Five-Year Thematic Review of Suicides by People in Contact with AWP Services 2008-12

Anthony Harrison
Linda Hutchings
Chris Ellis
Simon Joseph

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Executive summary

- Although our suicide rates are consistent with national rates, individual variations within localities do occur, and reminds us of the continuing need for awareness of suicide risk indicators and suicide prevention activities.
- There are no marked differences in patient suicide rates between AWP and England and Wales, and when compared to a selected sample of other mental health trusts within the southern region.
- A higher proportion of our patient suicide deaths were female when compared to the rate for England and Wales.
- Risk assessment, risk formulation and risk management require continued attention and improvement across teams.
- Patterns of patient suicide vary within and between localities in relation to gender and method.
- The impact of changes in the commissioning, provision and organisation of mental health services may have had an impact on patient suicide rates.
- We are able to reliably report suicide numbers for each year and locality, however changes in mental health service provision and population sizes mean it is not possible to provide patient suicide rates.
- Variations in the patterns of suicide within localities should inform LDU-specific actions in relation to on-going suicide prevention work.
- Findings from this review should inform the updating of key learning in relation to practice guidance for staff, patient safety initiatives, and mandatory risk and suicide prevention training.
- The data collection processes relating to routine monitoring of unexpected deaths should be modified to make it coterminous with that produced for mental health providers the NCISH.
- Commissioners should consider establishing a pan-local good practice network focusing on patient suicide data collection and sharing.
- The AWP Trust Board to consider commissioning a suitable external expert to undertake future thematic reviews as a means of ensuring academic and statistical rigour.
Abbreviations used in this report

AWP – Avon & Wiltshire Mental Health Partnership NHS Trust

B&NES – Bath & North East Somerset

CQC – Care Quality Commission

LDU – locality delivery unit

NCISH – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness

ONS – Office of National Statistics

RCA - Root Cause Analysis

SDAS – Specialist Drug & Alcohol Service

SUI – serious untoward incident (includes an unexpected death)

UD – unexpected death

UDA – unexpected death audit
Author details

Anthony Harrison
Is consultant nurse for liaison psychiatry and AWP suicide prevention lead, chairing the Trust Suicide Prevention Group. He is also suicide prevention lead for the B&NES LDU, representing AWP at the B&NES Suicide Prevention and Self-Harm groups. He is currently leading a Trust-wide project to implement self-harm registers across liaison teams, and supports several teams to implement a postcard follow-up intervention following acute hospital presentation for self-harm.

Linda Hutchings
Is the Head of Patient Safety Systems and has worked in a variety of management positions in the NHS for the past 20 years. She manages the processes surrounding serious untoward incident management in the Trust, including Being Open and Duty of Candour and established the internal approach to root cause analysis training. Linda and her team support and assist the coroners in their inquiries into all unexpected deaths involving the Trust’s service users past and present.

Chris Ellis
Is consultant nurse for intensive services and suicide prevention lead for Bristol, representing AWP at the Bristol Suicide Prevention Audit Group, run by the Bristol City Council Public Health Team. He is Chair of the Suicide Prevention Conference Planning Group and is currently a facilitator in a national project exploring the effectiveness of mental health crisis/intensive teams.

Simon Joseph
Is clinical audit and improvement manager, co-ordinating and monitoring all clinical audit activities across AWP. He is currently undertaking a postgraduate certificate in NHS Leadership.
1. Introduction

Reason for this review

This review is an attempt to explore and understand some of the data concerned with our statutory and contractual reporting of the range of actual and suspected suicides of people receiving care from AWP between 2008 and 2012. We wanted to identify whether there were any particular trends or themes that emerged from exploring the data as a whole. Wherever possible we have attempted to make comparisons with published regional and national data relating to suicide, although there were some practical limitations to this, which are explained in more detail further on in the report.

It is very important to us that we attempt to identify and learn lessons from unexpected deaths, to identify whether there are actions we can and should be taking to improve care, and this review informs part of our broader patient safety work.

Who undertook this review?

The following staff undertook the thematic review:

- Chris Ellis – Consultant Nurse
- Anthony Harrison – Consultant Nurse & AWP Suicide Prevention Lead
- Linda Hutchings – Head of Patient Safety Systems
- Simon Joseph – Clinical Audit & Improvement Manager

How we undertook this review

- We reviewed all of the routine data that are collected following each suicide and suspected suicide in AWP for the years 2008-12; this included information obtained from the detailed management investigations and the root cause analysis reviews (RCAs) undertaken following an unexpected death.
Using the RCA data for each case, we identified the most commonly occurring themes emerging from these reviews.

Where we refer to ‘suicide deaths’ in this report we include those deaths from all three coroner determinations – suicide, open and narrative – in line with national practice in classifying suicide.

We made a comparison with the data on suicide within AWP which is collected by the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH).

How this report is presented

This report is divided into four sections:
1. Relevant background information, including aims, methodology and definition of key terms;
2. Summary of suicide in the general population, including headline trends;
3. Incidence of suicide in AWP and an explanation of routine unexpected death data collection processes;
4. Description of AWP suicide data;
5. Comparison of AWP suicide rates with those in England & Wales;
6. Analysis of most commonly occurring findings from AWP’s unexpected death review processes;
7. Recommendations.

Key findings

- Although our suicide rates are consistent with national rates, individual variations within localities do occur, and reminds us of the continuing need for awareness of suicide risk indicators and suicide prevention activities.
- There are no marked differences in patient suicide rates between AWP and England and Wales, and when compared to a selected sample of other mental health trusts within the southern region.
- A higher proportion of our patient suicide deaths were female when compared to the rate for England and Wales.
• Risk assessment, risk formulation and risk management require continued attention and improvement across teams.
• Patterns of patient suicide vary within and between localities in relation to gender and method.
• The impact of changes in the commissioning, provision and organisation of mental health services may have had an impact on patient suicide rates.
• We are able to reliably report suicide numbers for each year and locality, however changes in mental health service provision and population sizes mean it is not possible to provide patient suicide rates.

Limitations of this review
We were unable to adjust our data for the impact of normally occurring population fluctuations; this means that we could only report on the raw data and the annual variations in the numbers may not necessarily indicate a change in the suicide rate for that period. We have not been able to describe the impact, or otherwise, of the changes to the way that mental health services have been commissioned, provided and organised on the findings presented in this report.
2. Terms of reference

The terms of reference for this thematic review are to:

- Where possible, benchmark the incidence of death by suicide in AWP against national rates;
- Outline the characteristics of cases;
- Provide a themed analysis of learning from incident reviews following unexpected death;
- Identify any recommendations arising from this review in order to inform practice and service delivery.

3. Methodology

- The sample has been determined by the total number of AWP reported deaths determined to have been suicides during the period 2008 to 2012.
- Cases with the following coroner’s determinations were included in the sample (Box 1):
  - Suicide
  - Open
  - Narrative
- Demographic and clinical information regarding each case was identified, collated and analysed. All data were anonymised.
- Information regarding each case was cross referenced with one or more of the corresponding post-death investigation reports completed following every unexpected death; these reports were:
  - Root cause analysis report (RCA)
  - Unexpected death audit report (UDA)
  - Management report/enhanced management report
- Data regarding lessons learned and recommendations were obtained from the individual case reports, clustered into core categories, and then grouped into key themes. To increase internal validity a sample of cases were cross-checked between the authors.
• No additional cross-checking or triangulation occurred beyond an analysis of the content of each case report – i.e.: archived clinical records or other patient-specific information was not accessed as part of the thematic review. The findings and analyses are based solely on the information provided by clinicians and managers in the respective post-death reports identified above.

• Quantitative data were obtained following collation of core demographic (patient) and service characteristics of each case.

• After agreeing the methodology, three of the authors shared 10 of their cases with their author colleagues, who then undertook their own analysis of these cases, followed by a group discussion and consensus of the findings.

• The qualitative themes and their associated categories were derived following extensive reading and re-reading of each post-death report; categories (patient safety issues/concerns, service and care delivery problems, characteristics of the individual patient/service user, and good practices) were all highlighted. After collapsing these categories they were grouped thematically.

Box 1: Coroner’s determinations

Suicide
A determination of suicide is returned when the coroner is satisfied, beyond reasonable doubt, that the individual intended to take their own life. This verdict requires the coroner to be presented with some clear, unequivocal evidence that bringing about their own death was the individual’s intention (e.g.: a suicide note). Suicide and open are known as ‘short-form’ determinations.

Open
An open determination is returned when the circumstances of the person’s death do not satisfy any other form. There may or may not be a suggestion, or intimation, that self-inflicted death may have been the person’s intended outcome. A majority of deaths given open determinations are likely to be suicide (health services have less stringent criteria in formulating a judgement regarding suicide, whereas the coroner has to be satisfied beyond reasonable doubt). For this reason, both determinations of ‘suicide’ and ‘open’ are used when calculating suicide rates and in suicide research.
Narrative

Narrative is an alternative to one of the short-form determinations and is recorded by the coroner in several sentences, detailing how and in what circumstances the death occurred. Narrative accounts are intended for use when the coroner wants to detail complex circumstances or multiple factors/agents implicated in the person’s death. However, they are used increasingly when reaching a decision is difficult (as an alternative to an open determination), or simply when a coroner wants to provide more details about the circumstances of the person’s death. The decision as to whether to use a narrative verdict is at the discretion of the individual coroner.

In the UK the number of narrative determinations continues to rise annually, and there has been professional and academic debate regarding the possible impact of this rise on the overall reliability of national data on suicide (Gunnell et al, 2011), as they present potential coding and analysis difficulties for the Office of National Statistics.

It is still possible that some cases of suicide are classified as accident or misadventure.
4. Incidence of suicide in the general UK population

Most recent data from the ONS identifies the following:

- In 2012, 5,981 suicides in people aged 15 and over were registered in the UK, 64 fewer than in 2011.
- The UK suicide rate was 11.6 deaths per 100,000 population in 2012, but there are significant differences in suicide rates between men and women.
- Male suicide rates were more than three times higher at 18.2 male deaths compared with 5.2 female deaths per 100,000 population.
- The highest suicide rate was among men aged 40 to 44, at 25.9 deaths per 100,000 population.
- The most common methods of suicide in the UK in 2012 were hanging, strangulation and suffocation (58% of male suicides and 36% of female suicides) and poisoning (43% of female suicides and 20% of male suicides).
- In 2012 in England, the suicide rate was highest in the North West at 12.4 deaths per 100,000 population and lowest in London at 8.7 per 100,000 population.

Figure 1 provides an overview of age-standardised (aged 15 years and over) suicide deaths registered each year between 1981-2012.

Compared to other regions of England, the South West has the fourth highest suicide rate for males (18.1 suicides per 100,000 population) and the second highest suicide rate for females (5.6 suicides per 100,000 population). Figure 2 provides a comparison of suicide rates by English region.
Figure 1: Age-standardised UK suicide deaths registered each year between 1981-2012.

Figure 2: England & Wales suicides registered in 2012, based on boundaries as of August 2013.
5. Incidence of suicide in AWP

Nationally and in the South of England (former NHS regions South West, South Central and South East Coast) there has, in line with predictions, been an increase in the suicide rate within the general population since 2011; this is thought to be most likely related to wider social factors such as the economic downturn and unemployment.

To increase our understanding of suicide among people in contact with mental health services, comparisons have been made with the national data set as maintained by the NCISH – see Section 3, above.

It should be noted that the NCISH use different (narrower, more specific) criteria for mental health service contact than those used by the NHS National Reporting and Learning System (NRLS) reporting requirements. The main difference is that the NCISH does not collect information on two groups of individuals on which AWP reports:

1. People who have been assessed by mental health services, but who have not been taken on to a team caseload;
2. People who die in the period between referral to, and being seen by mental health service.

It should also be noted that NCISH’s data includes service users aged 10 years and over, and the ONS’s general population suicide data refers to people aged 15 years and over. The AWP data presented here relates only to people aged 18 years and over.

AWP incident reporting is a largely proactive process and occurs as close to real-time as possible. The NCISH data collection is retrospective, and only occurs once the coronial inquest process has been completed, and registration of the suicide has been logged by the ONS. Details of

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1 ‘Suicides’ in this report refers to ‘suicides and deaths from injury undetermined whether accidentally or purposely inflicted’. This is shortened to ‘suicide and undetermined deaths’ or,
demographics and service provision are obtained by contacting a named clinician (usually a consultant psychiatrist) within AWP and requesting that they complete a questionnaire about the deceased’s psychiatric history and contact with mental health services. Currently, AWP processes do not allow for routine sharing of suicide data reported to NCISH by senior clinical staff. Occasionally, 'suicide'. The definition is taken from the International Classification of Diseases 10 (ICD-10).
6. Background to data collection and recording of unexpected deaths within AWP

AWP aims to capture data relating to all patients who die unexpectedly and investigate those cases in accordance with the prevailing national guidance available at the time. Between 2008-12 there were a number of amendments to the national reporting guidance, and we have therefore had to adjust our data capture accordingly.

Prior to two sets of guidance issued by the National Reporting and Learning Service (NRLS) in 2012, AWP had recorded unexpected deaths of current service users and the unexpected deaths of those who had been discharged from the service within the previous 12 months. The 12-month timeframe is consistent with the NCISH inclusion criteria.

In 2012/13 the NRLS stipulated mental health trusts should only report UDs of current service users – ie: in contact with the service at the time of their death. Subsequently, the NRLS agreed a revised process with the Care Quality Commission (CQC). This revised guidance specified that UDs of those who had been discharged from services, or who had been referred but not yet taken on should also be reported to the NRLS, but only if there were concerns about access to services or discharge arrangements. At this point (from 2013/14 onwards) AWP largely reverted to its previous practice of including the unexpected deaths of current, former and prospective service users in its internal data.

Whilst it is felt that there may have been minor fluctuations in reporting criteria over time, their impact is minimal, except for 2012 and 2013, when AWP did not include ex-patients as described above, and is this that is most likely to provide the explanation for the reduced number of suicide-related deaths reported in 2012.
Wherever possible we have attempted to provide descriptions of the unexpected deaths using the same data headings as the NCISH, but for some of the areas we have not been able to describe it to the same level of detail. The areas where AWP have not routinely been collecting data within their unexpected death investigation/management reports relate to the areas of:

- Employment status;
- Whether or not the person had missed any appointments with services prior to their death or discharge;
- Primary diagnosis.

Changes to the commissioning and delivery of AWP mental health services took place during the period covered by this review, some of the most significant being the re-commissioning of child and adolescent mental health services from AWP to another provider (2010), community service redesign (2012), and reorganisation from a clinical directorate structure to a locality-based management structure (2012/13). However, there has been no way for us as authors to capture and reference all of these changes and developments, and therefore we have not been able to comment on the extent to which this factor may have influenced the findings presented in this report. However, it is possible that changes to, for example, service specifications and AWP’s patient population will have had some impact on the pattern of suicides as described in this report.
7. AWP suicide data 2008-12

During the five year period 2008 to 2012, there were 259 suicides among AWP mental health service users. This includes those receiving care at the time of their death or within 12 months of being discharged from an AWP service. For consistency the unexpected deaths referred to in the remainder of this report are those suicides and probable suicides of people in touch with mental health services at the time of their death\(^2\).

National data compiled by the ONS or the NCISH both include suicide *rates*. Rates are based on the number of suicides per 100,000 population. Figures in this report do not give rates as we are unable to accurately determine the AWP population size in any given year. This means that an increase or decrease in a single year cannot be used to infer a change in the suicide rate for that particular group. It also means that direct comparisons with the findings from national data analysis, such as the NCISH annual reports is not possible. Table 1 provides a breakdown of coroners’ determinations of the causes of these unexpected deaths. The mean number of suicides annually was 52. Figures include service users in Secure Services or Specialist Drug and Alcohol Services (SDAS), as well as those from a defined locality.

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<th>2011</th>
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<td>5</td>
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<td>48</td>
<td>54</td>
<td>65</td>
<td>40</td>
<td>259</td>
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Table 1: Breakdown of coroners’ determinations by type for all AWP unexpected deaths, 2008-12

\(^2\) “At the time of death” includes all those people who had been discharged within 12 months of their last contact with the service (NCISH criteria), and those who were assessed, but not taken on to caseload, and those who died between the point of referral and assessment.
Commentary

The overall number of UDs that can be considered as suicide has remained fairly consistent (with the exception of 2012, which is most likely to be explained by the variation in reporting criteria for this year). In line with national trends there has been a steady increase in the number of deaths assigned a narrative determination by the coroner.

AWP suicides by locality area

AWP provides mental health services across six locality (CCG commissioning areas); Table 2 provides a summary of all suicide deaths across localities and Tables 3-8 provide a breakdown of UDs and their coroners’ determinations for 2008-12. Figure 4 provides an overview of suicides by LDU with associated linear trend lines for each locality between 2008-12. Between them Bristol and
Wiltshire localities account for well over half of all the suicide deaths - 31 per cent and 23 per cent, respectively.

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<tr>
<td>Total</td>
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<td>48</td>
<td>54</td>
<td>65</td>
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Table 2: Summary of suicide deaths by year across all locality areas, 2008-12.
### Bath & North East Somerset (B&NES)

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<tr>
<th>Coroners' determination</th>
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<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Narrative</td>
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<td>2</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Total</td>
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<td>8</td>
<td>7</td>
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<td>35</td>
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Table 3: Breakdown of coroners’ determinations by type for AWP’s B&NES suicide deaths, 2008-12

### Bristol

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<th>Coroners' determination</th>
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<td>9</td>
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<td>56</td>
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<td>14</td>
<td>21</td>
<td>18</td>
<td>81</td>
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Table 4: Breakdown of coroners’ determinations by type for AWP’s Bristol suicide deaths, 2008-12

### South Gloucestershire

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<thead>
<tr>
<th>Coroners' determination</th>
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<td>10</td>
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Table 5: Breakdown of coroners’ determinations by type for AWP’s South Gloucestershire suicide deaths, 2008-12
North Somerset

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<th>Coroners’ determination</th>
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<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
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<td>Suicide</td>
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<td>Open</td>
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<tr>
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<td>Total</td>
<td>5</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>2</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 6: Breakdown of coroners’ determinations by type for AWP’s North Somerset suicide deaths, 2008-12

Swindon

<table>
<thead>
<tr>
<th>Coroners’ determination</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Open</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Narrative</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>4</td>
<td>23</td>
</tr>
</tbody>
</table>

Table 7: Breakdown of coroners’ determinations by type for AWP’s Swindon suicide deaths, 2008-12

Wiltshire

<table>
<thead>
<tr>
<th>Coroners’ determination</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>47</td>
</tr>
<tr>
<td>Open</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Narrative</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>10</td>
<td>16</td>
<td>12</td>
<td>9</td>
<td>60</td>
</tr>
</tbody>
</table>

Table 8: Breakdown of coroners’ determinations by type for AWP’s Wiltshire suicide deaths, 2008-12
**Commentary**

The greater number of deaths in the Bristol and Wiltshire localities is most likely to reflect their larger relative population sizes, and in the case of Bristol its higher rate of psychiatric morbidity when measured against similar cities in the UK.

There was a marked drop in total reported suicides in 2012 which coincided with the way in which the data was reported; it is not clear whether this is reduction can be accounted for solely because of the changes to reporting requirements.

In 2009/10 commissioners and public health colleagues in Bristol commented on the apparent increase in suicide deaths (Table 2) and discussed with AWP the need to review common themes associated with these incidents, as well as identify any additional learning which could inform future suicide prevention work. A stand-alone piece of work was commissioned from the then suicide prevention lead and identified a series of developmental and improvement actions within certain teams across Bristol (Kual et al, 2011). Much of this work continues to inform AWP’s broader suicide prevention activity.

Some noticeable variations are apparent in the total number of deaths in North Somerset, and the variation in numbers annually in Swindon, but it is not possible to draw firm conclusions as to whether these differences are a reflection of the expected yearly variations, or whether there is a specific causal factor(s) at work.
**AWP suicides by gender**

In the UK more males than females kill themselves, with a ratio of 3:1. In the AWP sample the split is different, with a ratio between males \((n=156)\) and females \((n=103)\) of 3:2 (Figure 5). In the UK, hanging is the most common method by which people end their own life and this national trend is reflected in the AWP sample; hanging was the most common method used, with the exception of females in 2011, when more women killed themselves following a fatal overdose. Figures 6 and 7 provide an overview of the suicide methods chosen by males and females within the AWP sample.

![Figure 5: Gender split for AWP suicides, 2008-12](image)
Figure 6: AWP male suicides by method, 2008-12

Figure 7: AWP female suicides by method, 2008-12
Commentary

When compared to the national picture (UK and England) proportionally more women took their own life in the AWP sample. Across the UK the rate is one female suicide to every three male suicides (25% and 75% respectively). Figure 5 shows these rates to be 40% and 60% respectively. However, these data remind us that no assumptions regarding suicide being a less common act in females can be made.

Consistent with the national picture, hanging and overdosing are the two most common methods by which people in our sample ended their lives. The marked reduction in hanging as a cause of death in 2012 is likely to partially reflect the overall reduction in suicide numbers for that year.

A total of five men ended their life by use of the emerging and highly lethal method of helium inhalation; no women in our sample used this method.

Between 2008-12 there were a total of 19 different causes of death given for the 259 cases of suicide discussed here. For the purposes of clarity, only the six most common methods have been highlighted, as some of the other methods applied in only one or two cases. Examples of the other methods included lacerations, burns, stabbing and hypothermia; all of these are included in the ‘other’ categories provided in figures 6 and 7. Our approach is consistent with that used by the NCISH, whose sample is generated following classification by the ONS on completion of the coroner’s inquest report. In practice, this means that the national categories provided by NCISH are confined to hanging, self-poisoning, jumping/multiple injuries, carbon monoxide poisoning, cutting/stabbing and firearms.

AWP suicides by age

Figure 8 provides a breakdown of suicides by age for 2008-12.
Commentary

Nationally suicide has become more common in people of middle age years and our sample reflects this. With the exception of those service users aged over 70 years, there were fewer suicides in all the other age groups. As people approach middle age the difference in the number of men compared to women who take their own lives begins to narrow. It is also possible that as a total proportion of individuals accessing services at any one time in AWP, more people are of middle aged years, hence the corresponding increase in deaths across this age range.
AWP suicides by ethnic group

Table 9 provides a breakdown of suicides by ethnic group.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/Black British/African</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Black/Black British/Caribbean</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mixed/Black + White/Caribbean</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed - White and African</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other White</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>North African</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>White Irish</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>White British</td>
<td>40</td>
<td>44</td>
<td>52</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Not known/Not stated</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 9: AWP suicides by ethnic group

Commentary

Reflecting both the general population within the AWP geographical area and AWP’s service users, the significantly highest ethnic group is white British. Other ethnic groups where suicides have occurred are such small numbers that it is difficult to draw any meaningful conclusions.
AWP inpatient suicides

Table 10 provides a breakdown of inpatient suicides by ward team and LDU between 2008-12. Of the 24 inpatient deaths, eight of these (1/3) occurred on the ward. None of the on-ward deaths were classified as ‘never-events’.

<table>
<thead>
<tr>
<th>Ward</th>
<th>LDU</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sycamore</td>
<td>B&amp;NES</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Silver Birch</td>
<td>Bristol</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lime Unit</td>
<td>Bristol</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Elizabeth Casson</td>
<td>Bristol</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Avonmead</td>
<td>Bristol</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Clifton</td>
<td>Bristol</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Oakwood</td>
<td>Bristol</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Juniper</td>
<td>North Somerset</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Avebury</td>
<td>Wiltshire</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Imber</td>
<td>Wiltshire</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ashdown</td>
<td>Wiltshire</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Beechlydene</td>
<td>Wiltshire</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Fairfax</td>
<td>Secure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 10: Inpatient suicides by ward team and LDU, 2008-12

---

3 A never-event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. In mental health services the inpatient never-event is death or severe harm to a mental health inpatient as a result of a suicide attempt using non collapsible curtain or shower rails.
AWP suicides within three months of inpatient discharge

There were a total of 36 deaths (36/259; 14 per cent of the total AWP sample) between 2008-12 which occurred within three months of discharge from inpatient care. Table 11 provides a breakdown by year.

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>36</td>
</tr>
</tbody>
</table>

Table 11: Suicide deaths within three months of discharge from an inpatient ward

Commentary

A death is recorded as an ‘inpatient suicide’ if the person’s episode of care was being coordinated by one of AWP’s inpatient teams at the time of death, irrespective of the precise geographical location of where the person died. For example, if a patient is on planned leave of absence from the ward when they die, but their actual place of death is their own home, this is recorded as an inpatient death.

Inpatient suicides accounted for nine per cent of our total sample of deaths. This relatively small number is largely a reflection of the fact that the majority of service users do not receive inpatient care throughout their period of care with AWP. During the period of this review a number of changes occurred to inpatient services, including an overall reduction in the total inpatient bed base, as well as a number of local service reconfigurations.

For the years 2009/10/11 the total number of inpatient suicides remained fairly constant, although there were much lower numbers for the years 2008 and 2012 respectively. The highest number of deaths per individual ward was two incidents across all years. Overall trends and conclusions are not possible due to the relatively small numbers involved, and the variation in numbers by year reflects expected annual fluctuations.

Nationally, a high degree of attention has been given to addressing suicide reduction within inpatient mental health wards, in particular this has involved improving the physical environment to address specific high risk areas such as non-collapsible shower curtains, other fixed ligature points, and the observation of patients.
AWP suicides by service type

Table 12 provides a breakdown of suicide deaths by service between 2008-12.

<table>
<thead>
<tr>
<th>Service</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>39</td>
<td>28</td>
<td>33</td>
<td>31</td>
<td>29</td>
<td>160</td>
</tr>
<tr>
<td>Intensive</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Inpatient - excludes secure wards</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>SDAS</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Secure</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1*</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
<td>48</td>
<td>54</td>
<td>65</td>
<td>40</td>
<td>259</td>
</tr>
</tbody>
</table>

* Inpatient death

Table 12: Suicides by service setting, 2008-12

Commentary

More than three quarters of all suicides in our sample were in receipt of community care at the time of death. This is most likely to reflect the fact that there is a much higher proportion of people in receipt of community care as opposed to inpatient care. Interestingly, in 2012, despite the fewer number of suicides overall in that year, the total number of community deaths remained relatively constant. The death assigned to ‘other’ services includes services such as general hospital liaison teams and primary care psychology (IAPT) services.
AWP suicides by time of year

Figure 9 provides a breakdown of AWP suicides by time of year in 2008-12.

![Suicides by Month 2008-2012](image)

**Figure 9: AWP suicides by time of year, 2008-12**

**Commentary**

In our sample there was a noticeable increase in number of suicide deaths in June; overall, suicide occurred most often in the spring and summer months (April – August) and this is consistent with overall suicide rates nationally.
8. Benchmarking AWP against the national picture

The information in the following section has been prepared by the NCISH\(^4\), who have calculated and analysed AWP’s suicide rates and compared these to those for the rest of England and Wales for the period 2008-12. This comparison allows us to draw some inferences and conclusions, and provides a means of benchmarking our suicide deaths with the national picture. With the exceptions of, i) individuals with a history of self-harm, and ii) suicides within one week of their last contact with mental health services, there were no significant differences between AWP deaths and the rest of England and Wales.

In 2008-12 there were 23,715 suicides in England and Wales (based on date of death), and 25 per cent of this sample were in touch with mental health services within 12 months of their death. Changes in the configuration of NHS regions during this time means that calculating a figure for the number of suicide deaths regionally has not been possible. As a compromise, the NCISH calculated the number of suicides in the former Avon, Gloucestershire and Wiltshire (AGW) region i.e. a larger geographical boundary than that of AWP; during this period there were 1,038 general population suicides in AGW area.

187 (18 per cent) of the 2008-12 AGW suicides (187/1,038 total population suicides for the AGW area), were in touch with AWP services within 12 months of their death, according to the NCISH data. The 187 suicides equate to 72 per cent (187/259) of the AWP sample reported here. The remaining 28 per cent of our sample can be accounted for by the fact that we report and investigate a greater number of suspected suicide deaths than meet the

\(^4\) The NCISH does not provide comparative data with other mental health trusts nationally, and it is not possible for us or our commissioners (or other stakeholders) to make direct comparisons with other local or regional providers. Benchmarking reports are not routinely published and are only made available to the mental health provider concerned. The NCISH do not have data-sharing agreements in place to allow for the publication of these data on a wider basis.
NCISH criteria. Please refer to Section 5 for further details of the differences in the categorisation of these deaths.

**Gender**

Sixty five per cent of those taking their own life were male and 35 per cent were female. There was no statistically significant difference between the AWP rate and the national rate. Figure 11 provides a comparison of the gender differences between AWP suicides with the rest of England and Wales for 2008-12.

![Figure 11: AWP and England & Wales - suicides by gender 2008-12](image)

**Age**

The median age that people within the NCISH sample died was 45 years (age range 18-95 years); nationally the median age was 46 years (age range 10-98 years).

**Ethnicity**

Ninety four per cent of suicides were of white ethnic origin. Figure 12 provides a comparison of the ethnicity between AWP suicides with the rest of England and Wales.
Employment status

Three quarters of AWP suicides were unemployed and 22 per cent were in paid employment at the time of death. Figure 13 provides a comparison of the employment status of AWP suicides compared with the rest of England and Wales, 2008-12.
Commentary

Across age, ethnicity and employment status there were no significant differences between AWP and the national picture. A high proportion – well over 40 per cent) of people who take their own lives were unemployed at the time of death, and a lack of meaningful employment is recognised as a major risk factor for both suicide and self-harm.

Patient status at the time of death

Eight per cent of individuals were classed as inpatients at the time of their death, compared to seven per cent across England and Wales. Thirteen per cent died within three months of discharge, compared to 18 per cent nationally. Eighteen per cent refused drug treatment before death, compared to thirteen per cent nationally. Eighteen per cent missed their last contact with services, compared to 24 per cent nationally. Fifty six per cent of deaths occurred within one week of the person’s last contact with mental health services.
services, compared with 49 per cent nationally. Figure 14 provides a comparison across the domains of inpatient status, death within three months of discharge, drug treatment refusal, and death within one week of mental health service contact compared with the rest of England and Wales, 2008-12.

**Figure 14: AWP and England & Wales - patient status at the time of death, 2008-12**

<table>
<thead>
<tr>
<th>Domain</th>
<th>AWP</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient at time of death</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Died within 3 months of discharge</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>Missed last contact with services</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Last contact within 1 week before death</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Commentary**

Across the domains of inpatient status, death within three months of discharge, missed last contact with services, and drug treatment refusal AWP’s profile is consistent with the national picture. A statistically significant\(^5\) difference was identified between our rate and the national picture, in that more patients took their own life whose last contact was within one week before death. The difference may be due to the AWP teams ensuring that their very high risk services users have regular contact and are in touch with services, or it could be associated with suicide risk factors being missed or not acted upon by staff.

---

\(^5\) p<0.05
All five domains are key in terms of suicide prevention and can be considered as 'high risk' factors in relation to suicide; an awareness of these should act as an important reminder for the need for continued vigilance in relation to care planning and risk management interventions.

Patient history

Seventy six per cent of suicides had a history of self-harm, compared to 68 per cent nationally; and 23 per cent had a known history of violence, compared to 22 per cent nationally. Forty seven per cent had a history of alcohol misuse, compared to 46 per cent nationally; and 38 per cent had a history of drug misuse, compared to 33 per cent nationally. Figure 15 provides a comparison across the domains of history of self-harm and violence, and drug and alcohol misuse compared with the rest of England and Wales, 2008-12.

![Figure 15: AWP and England & Wales - suicides and patient history, 2008-12](image-url)
Commentary

Across the domains of history of violence, and alcohol and drug misuse AWP’s profile is consistent with the national picture. AWP’s sample showed a statistically significant greater difference⁶ in the rate of people with a history of self-harm than the national rate. This is a well-recognised risk factor in relation to future suicide risk and is the subject of a number of service and practice development initiatives across the Trust.

Method of suicide

Five main categories of method of death were identified by NCISH – hanging/strangulation, self-poisoning (overdose), carbon monoxide poisoning, jumping/multiple injuries, and drowning. Figure 16 provides a comparison between methods in AWP and the rest of England and Wales, 200812.

---

⁶ p<0.05
Commentary

Death as a result of hanging/strangulation is the most common method, followed by self-poisoning (overdose). There are no significant differences between the method of death profiles of those suicides assigned to AWP and the national picture.

Primary diagnosis

Five main diagnostic categories were identified by the NCISH – affective disorders, schizophrenia and other delusional disorders, personality disorder, alcohol dependence, and drug dependence. Figure 17 provides a comparison between methods in AWP and the rest of England and Wales, 200812.

Figure 17: AWP and England & Wales - primary diagnosis, 2008-12

![Diagnosis chart]

Commentary

Affective disorders, primarily depression, account for the most common primary diagnosis in those people who have ended their lives. Individuals may have more than one diagnosis, and there will be a range of precipitants linked to each incidence of suicide. There are no significant differences between the primary diagnosis profiles of those suicides assigned to AWP and the national picture.
Comparing AWP with the Thames Valley & Wessex NHS region

Another source of information which describes suicide rates across the former Thames Valley & Wessex NHS region (TVW) is available as a comparator for AWP. These data were published as part of a wider suicide-related benchmarking project hosted by Oxford Health NHS Foundation Trust; this study covered the years 2001-11. While direct comparisons between this and AWP’s five-year analysis are not possible, we have included it here as it provides an opportunity to contrast our suicide rates with those across several other comparable mental health trusts. Figures 18 - provide an overview of the comparisons between AWP and TVW.

![Figure 18: AWP & TVW - Patient demographics, 2001-12](image-url)
Figure 19: AWP & TVW - Employment status at time of death, 2001-12
**Commentary**

Comparing information about the characteristics of AWP’s suicide cases with those of a large region shows a relatively similar picture across each of the domains reported on by the NCISH.
9. Findings from the analysis of care and service delivery problems, recommendations and notable practice

From following the methodology described above, several qualitative themes and their associated categories were revealed. These were distilled into five overarching themes. A definition of each theme is provided in Box 1. The five themes were:

1. Opportunities for suicide prevention
2. Patient characteristics
3. Care delivery problems
4. Service delivery problems
5. Notable practice

Box 1: Description of themes

- **Opportunities for suicide prevention:**
  These categories have been identified as core elements associated with the delivery of safe and effective care; the absence or omission of these elements from the person’s care pathway are often also associated with an increase in overall risk, and in particular risk of suicide. None of the reports identified a direct causal link between these factors and the person’s death.

- **Patient characteristics:**
  These categories were individual, person-specific items (specific to the person) which are known to be associated with an increased risk of suicide. Their identification here did not necessarily indicate that there was a failure by the care team to recognise this association; in the majority of cases these characteristics were identified as part of the assessment and risk management processes.

- **Care delivery problems:**
  These are problems associated with the direct delivery of care, usually

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7 We noted that during the period 2008-12 the definition of good practice in investigation reports was amended from ‘good practice’ to ‘notable practice’. Notable practice is defined as practice that is over and above the standards set out in relevant AWP policies and/or guidance. Consequently, for the first two years (2008-10) we found it difficult to assimilate with the new definition and therefore decided to exclude these two years from the qualitative analysis.
actions or omissions by members of the care team. They have two essential features, a) care deviated beyond safe limits of practice, and b) the deviation had at least a potential direct or indirect on the eventual adverse outcome for the patient.

- **Service delivery problems:**
  These are problems associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery.

- **Notable practice:**
  One or more items of notable practice were identified in the many of the cases, and tended to focus on broader engagement and relationship issues between the staff team and the individual patient, or communication across the care system.

Within each theme the most frequently occurring examples of categories are identified in Table 10 below, ie: not an exhaustive list.
<table>
<thead>
<tr>
<th>Theme 1</th>
<th>Missed opportunities for suicide prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Poor inter-team communication, Risk management plan poorly formulated, Lack of clarity regarding diagnosis or formulation, Inadequate risk assessment, Suicide risk indicators missed, AWOL risk not assessed, Failure to address loss of contact with service, Not recognising high risk transition points on the care pathway.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2</th>
<th>Patient characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Repetitive self-harming behaviour, Dual diagnosis, Medication concordance, Problematic alcohol use, Repeated assurances to staff regarding non-suicidal intent, Chronic physical health problems or long-standing physical illness(s), Non-engaging with service(s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3</th>
<th>Care delivery problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Failure to adhere to clinical policy or procedure, Non-allocation of care coordinator, Inadequate staff knowledge base, Lack of clinical formulation, Failure to identify treatment priorities, Lack of and/or inadequate care plan, Lack of and/or inadequate risk management, Over-reliance of stated non-intent to self-harm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 4</th>
<th>Service delivery problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Lack of a specific clinical service, Lack of info sharing protocols, Lack of locality protocol for shared care, Inadequate staffing level, Lack of clarity regarding referral pathway [and care pathway post redesign], Ward design compromised patient safety, Inadequate ward nurse staffing levels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 5</th>
<th>Notable practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Assertive engagement, Comprehensive treatment plan, Sustained contact and engagement, Effective inter-agency/service collaboration, High standard of inter-agency communication and collaboration, Undertaking home visits to encourage engagement where home visits were not the norm.</td>
</tr>
</tbody>
</table>
10. Discussion

The context of the thematic review process

Undertaking and completing a broad thematic review on this scale posed a number of challenges for us as authors, not least of which was the lack of dedicated time and additional resources to pursue the project. The external categorisation and reporting of incidents has been (and continues to be) subject to revision and re-definition, and the routine publication and sharing of suicide-related data by the NCISH has meant that making direct comparisons with national and regional data sets difficult. However, we understand that from late 2015, the NCISH will publish performance scorecards which will include indicators relating to suicide, homicide and sudden unexpected deaths for each mental health provider in England and Wales (NCISH Private correspondence with the authors, 2015).

Our inability to standardise the data to take account of factors such as age and gender differences, differences in the patient and general populations, and the degree of psychiatric morbidity limits the overall usefulness of thematic reviews such as this. It means that making comparisons between our non-standardised suicide numbers (raw data) and the nationally published suicide rates (number of suicide deaths per 100,000 population) is problematic. There can be a tendency to over-emphasise the broader significance of a relatively small number of suicides within a given geographical area or time frame. While this is in no way meant to minimise the tragic nature of each individual death, a narrow focus on time/setting means that themes and trends can be missed.

When compared to the rest of England and Wales AWP’s suicide rates for the five years 2008-12 do not demonstrate that we are an ‘outlier’ or markedly different from the national picture. All providers need to work hard to promote and embed a suicide prevention culture across the organisation, along with a sense of therapeutic optimism that suicide is not inevitable and can be prevented. However, from both historical and statistical perspectives it would
be unrealistic not to expect a certain number of suicides within our service user groups.

**Analysis of themes in relation to care and service delivery**

It is unsurprising that both the overarching themes that have been captured from all of the 2008 to 2012 data, and the example categories that make up those themes, repeat many of the known issues and problems in relation to the provision of safe and effective mental health care. National findings and recommendations (NCISH, 2014) echo many of the deficiencies identified in our review. The deficiencies identified can be viewed as fundamental ‘patient safety practices’ by mental health staff; when implemented or delivered to a high standard, each of the categories demonstrates a focus on a patient safety culture across the service and the challenge is to ensure that all of these deficits form the basis for a comprehensive and consistent approach to mental health care service delivery.

**Theme 1: Missed opportunities for suicide prevention**

Knowing whether a particular event, situation or intervention is one which will reduce the risk of or prevent suicide is something that can only be known for certain after the event. For practitioners working daily with suicide risk a positive outcome (the person remaining alive) is often a non-event (no suicide). However, the clinical and personal significance of a number of suicide risk characteristics are often missed or inadvertently minimised in busy clinical teams with high workloads and high levels of patient acuity. Frequent examples of variable practice in relation to risk assessment, risk management, recognition of suicide risk characteristics, and over-reliance on stated non-suicidal intent were evident when analysing all the investigation reports.

It is noteworthy that the category, “Repeated assurances to staff regarding non-suicidal intent” (Patient characteristics) occurs again in the Care delivery
problems theme as the category “Over-reliance of stated non-intent to self-harm”. In 2012 and 2013 good practice guidance regarding these issues was published by the Trust and circulated widely, and the good practice points, along with the use of the structured professional judgement approach to risk assessment, forms the basis of AWP’s three-yearly mandatory training in suicide prevention and risk.

We also note that the categories relating to inter-team communication, and shared protocols etc. are even more important in 2015, with the precedence of multi-agency partnership working in the Bristol Mental Health Service, and greater prevalence of inter team working reflected across the Trust between AWP and third sector services, primary care services, and social care, compared with the situation in 2008.

**Theme 2: Patient characteristics**

Seven categories were identified as part of this theme and all of these are referenced widely in the published literature on risk, suicide, and suicide prevention. In many of the cases there was an apparent lack of awareness as to the significance of such characteristics within the context of risk assessment and risk recognition; many practitioners themselves identified a lack of understanding of the significance of individual patient characteristics, in particular the increase in risk associated with physical illnesses.

AWP, along with other mental health services, provides care for groups of people who are inherently at ‘high risk’ of taking their own lives; all psychiatric diagnoses carry a significantly increased risk of suicide. Safe mental health care can be achieved by a determined focus on the fundamentals of practice, namely clear and unambiguous access and transfer processes, timely response to referrals, standardised assessment, management and treatment pathways, and effective environmental and personal risk assessment and management.
A number of patient-specific characteristics, that is factors that are specific to the individual which make them more likely to take their own life, were present in many of the cases that we reviewed. A particular diagnosis or set of behavioural features may be associated with a particularly high mortality rate and an associated increase in suicide risk. Many of these characteristics are described in the published literature on risk assessment and suicide, and it is these factors which need to alert practitioners to the possibility of increased risk of suicide. For example, a history of self-harming behaviour should always result in an assessment (or re-evaluation) of the person's risks. The majority of these factors can be termed static or stable risks, but their presence should act as a prompt to assign the person to a high risk group for the purposes of risk assessment.

**Theme 3: Care delivery problems**

Care delivery problems (CDPs) featured most frequently in the cases that comprised our sample for this review and eight categories were identified within this theme. These problems are most often associated with the specific practices of staff, most commonly resulting in errors of omission. The reasons for care delivery problems occurring are complex and are most likely to be associated with ‘human factors’, such as mistakes/errors, forgetfulness, distraction, and preoccupation.

Non-adherence to particular policies or their associated procedures and guidelines were the most commonly occurring reasons for care delivery problems, and a number were also linked with environmental factors (such as the team’s work setting) and lack of adequate supervision, guidance and training. Very occasionally there was an incidence of deliberate or possibly malicious non-adherence to expected policy or procedure.
Many of the problems within these categories related to practice issues where guidance and procedures already exist and overlap with some of the categories in Theme 1. Extensive published literature and professional guidance identifies the need for adherence to semi-standardised processes, in particular the identification of an appropriate treatment pathway, comprehensive care plans and risk management plans, and a person-centred risk formulation.

CDP categories now inform the planning and delivery of AWP's risk assessment and suicide prevention training; anonymised cases are used to illustrate the relevance and importance of addressing these domains as part of core practice.

**Theme 4: Service delivery problems**

Service delivery problems (SDPs) generally focus on the wider organisational and systems issues which might bring about the conditions that make risk incidents more likely to occur. These may range from the absence of a particular clinical service, lack of policies and procedures, and unforeseen interruptions to the integrity of existing care pathways as a result of service re-design. In our sample of cases lack of policies and guidance were relatively frequent SDPs, while some examples, such as ‘ward design’ occurred only once.

**Theme 5: Notable practice**

Notable practice was identified in a significant number of cases that made up our sample and highlights the importance of ensuring a balanced description and analysis of care following suicide. Although less frequent overall, there were nevertheless a number of examples of practitioners and teams working with extra diligence and skill to deliver care to people with complex and
multiple problems. Notable practice occurred most often in cases where patients had complex presentations and co-morbid problems; much of this good work was demonstrated by a high standard of care coordination, often across multiple agencies and in challenging situations.
11. Recommendations

1. The variations within and across LDUs should be noted by management teams and the findings from this report should:
   a. Be presented and discussed at local quality and standards forums;
   b. Inform the development of LDU-specific suicide prevention action plans;
   c. Be shared with local authority public health/suicide prevention leads as a means of informing locality-based suicide prevention initiatives for mental health service users.

2. Use the findings of this report to inform Trust-wide learning regarding suicide prevention in the context of AWP’s Suicide Prevention Strategy by:
   a. Producing and publishing a further Safety Matters bulletin to highlight the key learning and suicide prevention messages from this review;
   b. Reviewing and revising the existing 10 Top Tips for Suicide Prevention for Practitioners and the 5 Top Tips for Suicide Prevention for Managers.
   c. Reviewing and revising the content of the AWP mandatory training programme CPA, Risk and Suicide Prevention.

3. Modify unexpected death data collection processes to include the routine collection of information regarding ‘primary diagnosis’ and ‘missed appointments prior to death’.

4. Address the variations in practice regarding risk assessment and management within teams to inform both LDU-specific and Trust-wide monitoring and quality improvement initiatives regarding patient safety.

5. Commissioner colleagues to consider establishing a pan-local Suicide Prevention Good Practice Network, with the aim of agreeing core data collection methods in relation to:
   a. A standardised data set across local mental health providers;
   b. Sharing NCISH data monitoring regarding patient suicides across providers;
c. Sharing transferable good practice and suicide prevention initiatives across the local provider network.

6. For the Trust Board to consider commissioning an external provider to undertake future thematic reviews in relation to suicide deaths, with the aim of standardising our data as a way of making meaningful and robust comparisons regarding suicide rates within AWP.

7. The AWP Information Team to amend their systems to report on changes to service commissioning and configuration by calendar year, and for this information to be published in a summary timeline on OurSpace.
12. References


