Filename: Suicide MH – v1

Title: Revised guidance on reporting suicide and severe self-harm to NRLS for trusts providing specialist mental health services

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Revised guidance on reporting suicide and severe self-harm to NRLS for trusts providing specialist mental health services

Change to guidance

This is a revision of guidance issued in 20/10/2011. The revision has taken place mainly to clarify the responsibilities of other types of trusts and providers, and there are no substantial changes to reporting requirements for mental health trusts. NHS trusts providing specialist mental health services 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 was 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.

Note that Strategic Health Authorities and commissioners will have differing requirements for when suicides are reportable via STEIS; see National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and *Information Resource to Support the Reporting of Serious Incidents (2010).*

This guidance issued on **01/04/2012** replaces the previous guidance issued on reporting suicide or severe self harm.

A. Reporting actual or apparent suicides

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

The CQC acknowledges that determining if the death of a person 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 the reporting of suicides and severe self harm;
- ensure the NRLS definitions of severity of harm[†] are used correctly

[*] 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 receiving NHS funded care.* 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 receiving NHS funded care.* Severe harm = *Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons receiving NHS funded care.*. Death = *Any unexpected or unintended event that caused the death of one or more persons receiving NHS funded care.*. 'Harm' includes self harm.

- reflect the requirements of the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA, 2010) and associated guidance
- reflect national policy requirements of *No Health without Mental Health* (HM Government, 2011) and the forthcoming cross-government *Suicide Prevention Strategy*.

Further information on the rationale for the changes to this guidance is provided in an accompanying document.

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 NRLS 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, but only unexpected deaths related to their provision of care and treatment. 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);

[‡] 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.

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.

The trust providing specialist mental health care (either inpatient or community based care) to the patient at the time of the apparent suicide/self-harm should report the incident as soon as they are aware of it, even if the harm or death occurred elsewhere.

The CQC recognises that trusts providing specialist mental health care may not always be informed when a patient who is in contact with community based services has self-harmed or committed suicide. Trusts should report the incident without delay as soon as they become aware that it has occurred. In its new separate guidance to non-specialist Mental Health providers it encourages all other providers to liaise with the appropriate mental health trust.

The CQC would expect the mental health services provider to report suicides and severe self-harm to their current inpatients or community patients themselves, even if the incident has also been reported to the NRLS by others (e.g. an acute trust where they were treated). Whilst duplicate reporting to NRLS is acceptable, arrangements for declaring a Serious Incident and coordinating the investigation should be coordinated by a lead trust in line with The *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation* (2010).

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, including acute services that operate the Mental Health Act 1983, 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.

B. Reporting 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 NRLS 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