

Learning from suicide-related claims

An updated thematic review



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Foreword

Why this review matters

Every suicide related claim reflects a tragic loss of life, with profound consequences for the individuals, families, communities and staff involved. While no report can fully capture the human cost of suicide, this updated thematic review offers an important opportunity to listen, reflect and learn from related claims seen by NHS Resolution, providing a unique source of insight through claims data.

Although this data does not represent all incidents or all experiences of mental health care, it can reveal patterns in cases where there have been clear breaches in duty and where learning may support improvement across the system. This review builds on [NHS Resolution's 2018 report](#) and considers suicide related claims notified between 2018 and 2025, a period during which mental health services, patients, families and staff have experienced significant change and pressure.

What the claims data tells us

Of 2,200 clinical negligence claims brought within NHS mental health services during the review period, 960 were suicide related.

The value of notified suicide related claims was £141 million, but the financial cost is only one part of the picture. The greater importance of this review lies in what these claims tell us about opportunities to strengthen care, improve communication, support staff and involve patients, families, carers and significant others more meaningfully in risk assessment, care planning and safety decisions.

Communication emerges as the central thread running through the analysis. The report highlights the importance of hearing the family voice, understanding information sharing and consent, moving beyond static risk tools towards formulation-based approaches, and ensuring that teams have clear responsibilities, effective handover and shared understanding across care settings. It also recognises the pressures facing mental health services and the need for compassionate leadership, just culture principles and organisational conditions that enable staff to provide safe, therapeutic care.

How this report should be used

This report is not intended to replace existing national guidance or strategies, nor does it seek to make new recommendations. Instead, it adds a further lens to the existing evidence base by drawing attention to recurring themes in claims where learning may help prevent future harm. The findings align with wider national reports and guidance, including the

- Department of Health and Social Care (DHSC) [suicide prevention strategy](#)
- National Institute for Health and Care Excellence (NICE) [guidance on self-harm](#)
- NHS England [Staying Safe from Suicide guidance](#)
- The National Confidential [Inquiry into Suicide and Safety in Mental Health](#)
- Health Services Safety Investigations Body (HSSIB)'s [work on mental health inpatient settings](#)
- [Patient Safety Incident Response Framework](#)
- NHS Resolution's [Being Fair publications](#)

Together, these sources reinforce the need for family involvement, high quality formulation, safer transitions, effective communication, compassionate leadership and a just culture. This review asks organisations to consider how claims data can be triangulated with incidents, complaints, Prevention of Future Death reports, staff feedback and the experiences of people who use services and those close to them.

The learning set out in this review is important because improvements in communication, engagement with families, handover processes and risk formulation all contribute to safer care and better outcomes. Above all, this review recognises those who have died by suicide, the families and communities affected, and the ongoing commitment of staff and organisations to learn and improve care.



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Executive summary

Purpose of this review

The impact of suicide is far reaching, and every claim relating to suicide represents the loss of life. Where compensation is paid, this is representative of the NHS not meeting safety standards and expectations. Using the unique insights of claims data, this review highlights potential gaps in care and safety provision within mental health settings. The findings of this review complement current guidance, national strategies and the existing body of evidence that identify where improvements can be made. We recognise the devastating effects of suicide on family members, friends and carers of the patient as well as on NHS staff. Failures in care can be systemic, and investigations must adopt a fair and just culture supported by compassionate leadership when addressing the system level issues identified^{1,2,3}.

- [NHS England Patient Safety Strategy](#)
- [NHS Resolution Being fair report](#)
- [NHS Resolution Being fair 2 report](#)

During 2024 to 2025, NHS Resolution was notified of 11,396 claims under the Clinical Negligence Scheme for Trusts (CNST), with the cost of harm under this scheme estimated at £4.9 billion. The cost of harm, as reported in [NHS Resolution's Annual Report and Accounts 2024/25](#), represents NHS Resolution's estimate of the full financial impact of patient harm arising from incidents that occurred in a single year, including both known and future claims, regardless of when they are paid.

Why an updated review was needed

During this financial period, clinical negligence claims within mental health NHS services in England accounted for 3.4% of the total number of claims notified under the CNST, which handles clinical negligence claims against NHS bodies that are members of the scheme.

This report covers a period between 2018 and 2025, where 2,200 clinical negligence claims were brought within NHS mental health services, of these, 44% were related to suicide. The value of the notified suicide related claims equated to £141 million, including damages paid to claimants and associated legal costs across all open and closed claims between April 2024 and March 2025; however, the human cost is immeasurable.

[NHS Resolution published a review of suicide related claims in 2018](#) which identified key themes and made nine recommendations. Since then, the NHS has faced the challenges of the COVID-19 pandemic, and the healthcare and related policy landscapes have change significantly. This prompted an updated analysis of the data that NHS Resolution hold concerning mental health, which has demonstrated that suicide related claims remain a priority area for learning and improvement.

While this report draws on claims to identify opportunities for learning and improvement, it is important to recognise that there are many examples of good care and recovery. The commitment of clinicians to providing high quality care, often in challenging circumstances, is evident, and the majority of people experience safe and effective care.

This review aims to understand the key safety issues behind suicide related claims and encourages healthcare leaders to utilise the unique lens of claims data within their governance and learning structures. There is an existing body of research and national strategic publications into suicide prevention in England which are discussed in this review. The findings and approach set out in this report have been informed by partnership working with key stakeholders across the system, including organisations with responsibility for suicide prevention and individuals with lived experience who have been personally impacted by suicide, all of whom have contributed to the review of this work.

Given this, this report does not seek to make further recommendations, instead it aims to provide key insights into lapses in care where there have been clear breaches in duty, and to share that learning.

To undertake this review, NHS Resolution's Claims Management System (CMS) was used and a search for all mental health compensation claims notified between 2018 and 2025 was completed. Claims are brought against healthcare providers and, where those providers are members of NHS Resolution's indemnity schemes, these are managed by NHS Resolution on their behalf.

In cases involving suicide, claimants are often family members of the person who took their life. The initial data screen found 2,200 results of which 960 were suicide related. There were 229 suicide related claims where admissions of liability had been made.

37 suicide related claims were qualitatively analysed from a randomised sample. Data saturation⁵ was reached at this point and no new themes were highlighted. Findings from the qualitative analysis were charted against The Yorkshire Contributory Factors Framework – Mental Health^{6,7} (YCFF-MH) and categorised into themes for discussion. The YCFF is a validated tool that was developed following systematic research of 83 research studies that focused on the causes of hospital patient safety incidents⁶, which was updated in 2020 for use in mental health⁷.

[A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services - PMC](#)

The three themes

This thematic analysis centres around communication challenges, which surfaced as a cross-cutting issue across three key categories:

1. Patient, family and significant others
2. Safety culture
3. Workforce

We recognise the complexity of mental health care and provision, and the holistic nature of people and interactions. It can be challenging to separate decision-making and subsequent actions. A conceptual framework has been developed to illustrate the interdependencies of the themes highlighted in this review.

Key findings

These key findings are based on a qualitative analysis of 37 suicide-related claims where damages were paid.

Patient, family and significant others

- Family, carers and significant others were often not involved in risk assessment or care planning. The absence of family engagement, or the family voice not being heard meant that key risks were missed or overlooked.
- The application of 'Consent to share information' was poorly understood by clinicians.
- **84%** of patients who went on to take their life had a previous psychiatric history. **38%** had a history of poor compliance with treatment or engaging with mental health teams.
- **68%** of patients had a history of self-harm with **59%** having also made a previous attempt at taking their life. **76%** of patients had previously stated they had thoughts of self-harm or suicide.

Safety culture

- **32%** of claims reflected delays in assessment, which were attributable to a range of factors such as poorly defined roles and responsibilities, lack of local guidance or adherence to referral processes, and demands for the services outweighing capacity.
- **86%** of claims indicated issues with the implementation of risk assessment. This largely concerned the use and completion of risk assessment tools.
- Where the physical environment in clinical settings was mentioned, risk factors such as poor layout of wards and visibility from the nurse's station were cited in **27%** of these claims.
- Clinical observations were not always aligned to patient risk, and documentation of rationale for the level of observation was often inadequate or absent.
- Suboptimal record keeping was cited in **86%** of the claims that mentioned risk assessment implementation issues. These included absent records, partially completed records, or records that had not been reviewed or updated.

Workforce

- Poor communication between staff was observed in **68%** of claims. A lack of verbal or written notes was a factor in **51%** of claims.
- There was a perception among families that services were complicated and difficult to understand, and as such they were unsure who was responsible for care, particularly when more than one service was involved. It was also noted in **14%** of claims that it was difficult to contact the correct professional.
- Concerns around clinical leadership were evident with **49%** of claims citing unclear responsibilities and **11%** including inappropriate delegation. Team factors included conflicting team goals, poor delegation, absence of feedback and lack of respect for colleagues.
- Challenges in joint working were evident with a lack of or inadequate joint working policy and awareness of how other services operate services.
- **24%** of claims described a high unit workload or caseload, and **19%** mentioned staffing shortages or skill mix.

Introduction

Note on terminology

The significant human cost and impact of suicide cannot be fully described. This report aims to address some of the gaps, challenges and barriers that contribute to lapses in care and where learning can be derived. As such there may be terminology that seem incongruous with the devastation that those bereaved by suicide experience, and the impact this has on staff involved in safety incidents. We wish to make explicit that every effort has been made to balance factual descriptors with sensitivity to its readers and those who have been affected by suicide.

It is recognised that there is not a singular term for people who access mental health services, nor indeed for those who take their own life. There may be a preference for 'service user' or 'patient', but for simplicity this review will use the term 'patient'. This aligns with the terminology used in [DHSC's Suicide prevention in England: 5-year cross-sector strategy in 2023](#).

In addition, this report recognises the large range of people who support individuals who have lost their life to suicide. For brevity, this review will refer to 'family' or 'significant others' which includes all people with whom the patient has had a close relationship with, this can include carers, friends and family. It is noted that the majority of people who brought the compensation claim in this review were close family members.

NHS Resolution handles negligence claims on behalf of the members of our indemnity schemes: NHS organisations and independent sector providers of NHS care in England and, since April 2019, beneficiaries of state-backed indemnity for general practice. The [NHS Resolution strategy 2025 to 2028](#), Resolution through collaboration, includes a focus on sharing data and insights as a catalyst for improvements that benefit patients, healthcare and the justice systems. Our Safety and Learning directorate plays a key role in achieving this strategic priority by bringing together key partners working to target safety activity, share learning across the system and drive improvement.

[NHS Resolution Learning from suicide-related claims report 2018](#), examined 101 suicide related claims that were funded through NHS Resolution's discretionary CNST arrangements for legal representation at inquests between 2015 and 2017.

This report identified five major themes:

1. Substance misuse
2. Communication
3. Risk assessment
4. Observations
5. Prison healthcare

[In 2024, there were 5,717 deaths by suicide registered with a rate of 11.1 per 100,000 people](#) compared to the data published in 2017, where there were 4,451 deaths at a rate of 9.1 registered suicides per 100,000 people. Of the suicide related claims that were settled with damages paid between 1 December 2017 and 31 October 2025, 44% of fatalities in mental health related clinical negligence compensation claims were linked to suicide.

[DHSC published the Suicide prevention in England: 5-year cross-sector strategy in 2023](#). This illustrates the significant investment that has been made since 2012 when the last suicide prevention strategy for England was published (now superseded by the 2023 strategy). [The NHS Long Term Plan](#) has seen a £57 million investment for suicide prevention with a total funding commitment for [mental health](#) of at least £2.3bn per year in real terms by 2023/24.

The need to reduce the number of suicides and the related suffering, emotional distress and impact of suicide is clear. With suicide related clinical negligence claims notified to NHS Resolution after 31 December 2017 and before 31 October 2025 totalling £141 million, there is also a strong economic case to learn from these claims to preserve funds for future NHS patient care and resources. This time period is relevant as a continuation from the NHS Resolution report published in 2018, chosen to ensure continuity for theme analysis and learning from previous findings.

The aim of this thematic review is to leverage the unique perspective of claims data to support system improvement in patient safety relating to suicide, by providing additional insight to the already known body of research and data, consider progress against the themes identified in our 2018 report and suggest areas for future focus.

It is important to note that there are many experiences of good care and recovery, and to recognise the commitment of clinicians to maintain good practice despite ongoing challenges. This report provides examples of where we can learn from claims; whilst recognising the excellent care that is provided to the majority of people.

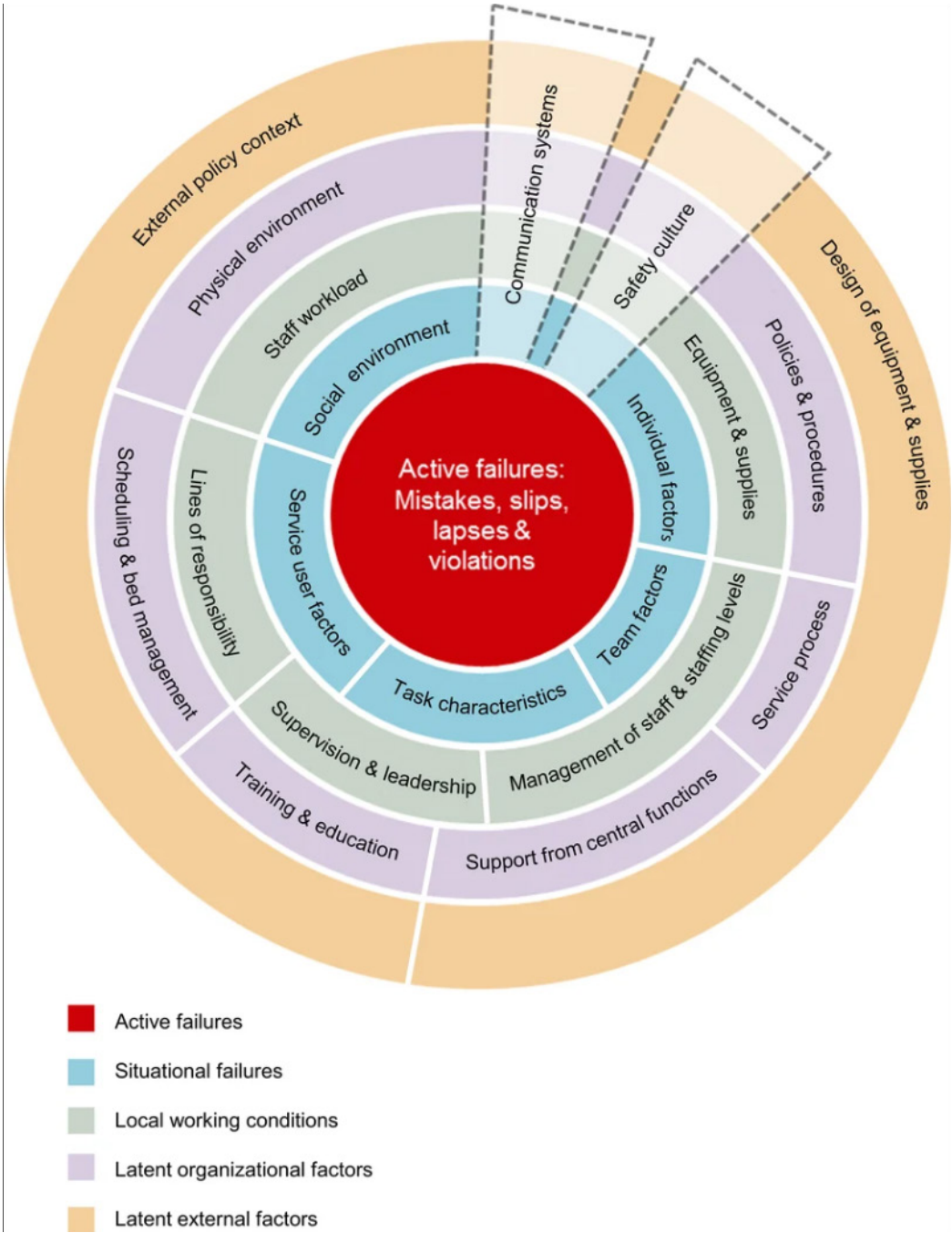
Methodology

To determine the focus for this review, data was extracted from CMS which holds, among others, records of clinical negligence claims brought against trusts that deliver mental health services in England. We examined claims notified under the CNST after 31 December 2017 and before 31 October 2025.

The initial data extraction included all claims (those where the legal threshold for compensation was met and unmet) to identify the emerging themes and trends. The quantitative and qualitative analysis was only performed on closed claims where a breach of duty had been admitted, and where damages had been awarded to the claimant. Open claims were not analysed as the costs associated with open claims are highly likely to change and the outcome remains uncertain.

The Yorkshire Contributory Factors Framework (YCFF) is an evidence based validated tool that was developed following systematic research of 83 research studies that focused on the causes of hospital patient safety incidents⁶ in 2020. This was adapted for use within mental health YCFF-MH. This framework was used to identify the contributory factors to each claim and can be seen in [Figure 1](#).

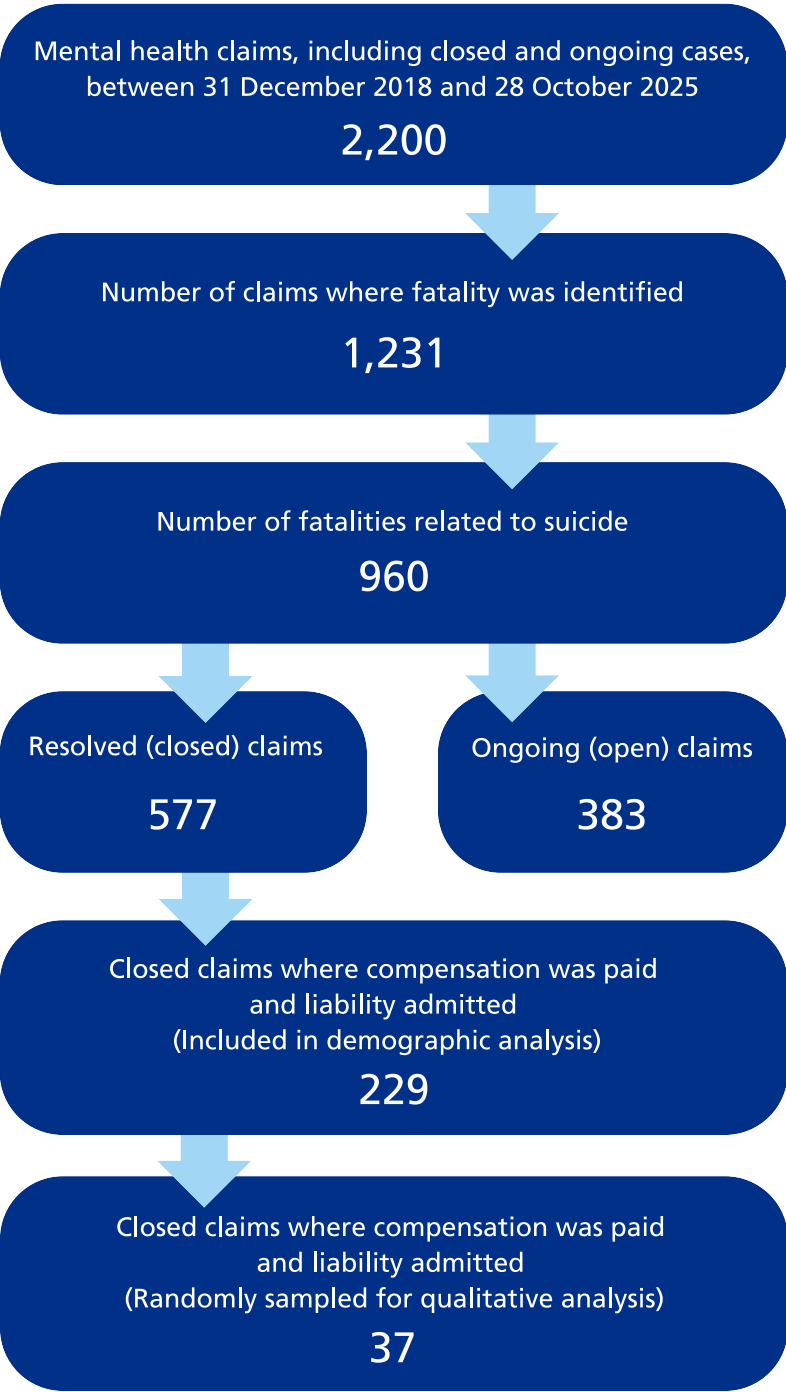
Figure 1: The Yorkshire Contributory Factors Framework – Mental Health



To reach data saturation, it is estimated that between 15 and 60 items (including interviews and cases) will need to be analysed before no new themes will be identified⁵. For this thematic review, data saturation was determined to have been reached following the analysis of 37 closed claims where damages had been paid, when no new themes emerged.

The analysis included reviewing letters of claim, NHS incident and investigation reports and coronial records. Themes arising from the information contained in this data set were quantitatively and qualitatively analysed and used to inform the proposed areas for further consideration.

Figure 2: Sampling framework



Limitations

There are a number of limitations to this report. CMS was primarily designed for managing claims, rather as a tool for identification of learning. Protected characteristic data is not routinely collected, except for sex and age, nor does the system hold a full and complete copy of healthcare records. Claims are coded by claims managers, and many codes relate to legal process rather than individual outcome, which can also restrict analysis.

It is important to highlight that claims data is not representative of all incidents that occur. Whilst claims analysis can provide a perspective on compensation, this lens can provide a narrow, historical view of adverse incidents as individuals pursuing a claim for clinical negligence have at least three years to do this from the point at which they realise an incident has resulted in harm. This results in a time-lag that prevents good practice taking place from being readily being revealed. However, it is an important lens for the identification of remediable errors and system learning. Due to this, the importance of providing a qualitative analysis is recognised alongside quantitative analysis.

Information governance

This was a retrospective anonymised review using routinely collected data held within the NHS Resolution CMS.

Research ethics committee approval was not required because this was a review of routinely collected data. All personal data held and used by NHS Resolution is processed in accordance with the UK implementation of the [General Data Protection Regulation](#). Staff involved in this work (and all those who work for NHS Resolution more generally) are subject to confidentiality obligations. Part of NHS Resolution’s remit is to learn from the information held for claims and to disseminate this learning as widely as possible across the NHS to improve patient safety and reduce harm. This report has used the data held for this purpose and, as far as possible, the review has reduced the use of identifiable material to a minimum during the research process.

Results – demographic analysis

The initial data extraction took place in 2025 and identified 2,200 claims against mental health trusts in England that were notified to NHS Resolution after after 31 December 2017 and before 31 October 2025 under the CNST in [Figure 2](#).

A total of 960 of these claims were related to suicide, of which 577 were closed cases, the rest were open at the time of data extraction. 229 were included in the quantitative analysis of this thematic review as these claims were where liability had been admitted and damages paid.

Financial analysis

The total cost of the 577 closed suicide related claims was £39.2 million. This includes NHS legal costs, claimant legal costs and total damages awarded. Of these claims, 348 (60%) were closed with no admissions of liability made. 229 (40%) were closed with admissions made and resulted in damages being paid. Closed claims where damages have been paid references where there has been a settlement or court order in relation to damages, for either nil or an amount for payment to the claimant.

The total cost of damages paid for these claims was £19.8 million, this is the compensation award that was granted to claimants and does not include legal costs.

Demographic analysis

Sex

Of the 229 claims analysed for this review, 65% were male and 35% female. In comparison, our 2018 analysis found a male to female split of 55% to 45%. In a broader context, between 2018 and 2024 there were 32,552 recorded suicides in England, of these 74% were male and 26% were female.

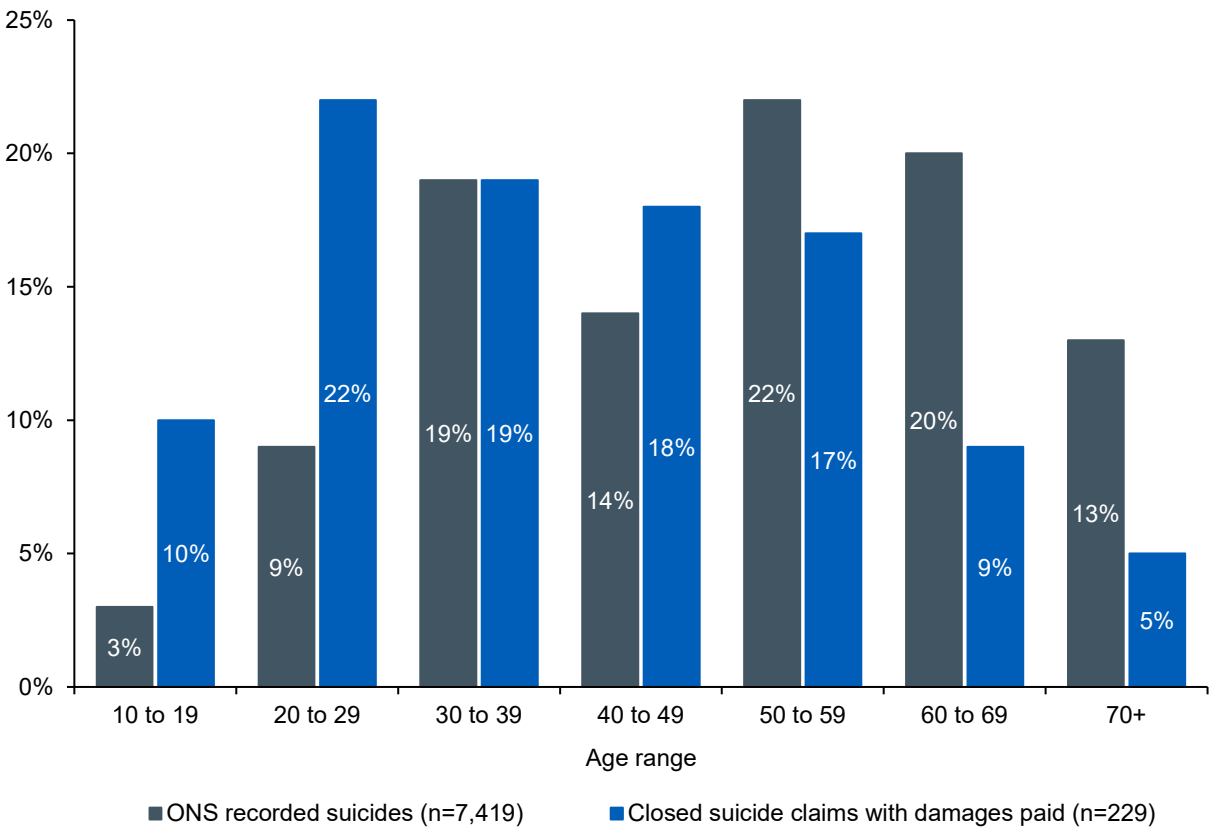
Age

The ages of the 229 claims reviewed were grouped into categories and aligned with figures obtained from the Office for National Statistics (ONS) as set out in [Figure 3](#).

There was a difference in the age ranges for the number of deaths, with the ONS recording the age range of 50 to 59 and 60 to 69 as the highest number of deaths. This is in contrast to the claims data that was analysed where the age range 20 to 29 resulted in the highest number of claims. Further discussion and analysis are required to understand the factors that influence an individual to pursue a claim for negligence and the relationships between

claimants and the person who took their life. This is particularly relevant to understand why claims are less in the highest age ranges for suicide and if this is linked to who is most likely to raise a claim in relation to the age profile. It was noted in the NHS Resolution 2018 review of suicide related claims⁴ that parents of a child (including adult children) were most likely to make a claim, followed by a spouse, then child, and lastly siblings/other family members. However, this may be indicative of the non-representative nature of claims data.

Figure 3: Age range of ONS data compared to closed claims where damages were paid %

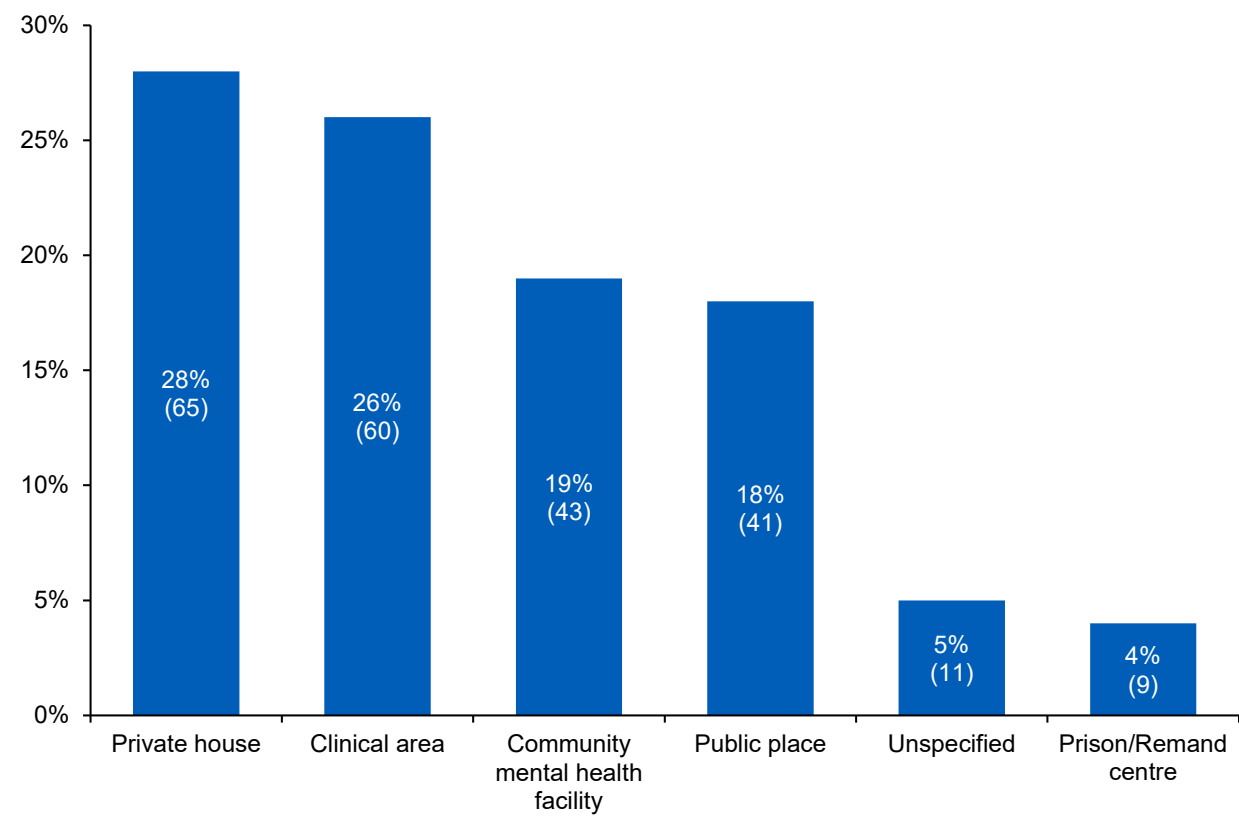


Location of death by suicide

Locations of death were mainly recorded in private residences, clinical areas or public places in [Figure 4](#). This included patients who were on leave from hospital as well as those receiving community care. Examples of clinical environments where death occurred included mental health wards and emergency departments. 4% of suicide related deaths were in prisons.

The site where the incident took place is not necessarily the provider responsible for the care. For example, emergency departments are included in this data, however, the failings in care may be attributed to a mental health team such as liaison psychiatry, meaning that the mental health trust are the accountable body.

Figure 4: Location of death in claims where damages were paid %



Percentages are based on a total of 229 claims where damages were paid.



Thematic analysis

Key findings

These key findings are based on a qualitative analysis of 37 suicide-related claims where damages were paid.

Of the 229 claims reviewed, we analysed in detail a sample of 37 closed claims where damages were paid. Records examined for this analysis included letters of claim, NHS incident and investigation reports, and coronial records, with findings drawn directly from these sources and reflecting stated data rather than perceived or subjective interpretation.

This analysis of the 37 claims found:

Patient, family, and significant others

- **84%** of patients had a previous psychiatric history. The remainder occurred during their first episode of care.
- There was an absence of family engagement in both risk assessment and care planning in **76%**.
- **38%** of patients had a history of poor compliance with treatment or engaging with mental health teams, of which **5%** also had not engaged with their General Practitioner.
- **38%** of patients were recorded as having a history of substance misuse.
- Self-neglect was evident in **24%**.
- **19%** of patients were detained under the Mental Health Act 1983 at the time of the incident. **22%** had recently been detained and were either discharged or under informal admission at the time of their death.

Safety culture

- **86%** indicated issues with the implementation of risk assessment.
- **68%** of patients had a history of self-harm and **59%** had survived a previous suicide attempt. **76%** had previously stated they had thoughts of self-harm or suicide.
- Administrative errors were evident in **35%**.
- **32%** found delays in assessment.
- Ward layout and poor visibility was observed in **27%**, of which, **19%** involved ligature risk.
- Observation was a factor in **6%** where the level of observation had been reduced in the days preceding the patient's death.
- **24%** indicated a failure to follow up. **8%** of patients were discharged from caseloads prior to their death.

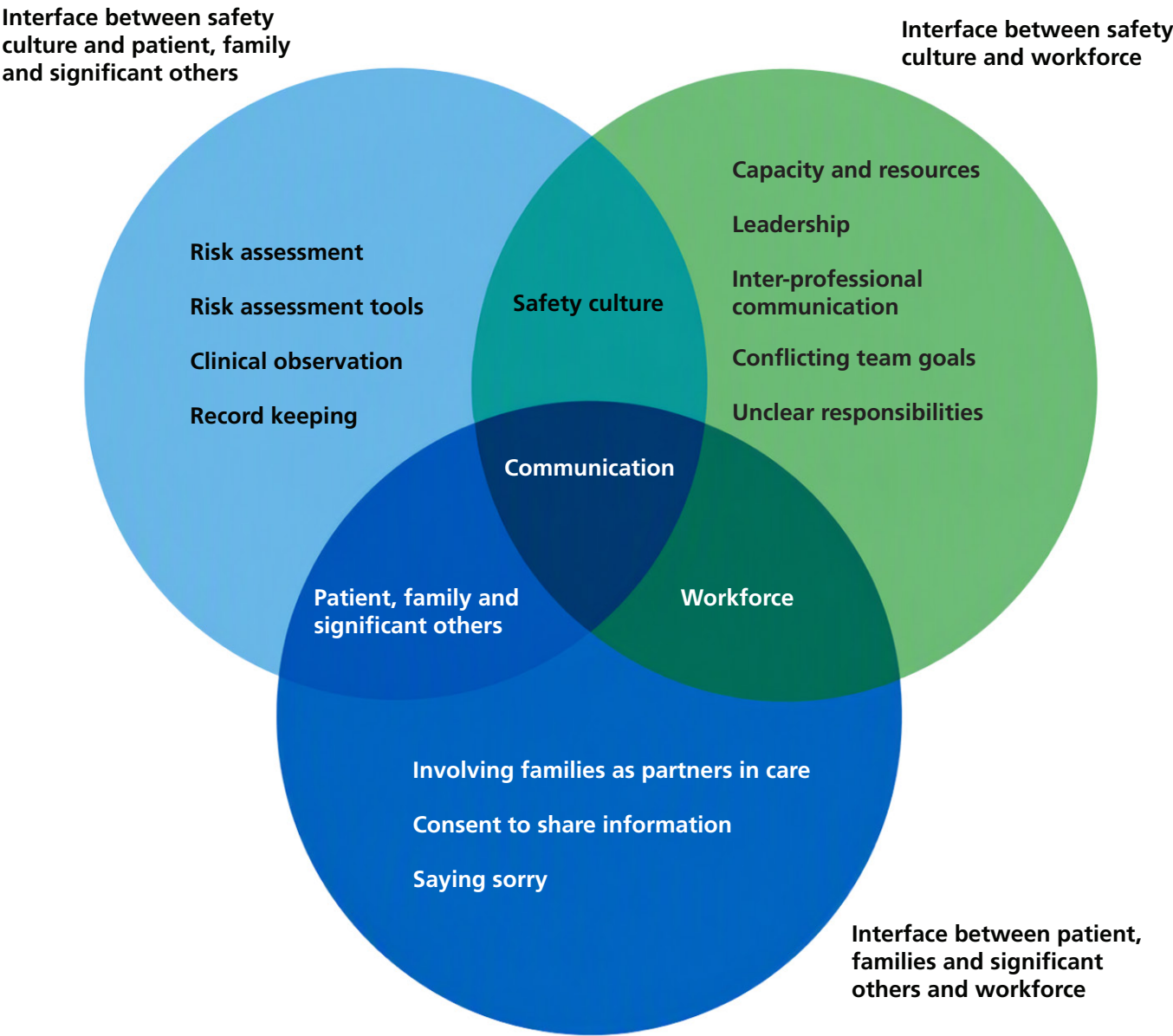
Workforce

- There was a lack of verbal or written records in **51%**.
- Concerns around leadership were evident in **49%**.
- **24%** described a high unit workload or caseload, and **19%** mentioned staffing shortages or skill mix. In **14%** there was difficulty in contacting the right professional involved in care.

Discussing the key themes

The discussion is a thematic analysis of the cohort sample. For each of the 37 claims, we charted the key themes emerging from the narrative data held within the claim’s documentation utilising the YCFF-MH⁶. This allowed us to determine which themes occurred most frequently, which is demonstrated in the conceptual framework below in Figure 5.

Figure 5: Themes identified in the qualitative analysis of 37 closed claims where damages were paid



This conceptual framework demonstrates the complexity and interdependencies within mental health care and provision. It is difficult to categorise and separate decision-making and subsequent actions given the holistic nature of people and interactions. However, this framework identifies some key areas for potential improvement. Communication in all its forms is at the heart of this thematic analysis, with sub-themes around engaging and listening to patients, family and significant others, safety culture, and the workforce.

The following discussion follows these three key sub themes of communication and the relevant topics contained within them, remembering that these are not wholly distinct from one another.

Comparison of findings

This table illustrates the key themes identified in the NHS Resolution 2018 thematic analysis benchmarked against the findings in this report along with its corresponding page reference.

Clinical theme and recommendation	2018 report	2025 analysis	Page reference
Risk assessment – involving families as partners in care	Yes	Yes	24-26
Risk assessment – consent to share information	Yes	Yes	24-26
Risk assessment tools	Yes	Yes	28-29
Clinical observation	Yes	Yes	30-31
Record keeping	Yes	Yes	30-31
Patient factors – previous psychiatric history and substance misuse	Yes	Yes	26-27
Lack of family and staff support through investigation and inquest process and saying sorry	Yes	Yes	26
Prison healthcare	Yes	Yes	18
Poor quality of root cause analysis	Yes	x	NA
Poor quality of recommendations to reduce incidence of future harm	Yes	x	NA
Inconsistency in issuing Prevention of Future Death reports from coroners to trusts and poor mechanisms of reporting changes in response to the report	Yes	x	NA
Workforce capacity and resources	Yes	Yes	32-34
Leadership	No	Yes	32-33
Interprofessional communication	Yes	Yes	32-33
Conflicting team goals	No	Yes	32-33
Unclear team responsibilities	No	Yes	32-33

Patient, family, and significant others

Engagement and consent

Absence of family engagement, or the family voice not being heard in both risk assessment and care planning, was the prominent theme emerging from the analysis and seen in **76%** of the 37 claims reviewed. Important information families had concerning risk and behaviour was perceived to be largely ignored and not incorporated into care planning and risk assessments.

Evidence was found of families passing on information to clinicians of the patient's intent to self-harm, or that the patient was concealing suicidal ideation to avoid detention under the Mental Health Act. This information was not taken into account or reflected in the associated risk documentation. This included cases where there were increased phone calls from families chasing up appointments due to deterioration in the patient's mental wellbeing, with families feeling they were on 'suicide watch'. Often increased frequency of family calls was not fully recognised due to there being no single point of coordination and no clear record of calls and their content.

Consent was poorly understood by clinicians, and where consent to share 'care' related information was not given by the patient, engagement with family often ceased. Family who recognised the patients' indicators and triggers for deterioration of their mental health were not included in collaborative assessments, even where no issues for consent to share had been identified.

Where families had asked clinicians for advice there were missed opportunities to discuss what support could be offered if they had concerns, or if the family could not contact the patient. This included discussions about keeping someone safe, for example the removal of potential means of suicide where families had expressed worries about the same.

The analysis found that families of younger people (10 to 19 years of age) who lost their life to suicide, were not supported with contingency planning where younger people did not consent to their information being shared with their parents. This included being notified of increasing risks, information about medication and dosages along with treatment compliance. There was poor evidence of contact with parents throughout their child's hospital admission if they were an inpatient.

In the 37 claims analysed, The NICE guideline, Self-harm: assessment, managements and preventing recurrence [NG225], was not always followed.

This states:

"Clinicians should understand how issues of capacity and competence to consent apply to children and young people of different ages, be aware of the benefits of involving the person's family and carers and sharing information, and should recognise the need to seek consent from the person as early as possible, and should recognise that if it is necessary to breach confidentiality, they should ensure that the person who has self-harmed is still involved in decisions about their care and, where possible, is informed about the breach of confidentiality." [NG225]

DHSC have also recognised the need to understand consent better, stating that they have "heard from a number of families bereaved by suicide about their experiences with services, and issues of confidentiality have been a recurring theme. They have repeatedly raised concerns that practitioners can seem reluctant to take information from families and friends or give them information about a person's suicide risk."

This prompted a 'consensus statement' being issued by the DHSC to reflect the legal positions for sharing information and suicide prevention¹⁷.

"It is important to note that even if consent to share information is not granted, family, carers and significant others can still provide information. This information should be received and considered by clinical teams in risk assessment and care planning." [NG225]

Communication as a contributory factor was not limited to issues of consent. Claims arose where families were not engaged in decisions about discharging or admitting patients to hospital. There were instances of patients who were assessed as high risk being granted leave from hospital without taking into consideration the nearest relatives concerns, or the family's ability to manage risk at home. Details in trust's written records did not always reflect the concerns or anxieties of nearest relatives about the patient's safety if they were left alone.

Involving families in incident investigation

Prior to an investigation taking place saying sorry is always the right thing to do. The statutory and professional Duty of candour have been in place for several years^{18,19,20}.

NHS Resolution's guidance on [duty of candour](#) explains that apologising is not an admission of liability and supports an open, honest and transparent approach to learning and patient safety.

The importance of involving family members as a source of information for learning from significant harm was recognised in [our 2018 report](#) which identified that families were not involved in serious incident investigations into the care of their loved ones. Furthermore, the 2018 analysis found that many families were not involved in setting the terms of reference or would be informed of the outcome of the investigation.

Since then, the [NHS England Patient Safety Strategy](#) was launched in 2019, and the [Patient Safety Investigation Response Framework](#) replaced the Serious Incident Framework in 2022. Both of these changes indicate a shift in the way the NHS responds to patient safety incidents with an emphasis on learning and improvement across systems. There is a greater opportunity for trusts to invest and learn from incidents with key deliverables around safety culture, safety systems, improvement and involvement of people who work in services and those who receive care.

There was some evidence of change of approach to investigations and aligning the patient safety investigative processes with the needs and expectations of those affected.

Patient factors

In terms of patient medical history, **84%** of this cohort had a previous psychiatric history with the remaining patients experiencing their first episode of care. **38%** had a history of poor compliance of treatment or engaging with mental health teams, and **5%** had not engaged with their General Practitioner. In **24%** of the claims reviewed, self-neglect was evident. This was not always observed by clinical teams, particularly if they were unaware of the patient's home circumstance and living arrangements.

It is estimated that up to 10% of people who self-harm will go on to lose their life to suicide within ten years²², and [the risk of suicide is elevated by between 30 and 100-fold](#) in the year following an episode of self-harm, compared to the general population. In the claims analysed for this review, **68%** of patients had a history of self-harm with **59%** having also survived a suicide attempt. **76%** of patients had stated they had thoughts of self-harm or suicide.

In cases of repeated self-harm, the nature and degree of risk was often known to the clinical team but not fully acknowledged or reflected in risk management plans. It is important to note that not all self-harm is indicative of suicidal intent, and that this may be a mechanism for preserving life and to relieve any suicidal thoughts or further actions²³. However, given that there is greater risk of suicide in those who self-harm a full psychological formulation of individual risks and protective factors should be present.

Since our first report was published in 2018, the outcome of a [national inquiry into suicide by people in contact with substance misuse services in the UK](#) was published in 2019. This cites that over half of the people who die by suicide and who are in recent contact with mental health services have a history of alcohol or drug misuse. Of the 37 sampled cases in this analysis, **38%** included individuals who were recorded as having a history of substance misuse. Within the data, it was not possible to determine how substance misuse was managed, although a lack of engagement with substance misuse services was evident.

This analysis indicates that 19% of patients were detained under the Mental Health Act 1983¹⁵ at the time of incident, and 22% had recently been detained and were either discharged or under informal admission at the time of their death. The National Confidential Inquiry into Suicide and Safety in Mental Health 2024 stated that 30% of inpatient suicides were detained under the Mental Health Act²⁴ and that 75% of those were assessed as either low or no risk of suicide. In 30% of the claims analysed for this review it was found that there was an opinion of there being grounds to detain the patient under the Mental Health Act, but this had not been carried out.

Safety culture

Risk assessment

It is recognised that risk and patient presentation can change quickly and that mental health clinicians do not always hold the right information to assess the patient sufficiently. Because of these factors, risks assessments are often dynamic²⁶. In the claims analysed the standard fell short with **57%** of claims citing a failure to react to a deterioration in mental health and **65%** failing to treat or manage the person's mental health adequately.

32% of claims reflected delays in assessment. These delays could be significant and occurred in a variety of settings including inpatient, psychiatric liaison, crisis teams and community mental health teams. Delays were attributable to a range of factors such as poorly defined roles and responsibilities, lack of local guidance or adherence to referral processes, and demands for the services outweighing capacity.

When assessing risk there was often a lack of professional curiosity and the depth of questioning stopped at the point of asking the patient if they were thinking of suicide. Suicidal ideation was documented but not explored in terms of intent or means, although NHS England's Staying Safe from Suicide best practice guidance published in April 2025 outlines that this line of questioning should only be used within the broader context of safety conversations and assessment.

There was also lack of exploration by clinical staff as to significant risk factors including feelings of hopelessness, unresolved stressors and social circumstance, lack of future plans or goals, and previous diagnoses.

Some of the presenting challenges to adequate suicide risk assessment involved focusing on immediate observable actions rather than the underlying thought process. For example, risk plans were based around managing violence and aggression, or preoccupation and distress. Clinicians in these claims did not perceive the observable immediate presentation to be a reflection of the patient's underlying diagnosis, and this appeared to be a barrier to completing a full assessment of needs and risk.

86% of analysed claims indicated issues with the implementation of risk assessment.

This largely concerned the use and completion of risk assessment tools. There was no single risk assessment tool identified, with trusts using a variety of tools. NHS England's Staying Safe from Suicide report reflected that forms and checklists in utilisation can be unvalidated with no predictive value.

Risk assessment tools were either not completed, partially completed, or not updated when new information presented itself. This was also identified in our previous 2018⁴ report which cited the growing clinical consensus that risk assessments are generally poor at predicting which patients will go on to die by suicide.

Since our first report was published in 2018, NICE have updated their guidance for Self-harm: assessment, management and preventing recurrence [NG225]. This guideline now makes clear that risk assessment tools and scales that predict future suicide or repetition of self-harm should not be used, rather a risk formulation should be undertaken as part of every psychosocial assessment.

This is further emphasised in NHS England's Staying Safe from Suicide best practice guidance, which states that

"The use of static risk stratification, often based on simplistic questions, is still widespread, but it is unacceptable."

Advocating instead formulation, therapeutic engagement and collaborative exploration of risk and safety plans along with a biopsychosocial approach.

The National Confidential Inquiry into Suicide and Safety in Mental Health 2024 also reaffirms that

'risk assessment tools should not be seen as a way of predicting suicidal behaviour'.

The Health Services Safety Investigation Body (HSSIB) discussed the continued use of risk assessment tools and scales as a predictor of suicide in their 2025 mental health inpatient settings investigative report, concluding that over reliance on protocols could reflect a defensive approach that prioritises compliance over critically thinking and reflecting on patient-specific needs and risks.

Our analysis also found evidence of diagnostic anchoring which has been identified in research to be the most common cognitive error in clinical settings. This occurred where risk assessments were not viewed independently, and previous information influenced the clinical decision making and care plans despite new information being available. This could be explained by electronic patient records pulling through previous risk assessments into new records.

It was evident through the analysis that some clinical teams did use risk formulation in addition to a risk assessment tool. However, in those instances the formulation was considered inadequate for reasons such as lack of family inclusion, not in collaboration with the patient, or not having the appropriate professional involved.

Environmental risks

There were risk factors in the physical environment such as layout of wards and poor visibility in **27%** of claims. The largest factor (**19%**) was clinical environments having an environmental risk for ligature present. This included doors where there were no door alarms fitted, or where there were no collapsible rails. There were also instances where door alarms did not activate upon weight being detected.

Observations within mental health care

Observations within mental health care are a therapeutic clinical intervention that aim to reduce factors that contribute to risk to self and/or others. NICE define observation as being ‘A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user’s safety and the safety of others’³⁰ [NG10]. The guidance also outlines the frequency of observations.

Of the 37 claims that were qualitatively analysed, 5% were under 15-minute intermittent observations, 3% under one to one observation and 16% were recorded as general observations (hourly). Not all of the claims contained information around the use of observations if that was not relevant to the claim, so it is likely that more patients would be observed with the general hourly standard. 6% of claims had their observation level reduced in the days preceding their death.

This is in contrast to the findings of the National Confidential Inquiry into suicide and safety where it was recorded that 28% of inpatients who died by suicide were on either medium or high observation levels. However, the sample of claims analysed is likely not representative of all who die from suicide¹³.

In the claims where observation was a factor, it was evident that observations were not always aligned to risk e.g. assessed as significant risk of suicide but on general hourly observations. There was also instance of the observation level being reduced from one to one continuous observation to general within the space of 24 hours, despite there being no documented evidence of stability or improvement of the patient’s mental state. Documentation of rationale for the level of observation was often inadequate or absent. Whilst it is recognised that there is a balance between the least restrictive practice and maintaining someone’s safety, the qualitative analysis reflected that in combination with the patient’s other presenting factors, the use of observations could provide an opportunity for therapeutic engagement and further monitoring/assessment of mental state.



Record keeping

Record keeping was cited in 86% of the claims that mentioned risk assessment implementation issues. This was a mixture of absent records, partially completed records, or records that had not been reviewed or updated.

Record keeping electronic systems were mentioned in several of these claims – some records were hard to find or not immediately accessible on the system the trust used. There were also issues of the system ‘pulling’ data through to new assessments and therefore a reliance on ‘copy and paste’ of assessment and intervention plans which were out of date or did not contain reference to recent risk behaviour.

There was often a lack of documentary evidence to support decision making, particularly in relation to managing risks that had previously been identified, for example when decisions were made about leave or discharge. 8% of the sample analysed were discharged from the consultant’s caseload just prior to their death.

The NHS Resolution 2018 report discussed the recommendations that were made in serious incident reports to improve standards and depth of record keeping, the most frequent recommendation being to ‘follow documentation policy’, closely followed by ‘document clinical discussions’.

The range of trust recommendations also included ‘document discussions with carers’, ‘document multi-disciplinary team discussions’, and ‘improve care planning documentation’.

From these recommendations, service pressures and the constraints of clinical practice were not always taken into consideration, especially when taking into account the nature of mental health practice and the depth and length of many discussions that take place. Similar recommendations were evident in this analysis of claims, and these did not address the systemic and organisational issues presented to trusts and what could be implemented to support the achievement of the ideal handover and record keeping.

Pressures of service contributed in part to poor record keeping, particularly with maintaining contemporaneous documentation. There was not always enough time between community appointments for care coordinators to write up the detailed outcomes, and this was usually completed at the end of a shift.

Administrative errors were evident in 35% of claims, this largely centred around referrals between services and professionals and appointment errors. 24% of claims indicated a failure to follow up. This included discharge from inpatients and the patient not being seen within the seven day follow up timeframe, failure to refer to a care coordinator for follow up, and failure to follow up from Did Not Attend (DNA) appointments.

Workforce

Interprofessional communication

- Poor communication between staff was cited in **68%** of the claims reviewed.
- A lack of communication (verbal or written notes) was a factor in **51%**.

This was particularly evident around the implementation of the [Care Programme Approach \(CPA\)](#). Allocation of care coordinators was often delayed, and as such there was inconsistent follow up upon discharge without a central person holding the ring. This resulted in lack of overview of information and pulling this together to reveal deteriorating behaviour or recognising frequency of suicidal thoughts or behaviour.

It is worth noting that between 2021 to 2024 early adopters have been in place to support [The Community Mental Health Framework for Adults and Older Adults](#), published in September 2019. This framework proposed replacing the CPA for community mental health services, while retaining its sound theoretical principles based on good care coordination and high-quality care planning. The claims analysed for this review had specific mention of CPA and may have not been an early adopter or yet to change their process in this respect.

There was a perception from families that services were difficult to understand and complicated, and they were unsure who was responsible for care, particularly when more than one service was involved, or the patient was in transition between services, for example from crisis teams to community mental health teams.

Handover issues were a contributory factor in **35%** of claims analysed. Expectations from organisations as to handover requirements between teams were not always clear, along with how this should be communicated to patients and their families. Crisis plans were missing in **3%** of claims.

Where crisis plans existed, they were often inadequate, with some amounting to a list of telephone numbers which were unreachable out of hours. It was difficult to contact the correct professional in **14%** of claims.

Leadership, conflicting team goals and unclear responsibilities

Concerns around leadership were evident in most of the claims analysed, with **49%** of claims citing unclear responsibilities and **11%** including inappropriate delegation. Team factors were many and varied including conflicting team goals, poor delegation, absence of feedback and lack of respect for colleagues. This may be in part due to recruitment and retention challenges. There were instances of gaps and vacancies in team leadership such as ward managers. Low staff morale was reflected in inquest and incident investigation documentation, in part attributed to the nature of the staffing resource and absence of leadership where there were vacancies.

There were instances in claims where standardised agreed approaches to shift coordination were ill defined. This resulted in variation in how the shift coordinator managed and received referrals, and how they allocated the assessments.

Management of risk was a particular challenge in acute healthcare settings where there were conflicting team goals and expertise in managing physical health vs mental health. Plans provided by liaison psychiatry teams were often limited in nature and made unactable by the physical environment and resource available in acute care such as ligature risk or ability to carry out observations. Care plans concentrated on managing the immediate risk such as removing objects that could be used for self-harm, but not on how to manage presenting behaviour, nor when it would be appropriate to escalate concerns.

The analysis gave concern about the assuming of shared skills and language across clinical settings, particularly with the use of some mental health expressions that acute teams would not usually be familiar with.

The level of understanding of risk between teams was not always shared, with acute care teams not appreciating the sense of concern from an assessing mental health professional. This was evident where there was a lack of written record or robust risk management plan provided to the acute care teams. In the [2018 NHS Resolution report](#), challenges in joint working were highlighted in 14 serious incident reports. This included unclear boundaries of responsibility between teams, lack of or inadequate joint working policy and lack of awareness of other services and how they operate.

Organisational policies were not followed in some of the claims analysed. This included where policy was not explicit as which role should complete certain assessments, and there was team disagreement as to who should be responsible such as a care coordinator or team psychologist, this resulted in delays in assessments being completed. However, there was particular focus on following the DNA appointment policy with **8%** of claims showing gaps in this process. **8%** also did not follow trust visitor policies, primarily in the remit of bringing in items that could be utilised for self-harm that visitors may not have considered including lighters, belts and clothing items, or where visitors were restricted to certain visiting times when it would have been of therapeutic value to visit at other times.

Staff training was considered inadequate in 16% of claims analysed. This included training in policies and procedures and risk assessing.

Capacity and resources

Working conditions in relation to workforce data, caseloads and acuity of service were not always referenced in the serious incident reports or claims data. However, where this data was captured, **24%** described a high unit workload or caseload, and **19%** mentioned staffing shortages or skill mix such as being unable to provide the scheduled number of registered nurses per shift. High staff turnover was referenced in **8%** of claims analysed, along with **14%** having agency staff in place who were unfamiliar with the service.

Capacity issues were identified in waiting times for services and delay in referral response. Significant delays of several months were noted for psychological therapy services, and triage delays within mental health liaison teams and community mental health services were noted with **19%** of patients experiencing a delay in the provision of care. **5%** of patients experienced a lack of support out hours.

14% of claims cited staff inexperience, including newly qualified clinicians or junior staff. Inexperience was problematic when it came to understanding when to escalate to senior medical staff, or where the level of skill to assess risk was poorly understood. Where these were indicated in the trust investigation reports, although there was some acknowledgement that these could be a contributory factor to gaps, or substandard care, there was little indication as to what support was offered to staff or how they were supported through the investigation process.

Individual workforce factors such as fatigue, stress, and feeling distracted or rushed were not always illustrated in the claims.

Supporting staff

It is important to recognise the impact of suicide on the staff delivering the care and how this is subsequently investigated. The [NHS England Patient Safety Strategy](#) and its approach to learning from incidents recognises that compassionate leadership and a 'just culture' is vital to promote an open and honest learning environment. This is also reflected in our [Being fair report](#) and [Being fair report 2](#) which set out the argument for organisations to adopt a more reflective approach to learning from incidents, supporting staff and promoting a person-centred workplace that is compassionate, safe and fair.

[Being fair](#) states that board members must have clear accountability and regularly review reporting on staff health, wellbeing and experience, and that there is mounting evidence that high workloads, long hours, understaffing and general lack of support, can cause burnout in the health care workforce, and put patient safety at risk.

This is reflected by [HSSIB \(2025\)](#) who reported that shortcomings in workforce planning across inpatient and community mental health care compromised safe, therapeutic care. Their investigation also highlighted morale issues and staff burnout, linked to workforce gaps and the inherent [emotional demands of mental health work](#).

Given the workforce issues highlighted in these claims it is prudent that organisations use the wealth of frameworks that exist to support meeting the health and wellbeing of staff along with compassionate leadership.



Conclusion

Best practice future considerations for organisations

The themes identified in this review highlight areas where continued focus, assurance and system collaboration may support further learning and improvement. These considerations reflect best practice and are offered to complement existing national guidance and strategies.

Strengthening the use of claims data within local governance

Organisations can consider how their claims data relating to suicide is routinely triangulated with other safety intelligence such as incidents, complaints, Prevention of Future Death reports and staff feedback concerning safety.

Ongoing assurance concerning family involvement and information sharing

Family, carers and significant others should be meaningfully involved in risk assessment, care planning and safety decision making. Organisations can consider whether local policies and staff training consistently reflect their involvement and how this is embedded in practice. Continued partnership with people with lived experience may support more inclusive understanding of risk and safety.

Continued shift from risk tools to formulation-based approaches

Organisations can reflect on how supervision, multidisciplinary working, and documentation practices support high-quality formulation in complex and pressured environments. Along with the continued transition from static risk assessment tools to formulation led, relational and therapeutic approaches that include patients and their significant others.

Inter-professional communication across care transitions

Further consideration of how shared language, documentation and expectations are supported and understood across teams could be explored. Particularly how organisations assure themselves of clarity of responsibility, escalation and handover when patients move between teams, settings or services (including acute, liaison, crisis and community).

These future considerations for organisations reflect best practice and reinforce the importance of sustained system learning, compassionate leadership and collaboration across organisations, in alignment with existing national recommendations, and informed by the experiences of patients, families and significant others to reduce suicide risk and improve safety within mental health care.

This review recognises the significant human cost attached to the loss of life and those impacted by suicide. We have highlighted a number of key themes and contributory factors to lapses in care provided by mental health organisations in England. These are derived from clinical negligence compensation claims where breaches of duty occurred, liability has been admitted, and damages have been awarded to the claimant.

These findings complement current research and national suicide prevention strategies and support established recommendations from relevant governing bodies. As such we recommend that organisations review these themes alongside the existing guidance to identify gaps and implement targeted interventions, and to reflect on the report's best practice future considerations as part of this process.

Building a positive safety culture and a transparent, supported, and open workforce is essential to sustaining improvements.

Above all, improving communication within teams, collaboration with those receiving care, and strengthening engagement with families and significant others remains central to delivering safe, therapeutic mental health care and reducing suicide risk.

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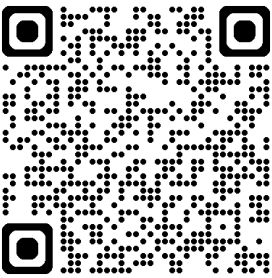
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An [online glossary](#) is available to support this document from the [NHS Resolution website](#)



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