NHS Improvement

Filename: CQC reporting suicides

Title: Revised CQC guidance on reporting suicide and self harm

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Revised CQC guidance on reporting suicide and severe self-harm

Change to guidance

NHS trusts must report all apparent or actual suicides of people with an open episode of care (both community and inpatient) at the time of death. This is a change to previous NPSA guidance that indicated that a reportable outpatient suicide should be linked with a patient safety incident rather than regarding the suicide itself as an incident. The Care Quality Commission (Registration) Regulations 2009 require such deaths to be notified.

A. Introduction

Statutory reporting to the CQC takes place via the National Patient Safety Agency's (NPSA) National Reporting and Learning System (NRLS).

The CQC acknowledges that determining if the death of a person with mental health needs was through suicide can be a complex issue, often with open verdicts being returned even after full investigation and inquest.

This guidance has been developed in order to:

- fulfil the CQC's statutory requirements;[*]
- ensure all providers of mental health care take a consistent approach to reporting of suicides/self harm;
- ensure the NPSA definitions of severity of harm[†] are used correctly.

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[*] From 1st April 2010, serious incidents reported to the NPSA are shared with the CQC in fulfilment of the requirements of The Care Quality Commission (Registration) Regulations 2009. Regulation 16 on the notification of death of a service user states that, for health service bodies (such as NHS trusts) "…the registered person must notify the Commission of the death of a service user where the death—
(a) occurred—
(i) whilst services were being provided in the carrying on of a regulated activity, or
(ii) as a consequence of the carrying on of a regulated activity; and
(b) cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment…"

[†] NPSA definitions: Low harm = *Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.* Moderate harm = *Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons*. Severe harm = *Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.* Death = *Any unexpected or unintended event that caused the death of one or more persons.*

B. GUIDANCE FOR REPORTING

The following incidents/outcomes SHOULD NOT be reported to the NPSA with an actual severity = ‘death’ or ‘severe harm’ or ‘moderate harm’[‡]:

1. Natural and expected deaths;

2. Actual or apparent suicides of former patients (inpatients or community patients) **except** in circumstances where a patient safety incident is believed to have contributed to the death (for example, a failure to provide community care or inappropriate discharge from inpatient care);

3. Deaths of inpatients, community patients or former patients from alcohol or use of street drugs **except** in circumstances where suicide is the suspected cause and/or where a patient safety incident is believed to have contributed to the death (for example, a delay in access to addiction services);

4. Unconfirmed hearsay reports of death.

NOTE: ‘Former patient’ is defined as any patient who has been discharged from the Trust’s services or who does not have a current open episode for inpatient or community care.

The following incidents/outcomes SHOULD be reported to the NPSA with an actual severity = ‘death’

1. All apparent or actual suicides of people with an open episode of care (either community or inpatient) at the time of death;

NOTE the terminology is *‘apparent or actual suicide’* i.e. trusts should report suicides where, in their reasonable opinion, the death appears to be due to suicide. Trusts are not expected to report all unexpected deaths. Incident reports should be updated when evidence of apparent suicide emerges where they were previously not regarded as apparent suicides. Similarly, if evidence is found that the death was not due to suicide the reported apparent suicide should be updated.

2. Actual or apparent suicides of former patients (inpatients or community patients) **ONLY** where a patient safety incident is believed to have contributed to the death (for example, a failure to provide community care or inappropriate discharge from inpatient care);

3. Deaths of inpatients, community patients or former patients from alcohol or use of street drugs **ONLY** in circumstances where a patient safety incident is believed to have contributed to the death (for example, a delay in access to addiction services) and/or where there has been an actual or apparent suicide;

NOTE: If what initially appeared to be an accidental death from use of street drugs is later found to be suicide, an incident report can be made or updated at that point, and the CQC will accept this as a legitimate reason for late reporting.

[‡] Ideally such outcomes unrelated to patient safety incidents should not be reported to the NPSA at all, but if it is convenient to do so for local administration purposes, the NPSA has no objection as long as they are **not** reported as moderate harm, severe or death. Incidents graded as low or no harm will not be routinely transmitted to the CQC unless related to possible abuse.

CQC needs to give further consideration about including a requirement for specialist NHS mental health providers to notify NPSA about the deaths of former patients within a certain period of their discharge from the specialist service, and this is likely to relate to conditions of registration of GP practices. Until further guidance on this is provided, these should **not** be routinely reported, but reported only in circumstances where a patient safety incident (for example, a failure to provide community care or inappropriate discharge from inpatient care) is believed to have contributed to the death.

NOTE: this guidance relates to deaths reported to the CQC via the NRLS. **All** deaths of patients who are detained or liable to be detained[§] under the Mental Health Act 1983 must continue to be reported directly to the CQC . This applies to all service providers and is a condition of their registration under the Health and Social Care Act. When the circumstances outlined above apply, the CQC encourages trusts to report deaths additionally to the NRLS.

C. Self harm not resulting in death

Mental Health service providers should apply the principles above to report actual or apparent self-harm incidents with an outcome of severe harm or moderate harm. Whilst the NPSA definition of severe harm is permanent harm, given the requirement for early reporting, a need for ITU or HDU treatment can be taken as a proxy for severe harm.

[§] People liable to be detained include, for example, those on Section 17 leave of absence from hospital, or those held under short-term powers of Sections 5, 135 or 136

Appendix: rationale

The CQC's rationale for these changes is as follows

There is considerable variation between NHS providers of mental health care in the number of deaths reported to the NPSA. An NPSA analysis of death incidents occurring between 1 October 2008 and 31 March 2009 indicated that as little as 9.2% of the reported deaths probably fell within the NPSA definition of a reportable death. Thus there is an apparent mismatch between reporting practice at a number of trusts and current guidance. CQC also feels that the current guidance is too restrictive in what should be reported to be fully consistent with regulatory reporting requirements.

From 1st April 2010, serious incidents reported to the NPSA are shared with the CQC in fulfilment of the requirements of The Care Quality Commission (Registration) Regulations 2009. Regulation 16 on the notification of death of a service user states that, for health service bodies (such as NHS trusts) "…the registered person must notify the Commission of the death of a service user where the death—
(a) occurred—
(i) whilst services were being provided in the carrying on of a regulated activity, or
(ii) as a consequence of the carrying on of a regulated activity; and
(b) cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment…"

This regulation is not applicable to deaths of patients who are detained or liable to be detained under the Mental Health Act 1983, but the CQC does encourage NHS trusts to continue to report relevant deaths to the NPSA.

The CQC is of the view that:

- an apparent/actual suicide cannot be reasonably attributed to the natural course of a service user's illness or medical condition, and thus is a notifiable event when occurring while, or as a consequence of, services being provided;
- the exclusion of the deaths of outpatients does not reflect the largely community based service provision for people with mental health problems.

Following discussions with appropriate experts, the CQC considers that it is appropriate that deaths from alcohol or drug abuse are not routinely regarded as notifiable, unless there has been a patient safety incident.