

Filename: Suicide Other providers v1

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

Issued by National Patient Safety Agency

Applicable from 1.4.2012 to date

Accessed from: NRLS Reporting portal - <https://report.nrls.nhs.uk/nrlsreporting/>

Revised guidance on reporting suicide and severe self-harm to NRLS for ALL PROVIDERS EXCEPT those providing specialist mental health services

Change to guidance

Guidance on the reporting of suicide or severe self-harm by providers of specialist mental health services has been updated, in part to align it with the requirements to notify CQC of certain incidents. Other providers also have responsibilities in relation to the reporting of suicides and self-harm, and this guidance aims to clarify the existing requirements.

This guidance applies to all providers of NHS care EXCEPT those providing specialist mental health services, including:

- NHS acute trusts
- NHS community services that are not part of specialist mental health services
- NHS providers of services to patients in the criminal justice system (prisons, police custody suites, immigration removal centres, secure training centres)
- NHS ambulance service trusts
- NHS care trusts
- NHS primary care trusts that provide care services

This guidance issued on 01/04/2012 replaces the previous guidance issued on reporting suicide or severe self harm. Further information on the rationale for the changes to this guidance is provided in an accompanying document. 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)*.

A. Reporting actual or apparent suicides or severe self-harm

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;*

* 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..."

- ensure all NHS providers take a consistent approach to the reporting of suicides and severe self harm;
- ensure the NPSA definitions of severity of harm[†] are used correctly
- 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*.

Specialist mental health services are required to report without delay all patients who appear to have committed suicide or severe self-harm whilst they are currently being treated by the mental health service, whether as inpatients, community patients or outpatients.

In most cases, the responsibilities of other providers will be met by ensuring they pass on any information they receive that indicates suicide or severe self-harm has occurred to the relevant specialist mental health trust, so that the specialist mental health trust can report it. Acute trusts who provide treatment for the self harm and GPs are often the source through which specialist mental health services become aware that one of their current patients has committed suicide or self-harm. Trusts should not report apparent or actual suicides directly to the NRLS where their only contact with the patient is to respond to the emergency unless a separate patient safety incident occurs whilst the patient is in their care.

However, where the apparent suicide/severe self-harm occurs whilst the patient was currently receiving care from an NHS trust other than a specialist mental health services provider (either as an inpatient or outpatient) that is directly relevant to their suicide or severe self harm, they are required to report the suicide/severe self harm themselves.

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.

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 in your organisation **relevant[‡]** to their suicide/self-harm (either community or inpatient) at the time of death;
2. Actual or apparent suicides of former patients (former inpatients or former community patients or outpatients) **ONLY** where a patient safety incident is believed to have

[†] 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.* ‘Harm’ includes self harm as well as harm to others.

[‡] An open episode of care = an ongoing plan of community visits, ongoing outpatient treatment or an inpatient episode. Relevant = any episode of care that did or should have involved assessment of mental health needs.

contributed to the death (for example, a failure to provide community care or inappropriate discharge from inpatient care);

Examples of when reporting would be required include:

- Patient A presents at an Accident and Emergency department having self harmed, they are treated for their cuts and discharged without an assessment of their mental state or any follow up for their mental distress and then go on to commit suicide. This is reportable because discharge may have been inappropriate without the assessment and/or follow up.
- Patient B is receiving outpatient treatment for a type of cancer which might reasonably be expected to require assessment of psychological well-being, but during the course of their treatment they commit suicide.
- Patient C is receiving home visits by a community based Occupational Therapist and attends outpatient physiotherapy sessions for rehabilitation and consultant outpatient appointments following a stroke; they are depressed and at times confused; they go on to commit suicide.
- A health visitor is regularly visiting patient D who has post natal depression who dies and it is suspected that this is a suicide.
- Patient E has been seen by a mental health in-reach team while in prison and has been staying in a hospital wing under the care of a mental health provider. The patient is returned to their cells and, shortly after commits suicide.
- Patient F has been assessed under the Mental Health Act 1983 as requiring detention in hospital; while being conveyed to the local mental health unit in the ambulance, the patient uses a concealed blade to cut themselves. Their wounds prove fatal and they die in the ambulance on the way to hospital.
- Patient G has been admitted to an acute hospital to treat an overdose; they leave the ward unnoticed and jump from a high building.

The CQC requirement for the mental health services provider to report suicides and severe self-harm to their current inpatients or community patients themselves, should not act as a bar to other providers also reporting the incident to the NRLS (e.g. a suicide in the post-natal period when both mental health services and health visiting services were actively involved with the patient). 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)*.

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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

[§] 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

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

NHS 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.