Filename: Reporting suicides (Wales only)

Title: Guidance on reporting suicides and severe self-harm to the National Reporting and Learning System

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Guidance on reporting suicide and severe self-harm to the National Reporting and Learning System

NHS organisations 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.

Introduction

All NHS organisations are required to report all patient safety incidents via the National Patient Safety Agency's (NPSA) National Reporting and Learning System (NRLS). Uploading to NRLS should be done **as soon as possible after the date that the incident occurred.**

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:

- provide clarity of reporting requirements in relation to inpatient and outpatient suicides;
- 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.

[*] 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.*

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 NHS Organisations 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. organisations should report suicides where, in their reasonable opinion, the death appears to be due to suicide. 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 should be made or updated at that point, and the Welsh Government should be notified / updated

[†]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 unless related to possible abuse.

NOTE: this guidance relates to deaths reported 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 Welsh Government Improving Patient Safety mailbox and Healthcare Inspectorate Wales. When the circumstances outlined above apply, NHS organisations are encouraged to report deaths additionally to the NRLS.

Self harm not resulting in death

Welsh NHS organisations should apply the principles above to report actual or apparent self-harm incidents with an outcome of severe harm or moderate harm to the Welsh Government, Improving Patient Safety mailbox. 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.

Rationale

The rationale is as follows

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 organisations and current guidance.

Rationale for this guidance:

- 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.

Deaths from alcohol or drug abuse are not routinely regarded as notifiable, unless there has been a patient safety incident.

[‡] 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