for seven West Yorkshire CCGs. The team provides a triannual West Yorkshire Learning Forum. The aim of this forum is to share and promote the dissemination of learning from SI investigations where learning is likely to be of use to other organisations in preventing harm to patients, staff or the public. The forums are used to exchange ideas and share examples of good practice, discuss and address issues of common concern, and to strengthen skills knowledge in relation to patient safety.

Another role of the forum is to consider new information that relates to policy development, research findings and the impact that these may have on patient safety. It is open to any organisation commissioned by a West Yorkshire CCG to provide NHS funded services – attendance is wide ranging, including healthcare professionals, members of serious incident management teams and others with an organisational interest in patient safety.

Supporting families and carers

Involvement in care

It is estimated that there are around 1.5 million family members, close friends and other informal carers who provide unpaid support for people with serious mental health problems. Over half of these people offer practical and emotional support for more than 20 hours per week.[134]

Family and carers can often offer the best insights into an individual and can act as useful sources of information, both in terms of understanding the individual's problems, and in supporting plans for treatment and ongoing care.

It is concerning, therefore, that 18 SI reports identified that family carers had not been involved adequately in care and that there were 21 recommendations to improve the involvement of family carers in the future.

Documentation

There were also issues highlighted about the way that conversations with carers were communicated and documented, with six recommendations relating to the recording of these important conversations. This reflected the feedback that was received from families:

> *"When we got hold of the notes and looked at how that meeting had been documented it did not reflect the content of the meeting as it happened. It was almost as if they had been at a different meeting. We couldn't believe it."*
>
> **Family member**

Leave arrangements

Family members are often tasked with supporting Section 17 leave for detained inpatients as part of a recovery plan. In two claims, patients had absconded from Section 17 leave after the requirements for constant supervision while on leave had not been clearly explained to the family facilitating the leave.

In these cases, both of the SI reports recommended that a leaflet was produced that clearly outlined the requirements when supervising Section 17 leave in order to support communication about this important role.

Evidence from elsewhere

The are many branches of mental health work that routinely involve families in discussions about care and treatment of their loved ones – CAMHS, early intervention services for psychosis and eating disorder services to name a few. Unfortunately, these levels of engagement are not seen across the spectrum of psychiatric services, despite evidence to suggest that family involvement can promote and support sustained recovery.[135, 136]

NICE guidance recommends that this includes jointly identifying needs and goals and offering both parties information about services available so they can decide which ones would best meet the needs of the individual.[39] Involvement with carers needs to come from a position of respect for what they can offer, with structures and processes supporting carers to express diverse views and have these considered. Attributes that are important when engaging carers include willingness to listen, and support and encouragement to express views and challenge.[137]

The Triangle of Care guide was launched in July 2010 as a joint piece of work between Carers Trust and the National Mental Health Development Unit, emphasising the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. The guide outlines key elements to achieving this as well as examples of good practice. It recommends better partnership working between service users and their carers, and organisations.[138]

Family and carer involvement in investigations

Following a tragic incident, information and support should be offered to patients and their family and carers. The Duty of Candour guidance[105] and the *Being Open* document produced by the NPSA in 2009 explain how this should be undertaken.[139]

In addition, the NPSA produced a toolkit, specifically designed around mental health services and suicide, which stated "NHS guidelines recommend that clinical teams offer family and carers 'prompt and open information' and 'appropriate and effective support' and involve them in a routine post suicide review".[140]

In spite of this clear advice, there were at least 18 families (18%) who were not informed that an investigation was happening, with 11 families being informed that the investigation was happening, but not being informed of the outcome.

Table 18: Breakdown of family carer involvement in the SI process in our cohort

	Yes	No	Unknown
Were the family informed that the investigation was happening?	65	18	18
Were the family involved in setting the terms of reference?	20	61	20
Was there evidence that the family had been, or would be, informed of the outcome of the investigation?	29	54	18

It has long been acknowledged that family and carers can "bring a perspective grounded in daily experience to ask questions that are worth asking, about healthcare worth investigating and outcomes that matter".[141] The increasing involvement of family and carers has been supported by updated guidance, and by 2013 the SI framework stated that "providers should involve patients and families/carers in their investigations"[104]

By 2015, the framework made it mandatory that patients, victims, their families and carers should:

- be made aware in person and in writing, as soon as possible, the rationale for the SI and its purpose;

- have an opportunity to express concerns and questions (acknowledging that the family offer invaluable insights);

- have the opportunity to inform the terms of reference and contribute to the investigation process; and

- be given access to the findings, including interim findings, and have an opportunity to respond to those findings.

Despite this guidance, families or carers were involved in the SI process in only 43 of the 89 SIs reviewed (involvement defined as any of the following: being allowed to comment on the SI contents; participating in the design or writing of the investigation; or reviewing a draft of the report before it was finalised). As at least 80 of the deaths occurred after the 2013 SI framework mandated family/carer involvement in investigations, it is disappointing not to see a higher proportion of SIs involving families and carers.

In only one SI report were the family involved in each of these steps.

Evidence from elsewhere

Before considering their involvement in investigations, it is important to recognise that families may not be informed of a relative's suicide, let alone be invited to contribute to an investigation. A study that identified psychiatric patient suicides in England and Wales between 2003 and 2012 identified that relatives were not contacted after the death in 33% of cases.[142]

When considering family involvement in investigations, there is evidence that involving the family or carers "promptly, fully and compassionately can help patients and professionals deal better with the after effects"[139] and that formal complaints and claims can be avoided if the investigation is open and honest.[143]

In their 2017 guidance *Learning from Deaths* the National Quality Board stated the importance of involving families as 'equal partners' in the investigation process.[11] They have recently released guidance for trusts in how to support families following a death.[122]

So why is family involvement in investigations so low? In some cases, the shock of a sudden bereavement, and the associated increased rates of stigma, shame, responsibility, and guilt in those bereaved by suicide may mean that they feel unable to contribute to an investigation, or have concerns that they may be in some way found to be responsible.[144] Additionally, the 60-day timeline from incident to report completion does not take into account the time that families may need to process their grief and then meaningfully contribute to an investigation. For those that do wish to contribute, the option should be available to delay the SI report, and commissioners should be sensitive to such requests.

Examples of good practice

The Meriden Family Programme

Birmingham and Solihull Mental Health NHS Foundation Trust have developed the Meriden Family Programme.[145] As well as delivering evidence-based family interventions for those with severe mental illness, they work with healthcare organisations to improve the way they work with families, encouraging them to become more responsive and sensitive to their needs both before and after the death of a loved one.

This can include providing training to staff around basic grief management, helping staff understand how to manage issues around confidentiality, and supporting and promoting effective staff supervision following an SI. Their model of working with families has been shared both nationally and internationally as healthcare services are beginning to prioritise the benefits of engaging fully with families.

Family liaison officers

Derbyshire NHS Foundation Trust have led the way in developing a family liaison service with which to support bereaved families through an SI investigation and the inquest process if necessary. The model is based on the concept of family inclusive practice and the knowledge gaps in engaging with families in all aspects of mental healthcare. The model was created on behavioural family intervention concepts developed in the Lambeth Early Intervention Services in 2001 by the Trust's director of nursing and influenced by direct experience of meeting siblings who had not wanted to engage with mental health services due to historical experiences and loss through completed suicide.

Following bereavement, the family is offered the services of a family liaison officer (FLO). The FLO acts as the link between the Trust and the family, keeping them informed as to the progress of the SI investigation and supporting them through the inquest process. The service was designed in 2014 and became operational in 2015. When naming the service, police service terminology was used to retain consistency across organisations.

The Trust does not have a full evaluation of their service – emerging evidence and analysis is required. Early feedback suggests that there has been a substantial reduction in family complaints about not being involved in investigations, reductions in other family complaints, and increase in staff confidence.

There is now a formal process and assurance that every family is offered support in all unexpected deaths.

The service offers families full involvement in investigations (including robust governance and compliance around this process), offers of direct referral to psychological services including Improving Access to Psychological Therapy services (IAPT) and family therapy work, including working with bereaved children and siblings. This all occurs within existing trust resources and, it should be noted, contributes to service pressures.

The Trust has supported many other organisations, both acute and mental health trusts, with access to their videos, service model, clinical policies and job descriptions. This has resulted in other trusts modelling this practice.

"She has been an absolute star. We couldn't have done this without her. I really don't think that without her help we would have got answers to lots of our questions. She's been our rock."

A family member commenting on their family liaison officer in Merseyside

However, not every family have had such a positive experience, which reminds us of the importance of evaluating our practice, while sharing good practice to support better care. Other trusts have adopted this approach to differing degrees, and there is currently significant variation in how the service is provided between trusts. If trusts wish to adopt a model of family support that includes a FLO, it seems important that their role in both the support and SI process is clearly defined – families particularly value the sense of independence the FLO has from the SI process, yet the FLO needs to have enough awareness of the investigation to provide accurate information to the family and to manage expectations.

Recommendation

Family members and carers offer invaluable insight into the care their loved ones have received. Commissioners should take responsibility to ensure 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.

As a minimum, active involvement is defined as ensuring that the family carers have been:

– given a sincere, individualised and heartfelt apology for the harm that has occurred;

– made aware an investigation will take place;

– given the opportunity and encouraged to inform the terms of reference at the beginning;

– empowered to contribute to the investigation process by providing an account of events, if they wish to do so;

– given the draft report and allowed to comment, ensuring it is written in language they can understand; and

– given the final report and granted an opportunity to discuss the report findings.

How should this be achieved?

At a national level

NHS England has recently published guidance to support trusts in offering information to bereaved family and carers, which can be adapted for use in most trusts. It outlines some of the processes following a death and introduces the prospect of contributing to an SI investigation.[122]

The new SI framework is also due to be published this year, and is expected to reinforce the importance of patient and family support. Compliance with this guidance will be supported by incorporating its expectations into the CQC's inspection regime.

In 2018 the Royal College of Psychiatrists published *Principles for full investigation of serious incidents involving patients under the care of mental health and intellectual disability provider organisations.* This document sets out 24 clear principles to support trusts, including the involvement of families, transparency and openness.[121]

Implementing the *Duty of Candour*[105] entails actively involving families and carers. NHS Resolution has produced a support tool for staff to use, to enable good duty of candour conversations, and to help them say 'sorry' after an incident.

This resource can be found at https://www.resolution.nhs.uk/saying-sorry-leaflet/.

At a local level

The oversight of SIs will remain with commissioners; however, improving the quality of investigations requires a local implementation of national recommendations. Each investigation will have a lead investigator. With the support of STP boards, lead investigators should take responsibility for improving the investigation process, ensuring that families and carers are actively involved in all SI investigations.*

Time frame for implementation

Commissioners should implement this recommendation with immediate effect.

*There may be a small number of SIs where, owing to the relationship between the individual and their family, it may not be appropriate to include them in the investigation. For example, in circumstances where the deceased individual has made it clear in their lifetime that they do not consent to information being shared about their care and treatment and/or if there is information pertinent to the investigation that family members might not be aware of, such as a history of abuse. This should be considered on a case-by-case basis, and any decision not to involve families in an investigation following a death should be discussed with the head of patient safety and documented in the final report.

Support for those bereaved by suicide

Emotional support for families

Survivors of Bereavement by Suicide (SOBS) is the only national charity providing dedicated support to adults who have been bereaved by suicide. They exist to meet the needs of, and break the isolation experienced by, those bereaved by suicide. They are a self-help organisation and aim to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. SOBS also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations. https://uksobs.org

Cruse Bereavement Care offers free confidential support for adults and children when someone dies, by telephone, email or face-to-face. www.cruse.org.uk 0808 808 1677

Support after Suicide Partnership provides helpful resources for those bereaved by suicide and signposting to local support groups and organisations. www.supportaftersuicide.org.uk

Samaritans is available round the clock, every single day of the year, for anyone who is struggling to cope. You can call Samaritans for free from any phone on 116 123, email them at jo@samaritans.org or visit www.samaritans.org to find details of your nearest branch.

PAPYRUS Prevention of Young Suicide exists to reduce the number of young people who take their own lives by shattering the stigma around suicide and equipping young people and their communities with the skills to recognise and respond to suicidal behaviour.

PAPYRUS HOPELINEUK is a confidential support and advice service for:

- Children and young people under the age of 35 experiencing thoughts of suicide.

- Anyone concerned that a young person could be thinking about suicide.

Call: 0800 068 41 41
Text: 07786 209 697
Email: pat@papyrus-uk.org

Opening hours are 10am–10pm weekdays, 2pm–10pm weekends and Bank Holidays.

Legal support for families

INQUEST is a charity that provides free and independent advice to bereaved families on investigations, inquests and other legal processes following a death in custody, detention and mental health settings. Further information is available on their website including a link to *The INQUEST Handbook: A Guide For Bereaved Families, Friends and Advisors*, which provides information for all families facing an inquest.
www.inquest.org.uk

Action against Medical Accidents (AvMA) is an independent national charity that specialises in advising people who have been affected by lapses in patient safety ('medical accidents'). It offers free advice on NHS investigations; complaints; inquests; health professional regulation; and legal action regarding clinical negligence. Most advice is provided via its helpline or in writing but individual 'advocacy' may also be arranged. It can also refer to other specialist sources of advice, support and advocacy or specialist solicitors where appropriate. www.avma.org.uk
0845 123 23 45

Supporting staff

One of the expectations of providers of NHS care is to ensure that staff receive support following an SI.[104] The primary concern for those individuals investigating the SI should be the needs of those involved, which includes supporting staff throughout the investigation.

NHS England's Serious Incident Framework[29] suggests that staff who are involved in an SI should have opportunities to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the SI investigation and their expected involvement in this process.

There was documented evidence that support to staff was offered in 45 claims (51% of SI reports reviewed); whether this offer was taken up is not clear. The most common type of support offered was a one-to-one meeting with a line manager. Other types of support listed were team debriefs, clinical supervision, referral to counselling services or a referral to occupational therapy.

Figure 14: Evidence of staff support in the SI reports

49%

51%

Total = 89

■ No evidence of support offered to staff

■ Evidence of support offered to staff
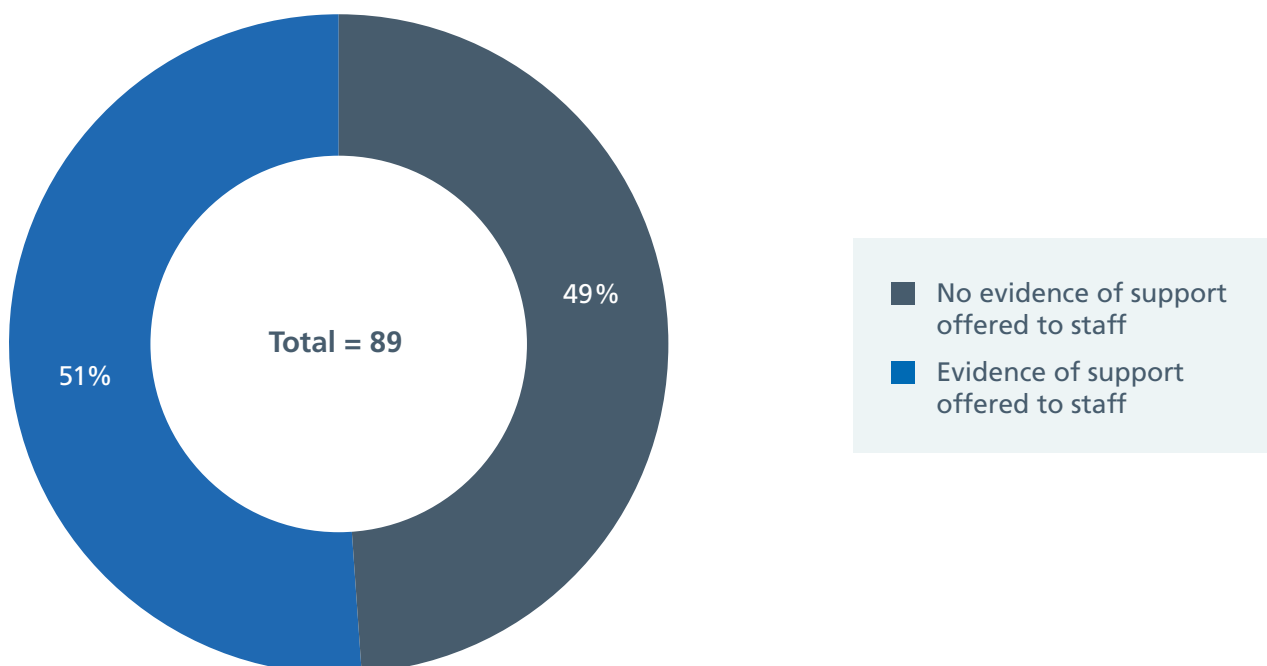
In one case, a staff member fed back to the investigating team how actively unsupported they had felt by their line manager following the incident and the negative impact this had on them.

Evidence of this lack of support is also demonstrated in the 2017 national NHS staff survey where only 54% of responders agreed or strongly agreed that "my organisation treats staff who are involved in an error, near miss or incident fairly".[146]

"I felt like I was being blamed for what had happened. I didn't feel like my manager really wanted to support me and I felt that my abilities as a nurse were being questioned."

Mental health nurse involved in an SI

Evidence from elsewhere

There is a large body of research examining the impact of adverse events on healthcare professionals. Such research has highlighted that health professionals can often experience distress, anxiety, guilt, feelings of failure and a loss of confidence in their professional skills following involvement in an adverse event.[147]

The 2017 national NHS staff survey recorded that 38.4% of staff reported that they felt unwell due to work-related stress in the last 12 months, with staff from mental health and ambulance trusts reporting higher than average levels of illness due to work-related stress.[146] The emotional impact of the event can be long-lasting[148] and sometimes healthcare professionals consider changing careers as a direct consequence of the adverse event.[149]

The phenomenon of 'burn-out' is widely recognised in mental health professionals,[150] and organisations which prioritise staff health and wellbeing show enhanced performance, improved patient care, improved retention of staff, and lower sickness and absence rates.[151, 152]

How to support individuals

The Health Service Executive suggests using the ASSIST ME model of staff support, which was developed to guide managers and staff during the process following an adverse event.[153] This document highlights the need for managers to provide staff with psychological support following an SI and suggests the type of support that can be included.

Such support should include: acknowledgement of the event and the impact on staff with empathy; assessment of the impact on staff and on their ability to continue normal duties; expression of regret for their experience; allowing time and space for them to recount what happened using active listening skills;

providing support such as debriefing within 24 to 48 hours of event occurring; providing information on other support available; and continued support and reassurance throughout the investigation process.
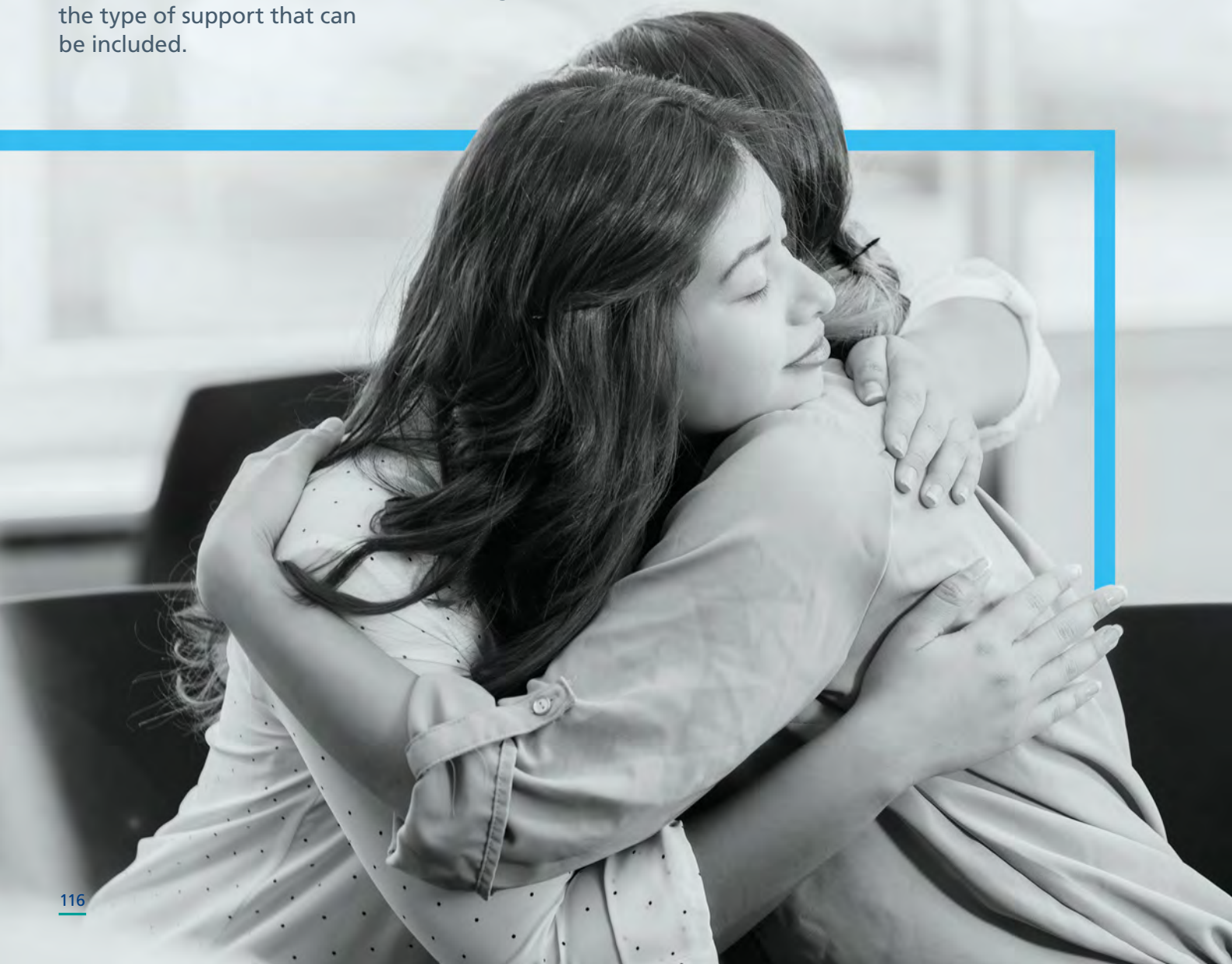
How to support teams

There are a number of support models that can be employed, both for day-to-day working, and following an incident. These can be supported or facilitated by those external to the team, for example Schwartz Rounds[152] or reflective practice sessions, or led by a member of the team, for example the practice of shift reflection.

A number of mental health trusts* have developed a Critical Incident Support Service (CISS).

This is a trust-wide staff support service offering a structured group-based intervention to teams that have been involved in a critical incident in the workplace. A team accepted by CISS for support can expect:

- A confidential space where staff affected are supported to construct a narrative of what has happened.

- A space for staff to reflect and self-monitor on how the experience has affected them emotionally and behaviourally.

- A safe space where staff affected can share perspectives and support each other.

*Including, but not limited to South London and Maudsley NHS Foundation Trust, Southern Health, Sussex Partnership, Lancashire Care, Hertfordshire Partnership, Coventry and Warwickshire Partnership and North Devon Partnership.

Supporting staff through an investigation

NHS Improvement are clear that a patient safety investigation must ask what went wrong and why, but should never look to establish 'who' is responsible or assign culpability.

We know, however, that sometimes line managers think that their staff require targeted support or intervention to work safely, even though the evidence shows issues are almost always due to systems and are very rarely about individuals.

When questions about a member of staff arise following a patient safety incident, NHS Improvement's *Just Culture Guide* supports managers to take an evidence based approach.[154] The *Just Culture Guide* helps managers consider, in a structured way, whether the issues causing concern were related to systems and processes before deciding to take any next steps that might target at an individual, whether those steps are intended as support, such as training, or as some form of formal intervention such as suspension or disciplinary action. The latter should be very rare indeed. Review of the performance of individuals should be conducted separately from any serious incident/patient safety incident investigation. The individual-focused review can make use of the findings from a good quality safety investigation report once complete, but they must never form part of the patient safety investigation itself.

Example of good practice

Mersey Care NHS Foundation Trust has overhauled the way that their staff are treated as part of the investigation process. The trust is working towards developing and maintaining a "just and learning culture" where there is a "consistent, constructive and fair approach to evaluating the actions of staff"[155] in SI investigations. There has been a switch in focus in investigations from 'who is responsible?' to 'what is responsible?'

This approach has seen a reduction in sickness rates in staff post SI, a reduction in the need for disciplinary procedures (meaning that staff are still able to work and contribute to the safe running of the organisation) and increased staff satisfaction around the investigation process.

Supporting staff through an inquest

Many healthcare staff will go through a career without ever being called to give evidence at a coroner's court. For those that are summoned, the experience – from writing their statement to standing in the dock to give evidence – is racked with nerves and a source of significant stress.

Example of good practice

Harrogate and District NHS Foundation Trust have developed a number of systems to support staff through an inquest.

- The risk manager in the trust has developed a Staff Support Pack which clearly details the timelines and expectations as much as possible for the staff member.

- Each member directly involved in the incident is offered a Staff Support Officer. This person sits outside the investigation team and acts in a similar manner to a FLO. They are available for support and information before and after the inquest, and can support with signposting to other support services if required.

- Where possible, before the day of inquest, staff are invited to meet with the risk manager to discuss the format of a coroner's court and how to approach giving evidence. They are encouraged to visit the local coroner's court in order to familiarise themselves with the court environment.

- On the day of the inquest, staff are supported by the risk manager in transport to the inquest (particularly if it is some distance away), offered a packed lunch, and have a meeting with the risk manager or legal team (if a solicitor representing the trust) before the inquest starts to go through any questions. After the inquest the staff are offered the opportunity to debrief with the risk manager. A summary of the inquest conclusion, together with a letter of thanks, are sent to all of the witnesses who gave evidence.

Recommendation

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.**

- **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.**

How should this be achieved?

At a national level

The National Mental Health and Learning Disabilities Nurses Forum are currently working on a guide for professionals attending coroner's court.

The NHS Resolution Faculty of Learning is developing a section around inquests. This will include guidance for members on how to support staff, with tutorials, interactive slide sets and case studies. It will be possible to access the Faculty of Learning via the NHS Resolution website: www.resolution.nhs.uk.

Where there is evidence that staff support services are working well, this work should be shared nationally at conferences, via member trust engagement meetings, and though national networks.

At a local level

Individual trusts should review their current staff support processes. For some, this recommendation will serve to confirm that they are on the right track; for others, it will be a call to action to improve support structures for staff within their services.

Local commissioning groups should consider requests for additional services to facilitate support for staff as an investment, owing to the evidence that promotes good staff support as important in maintaining safe and productive services.

A number of NHS Resolution's panel firms can offer a variety of inquest simulation training, teaching sessions and other resources to demystify the inquest process for staff, leading to increased confidence and reduced stress should they be called to give evidence. Trusts could consider accessing these opportunities via their legal teams.

Reports to prevent future deaths

Reports to prevent future deaths (PFDs) were given during 35 inquests by the coroner.

Seven of these were given in claims involving the care of prisoners (78% of the prison inquests in our cohort),

which was over double the frequency of receiving a PFD at inquest for care given outside the penal environment.

Figure 15: The number of PFDs given in prison death inquests compared to non-prison death inquests in our cohort

	Prison deaths	Non-prison deaths
No PFD	2	92
PFD	7	28
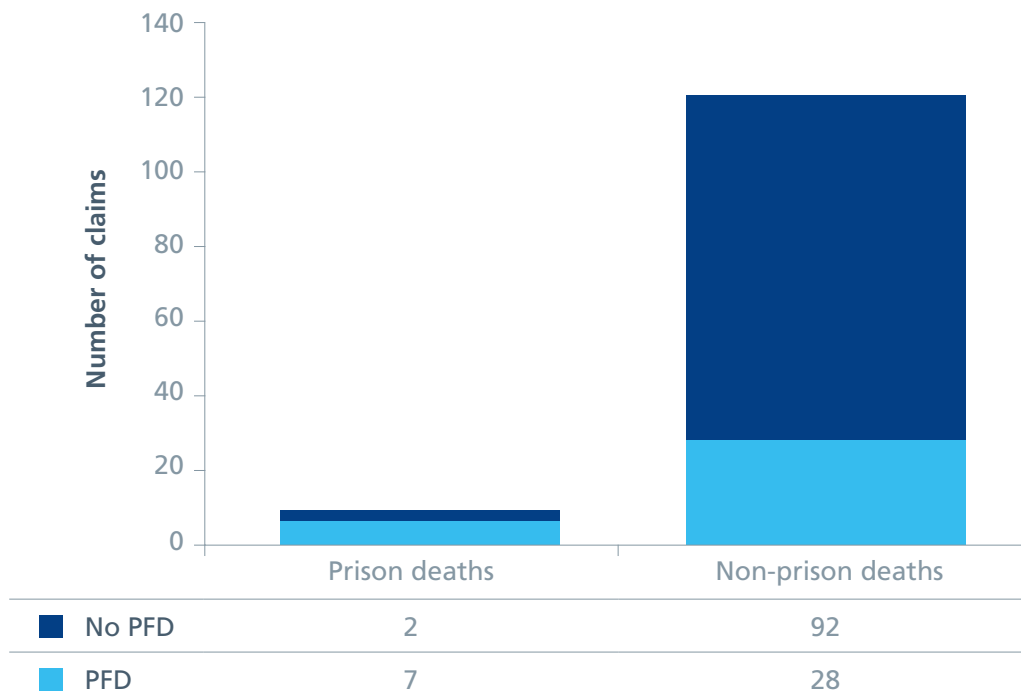
In the deaths occurring outside prison, there was a large difference in the likelihood of being given a PFD depending on which services were involved in care.

These differences are described in Table 19.

**Table 19: Probability of being given a PFD
depending on service involvement for cases in our cohort**

Care environment (not mutually exclusive)	Number of PFDs	Individuals using the service	Probability of being given a PFD
Inpatient	16	29	55%
Emergency department	7	16	44%
Medical ward	1	9	11%
Home treatment team	6	79	8%
GP	1	14	7%
CMHT	0	52	0%

Themes in the reports to prevent future deaths

The PFDs were themed in order to give an overview of the issues identified by coroners as significantly increasing risk to patients in the future. The PFD themes broadly reflected the clinical themes of our cohort. The three most frequently raised issues in care in the PFDs were:

Communication

Communication was picked up as being an issue in a number of ways. In two reports the coroner criticised the lack of availability of notes for different teams treating the same patient. We have seen that a PFD was avoided by one trust by making changes to their systems in this regard. Two PFDs highlighted inadequacies in joint working, as well as general communication being criticised between families and carers (three reports), GPs (three reports) and emergency services (one report).

Risk assessment

Thirteen PFDs highlighted a range of problems with risk assessment including: poor documentation of risk; limited involvement of carers in both evaluating risk by gathering collateral information, and the sharing of risk assessments with carers where appropriate; and risk assessments not being updated to reflect emerging risk.

Observation processes

Coroners raised concerns around staff knowledge and use of observation policies in trusts both relating to the physical requirements of observing a patient (including when to enter a patient's room and considering the timing of observations to ensure that they are not predictable) and the process of documentation. In particular, as was reflected in the general learning from the claims, timely and accurate documentation was an issue, with one coroner going so far as to question the probity of a set of recorded observations.

Prison PFDs

The themes highlighted in the PFDs following the inquests of those incarcerated at the time of death were remarkable, as coroners tended to focus on issues with the ACCT process, in addition to reflecting the themes noted above. In particular, coroners highlighted in a number of cases (four PFDs) that the healthcare team were not routinely present at the first review and that there should be systems in place to support this. Four reports commented on an unmet training need for both healthcare and prison staff in the ACCT processes and procedures, including risk assessment and risk management. Resuscitation procedures were mentioned by coroners in two of the PFDs relating to prisons (commenting on delays in summoning assistance and the availability of appropriate resuscitation equipment) – this is potentially significant as there were no 'non-prison' PFDs that attracted any comment on resuscitation processes.

Preventing a PFD

There were four cases in our cohort where it was apparent that a PFD had been prevented by the trust due to the changes that they had made following the death.

In two cases the trusts were able to demonstrate that they had made significant changes to address the issues highlighted in their SI reports. These included purchasing ligature knives for all staff members, and implementing changes to the electronic notes system in order to make them accessible to clinicians working in the emergency department.

"The Coroner advised, if not for the evidence of staff members from the trust confirming the changes that had been made, he would have issued Regulation 28 report against the Trust. The presence of senior management at the inquest was important and indicated to the Coroner that the Trust was taking the matter seriously."

Solicitor's report following an inquest

One coroner went so far as to comment that he would not be giving a PFD as:

> *"…is a changed trust from that (patient) was cared in."*
>
> **Coroner at inquest**

In two cases, the coroner asked the trust to write to provide evidence of the changes that they had made within 28 days.

Production of satisfactory evidence would prevent a PFD being issued to that trust.

It was unclear from the records held within the CMS if the trusts complied with this request.

The evidence from elsewhere

An investigation by The Guardian newspaper reported the 271 PFDs given to trusts between 2012 and 2017 that related to the care of mental health patients. In many of these cases individuals took their own lives. In reviewing the PFDs, the investigation reported that there was:

> *…inadequate supervision of someone who was a clear suicide risk, or NHS staff ignoring families' fears that their loved one would take their own life. In dozens of cases, staff made mistakes with the patient's medication, or failed to properly assess the risk that the patient would take their own life.*[156]

One of NHS Resolution's panel firms reviewed the 150 PFDs issued over an eight-month period (2017/18). They found that 44% of the causes of death were suicide, with 50% of the PFDs relating to concerns about inadequate communication, often involving valuable information about the patient's history or current presentation being missed. Another recurrent theme in this data was the failure of trusts to acknowledge the concerns expressed by family members.[157]

A number of panel firms have collaborated to conduct work to review PFDs being issued following deaths which have then become the basis for a claim. This unpublished work found that the leading cause of death in PFDs issued by the coroner was suicide (23% of all cases), with key themes emerging from the PFDs including: risk assessments; medical records; monitoring; prison healthcare; staffing levels; and emergency care.

In a series of focus groups, members and NHS Resolution panel firms reported that there appeared to be little consistency in the process for giving PFDs.

Panel firms reported that they had completed an informal review of the regional distribution of PFDs, and that this suggested that there were marked geographical variations in the frequency of PFDs being issued. Trusts reported that much of the focus of the SI action plan and recommendations revolved around steps that would prevent a PFD.

A bereaved family reported the belief that a PFD would have "forced the trust to learn from its mistakes", highlighting the view of some families that trusts are unwilling to learn from incidents and that without sanctions or enforcement from external agencies this will not happen.

Recommendation

NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies of the 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.

How will this be achieved?

At a national level

In his annual report the Chief Coroner highlights the difficulties in standardising coronial services on a national level due to the coronial system existing as a local service, with no national structure.[158] There have been numerous calls for a national service, with the service funded and run centrally, in a similar manner to other judicial services. The Chief Coroner has expressed support for this kind of service, but at the time of writing this has not happened and there are no plans to significantly alter the nature of service in the near future.

The Chief Coroner provides training for coroners and their officers each year under the auspices of the Judicial College (which trains all judges and tribunal members). Training is compulsory and conducted over two day residential training courses.

In 2015/16 there was a focus on mental health issues in investigations and inquests.

To support and add to the training offered to coroners, the Chief Coroner also releases written guidance which is published on the judiciary website.[159] In 2016, the first Chief Corner revised the guidance relating specifically to reports to prevent future deaths. The current Chief Coroner may like to consider, in due course, issuing further guidance on this issue to further support coroners.

The Chief Coroner is also planning to develop an appraisal scheme for coroners. This appraisal scheme should help to improve a consistent approach to practices and procedures as well as consistency in outcomes. It should also assist in monitoring the national training carried out through the Judicial College.[158]

PFDs are published by the Chief Coroner. The Chief Coroner supports the concept that it is for coroners to make recommendations and to put them in the public domain via publication. External organisations are then encouraged to review and learn from those PFDs (as in this report).[160] Responsibility for reports to prevent future deaths transferred from the Ministry of Justice to the Chief Coroner on 1 April 2013.[161] In 2013 the former Chief Coroner reviewed the first six months of PFDs for which he had responsibility.[161] A similar review has not been published since. From 2008 to 2013 the Ministry of Justice collated PFD reports, reviewed and published their findings. The Ministry of Justice continues to publish *Coroners Statistics* on an annual basis, but this document does not include PFD data in its review.[162]

The Department of Health and Social Care have been tasked with reviewing how learning from PFDs is captured and distributed following a Private Members Bill relating to the use of force in mental health units (Mental Health Units (Use of Force) Bill 2017-19),[163] which is due to have its second hearing in the House of Lords at the time of publication. This forms part of the work programme for the Ministerial Board on Deaths in Custody who aim to have considered strategies to capture learning across the Department of Health and Social Care, the Ministry of Justice and the Home Office by October 2018.

The CQC may also have a role to play in sharing and engaging trusts in learning from PFDs. As part of their inspections, the CQC already review the responses of trusts to PFD reports and the action plans that support improvements in practice.

As they have access to this information on a national level, avenues to share this data nationally with trusts could be considered.

At a local level

Local trusts should consider meeting on an annual basis, with the specific aim of sharing their PFDs and their responses to them. It is not uncommon for trusts serving similar populations to experience similar problems in care delivery, and this would be one way to share learning.

Trusts should work with their local coroners' offices and their legal teams to review how they consider inquests, particularly in relation to PFDs. If a PFD is issued, the trust should consider offering the family an opportunity to meet, discuss and explain their response to the PFD, in order to demonstrate the steps that the trust is taking to improve practice.

Where these changes are implemented and successful, the family should be informed again (if they wish for this) of the progress made.

Example of good practice

A Midlands trust meets with their area coroner a number of times a year to identify themes in the cases being taken to coroner's court. The trust reports that over time a positive and transparent relationship has developed with the coroner. Additionally, the trust avoids a defensive culture when completing their SI investigations, using the inquest to demonstrate how they have learned from an SI.

Attempted suicide claims

Attempted suicide may be between 10% and 40% more common than completed suicide[164, 165] and is the strongest clinical predictor for completed suicide.[166, 167] Significant injury and morbidity can occur as a result of an attempted suicide. In these cases, individuals may have new additional health and care needs and be deserving of compensation.

Attempted suicide is more difficult to study than completed suicide as it lacks generally approved reporting procedures. Similarly, when claims are reported to the CMS, they are often coded based on the injury code, and may not include information about the aetiology of the condition, i.e. that it has been caused by a suicide attempt.

NHS Resolution's panel firms were asked to provide details of claims relating to attempted suicide. Six panel firms offered reference numbers for a total of 27 claims, 25 of which were suitable for analysis.*

Table 20: Panel firms providing details of claims relating to attempted suicide

Panel firm	Number of cases
Bevan Brittan	3
Browne Jacobson	4
Capsticks	5
Hill Dickinson	2
Kennedys	9
Weightmans	2
Total	**25**

Cases were reviewed in a similar manner to the data relating to fatal claims, with a modified version of the data collection tool.

*Two claims were removed: one related to failings in medical care only, the other case was not found in the claims management system.

Detail of the claims

Given the non-random sampling method required to identify the relevant claims, it could be misleading to try to compare demographic data between the fatal and non-fatal cohorts.

It is worth noting that the incident dates spanned a longer period of time (2007–2017) and the claimants tended to be the individual affected, although a number were supported by a 'litigation friend' as their injury had left them lacking the capacity to instigate and engage with legal proceedings without support (nine claims).

As the cost of these claims has been reviewed and compared to the completed suicide attempts previously in this report, it is perhaps most appropriate to comment on:
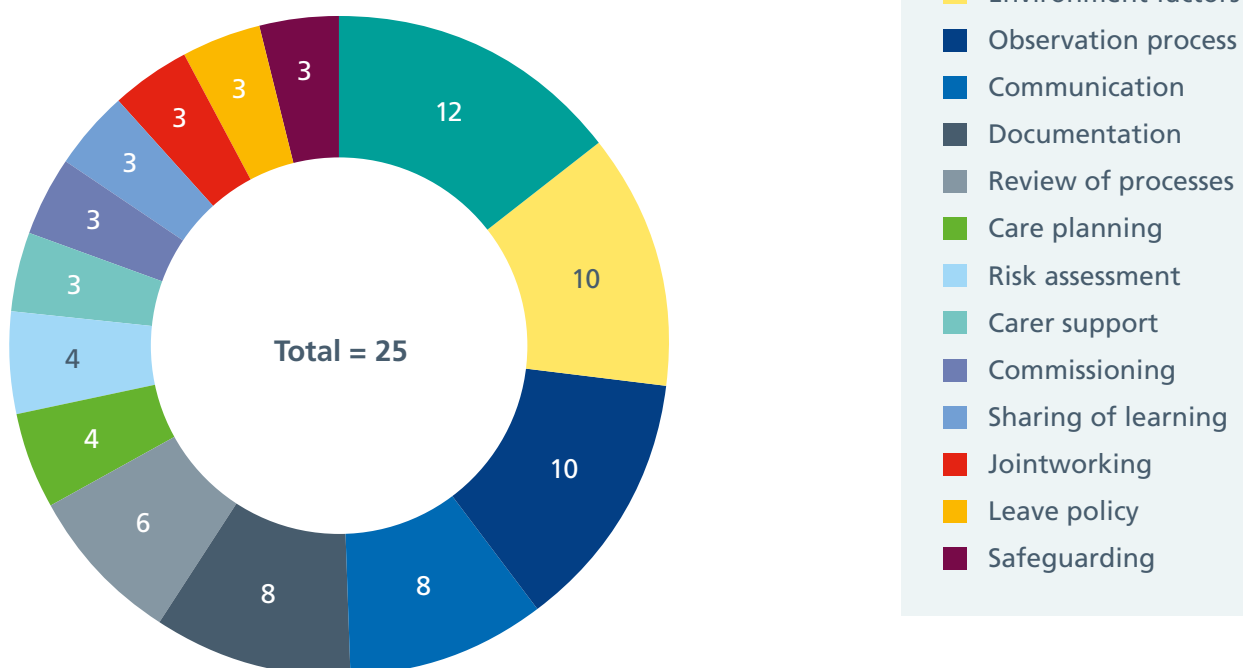
- the themes around learning that emerge from the claims.

- the significance of learning in the claims process for non-fatal suicide attempts.

Themes in learning

Generally, the themes that emerged reflected those identified previously in this review.

The number of times that the main themes in learning were highlighted across the 25 attempted suicide claims is shown in Figure 16.

Figure 16: The main themes in learning that arose from attempted suicide claims

Total = 25

- Staff training
- Environment factors
- Observation process
- Communication
- Documentation
- Review of processes
- Care planning
- Risk assessment
- Carer support
- Commissioning
- Sharing of learning
- Jointworking
- Leave policy
- Safeguarding

It would be expected that the themes identified from non-fatal claims would be similar to those of the completed suicide claims. It is interesting that risk assessment featured much less often as a learning point in these investigations, and the environmental factors were cited so frequently.

The requirement for improved staff training was the most frequently cited learning outcome in the non-fatal cases, whereas this was less of a feature in the learning from the fatal claims.

As the learning from both cohorts is similar, the recommendations in this report should also support trusts in reducing the incidence of non-fatal suicide attempts.

The significance of learning from suicide attempts

We have already seen in this report the importance of trusts learning from mistakes and identifying areas for improvement. In completed suicide, the trust is not only required to share this learning with its staff and the family of the deceased individual, but the coroner conducting an inquest will also want to be sighted on the learning that has happened following the death to prevent similar occurrences in the future. Where there has been no fatality, the additional level of coronial scrutiny for the trust is not present.

This is not to say that the learning is not equally as important – the claims in this report that relate to non-fatal attempts describe life-changing injuries both physically and psychologically; they are not 'near misses' by virtue of the fact that there was no fatality. They should have a comprehensive investigation, with insightful learning and a robust action plan to address any inadequacies identified.

It is interesting therefore, that the SI reports were uploaded to the CMS much less frequently than for the fatal claims. In the fatal cohort, there was an SI report available for review in 88% of all of the cases reviewed. When the discontinued cases are discounted, this percentage rises to 92%.

There were SI reports uploaded in 60% of the non-fatal suicide claims – a third less often. This may reflect a variation in attitudes towards these types of claim.

Anecdotally, our panel firms report that sometimes the incident occurs away from the trust that might be best placed to conduct an investigation and they are unaware that the incident has occurred. They also commented that the lack of pressure from an external process (such as the coroner demanding to see learning), combined with resource and workload pressures, mean that trusts may not investigate a number of these non-fatal cases. This is a lost opportunity for learning and trusts should be able to justify why they have not conducted a formal SI investigation for such events.

Conclusions

This review identified 101 claims where inquests were funded between April 2015 and November 2017 for those that had taken their lives. It also reviewed a selection of claims related to non-fatal suicide attempts. The costs to families, carers and staff involved are, and will always be, immeasurable. The potential litigation costs are difficult to establish, and will not include the potential future costs to the NHS of ongoing treatment, revision surgeries or psychiatric follow-up for suicide attempt survivors or those impacted by the events.

When reviewing the clinical and non-clinical themes five main areas were identified: the support available for those with active substance misuse; risk assessment; observation processes; communication spanning a range of environments; and the care provided to those in prison.

This review has looked at the quality of trusts' serious incident investigation reports, and the clinical and non-clinical features demonstrated in these claims. Areas of good practice nationally have been highlighted as examples of how trusts can begin to tackle some of these issues.

The review of SI reports revealed that family involvement in the SI process was often limited, and the RCA process frequently failed to determine why the incident occurred, leading to recommendations that were unlikely to prevent recurrence of the same issue in similar circumstances. The role of trusts in supporting staff was also explored, with recommendations made to improve this process.

This review also provides supporting evidence from other studies and reports that demonstrate similar findings, suggesting that the improvements required are neither straightforward nor simple. The recommendations of this review take into account this wider evidence, outlining not only what should be done, but who has responsibility for this and in what timescale improvements should be expected.

The limitations of this review have been discussed. Although a small proportion of the total number of suicides has been reviewed, the similarities within our data to larger national data sets allows us to be confident that our sample is reasonably representative and that the recommendations are likely to be applicable across the wider system.

Overall, care for those with mental health problems in England is very safe. This report demonstrates that there is much room for improvement, however, both in the way that we deliver care and in the way that incidents are investigated when things sadly do go wrong. By highlighting common failings in care, while sharing some of the excellent practice from around the country, it is hoped that this review will improve the safety of services for patients and in doing so reduce the incidence of harm in the future.

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