Luton
mental health and wellbeing service
provided by ELFT

NHS

Thematic Review of Unexpected Deaths across the Luton Mental Health Services April 2017 to March 2018.

1.0 INTRODUCTION

1.1 The 2017/18 thematic review of unexpected deaths provides findings relating to people who died by suicide or sudden unexplained death and were under the care of mental health services provided by the Luton Directorate of East London NHS Foundation Trust between

1.2 The review is limited to those unexpected deaths where the Serious Incident Reviews (SIRs) were completed between April 2017 and March 2018. This includes two cases of unexpected death reported prior to 1st April 2017.

1.3 The purpose of this review is to establish emerging themes, trends and note key recommendations and where applicable to match against the 2017 annual report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). It is of note the statistics quoted in the NCISH report cover a period from 2005-2015, hence no direct comparison can be made but themes can be drawn from the national data to analyse local data.

1.4 This report will also draw comparisons with the review carried out for 2016/17.

2.0 SUMMARY

2.1 Table 1 below shows the main social and clinical features of patients who died unexpectedly in 2017/18. These patients have higher rates of social isolation, e.g. living alone or unmarried. More than half have a co-morbid condition, and rates of previous drug and alcohol misuse are high.

	Percentage
Demographic Features	
Age range: 45-54	35%
Male	57%
Unmarried	43%
White British	72%
Clinical and Behavioural Features	
Primary diagnosis: Affective disorder	15%
History of drug or alcohol use	57%

Table 1 - Characteristics of Majority of Patients who died unexpectedly in 2017/18

3.0 RATES OF UNEXPECTED DEATH

3.1 There were seven completed SIRs into unexpected deaths in 2017/18, which is a 56.25% reduction from 16 completed SIRs into unexpected deaths in 2016/17.

3.2 It is of note that the NCISH report also recorded a fall in recent years of suicides nationally, particularly in England. The report recorded that the number of patient suicides has fallen by 36.08% since 2012, and has been falling consistently ever since.

3.3 While the numbers of unexpected deaths recorded in the Luton Mental Health Service is too small to draw statistical significance from by comparison to national figures, it is interesting to note that the trend in falling numbers is mirrored locally.

Month and Year	Number of Completed Serious Incident Reviews (SIRs)
Apr-17	2
May-17	0
Jun-17	0
Jul-17	0
Aug-17	0
Sep-17	3
Oct-17	1
Nov-17	1
Dec-17	0
Jan-18	0
Feb-18	0
Mar-18	0
Total for 2017/18	7

Table 2 – Number of Unexpected Death SIRs Completed by Month

4.0 UNEXPECTED DEATHS BY GENDER AND AGE

4.1 Of the seven incidents, four were male and three were female, hence a ratio of 1.3:1 by gender. This ratio is a lower ratio than the National ratio of 3:1 male to female suicides reported in the general population. For patients who are in contact with mental health services in England only, the reported male to female ratio in 2015 was 1.82 : 1 (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017).

In the previous year, the ratio of male to female was 2.5:1, indicating an overall reduction of unexpected deaths of male patients in 2017/18.

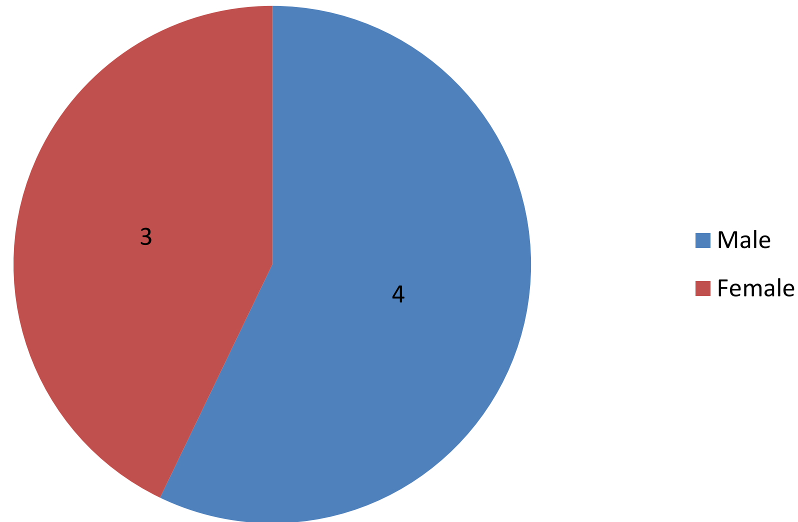


Figure 1 - Unexpected Deaths by Gender

4.2 Figure 2 below, shows the male unexpected deaths were highest among those aged over 65. However in one case, the patient died of a chronic subdural haematoma and hence not a suicide, though the death was unexpected. The data below therefore is not showing any particular risk groups in terms of suicides which took place in 2017/18. The national picture shows the highest rates of unexpected death or suicide among the 55-64 age group (see Figure 3 below). There were no unexpected deaths recorded of neither males nor females in this age group in Luton Mental Health Services in 2017/18.

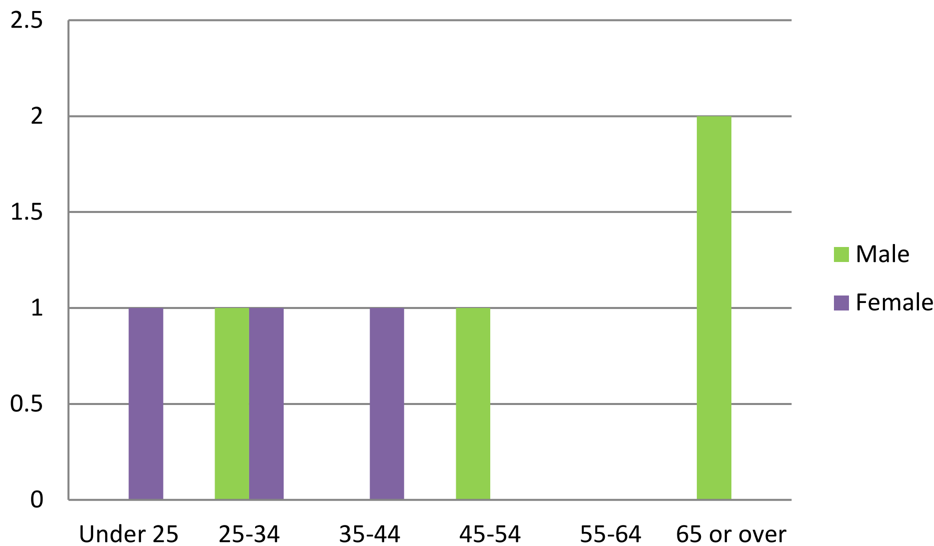


Figure 2 - Unexpected Deaths by Age and Gender

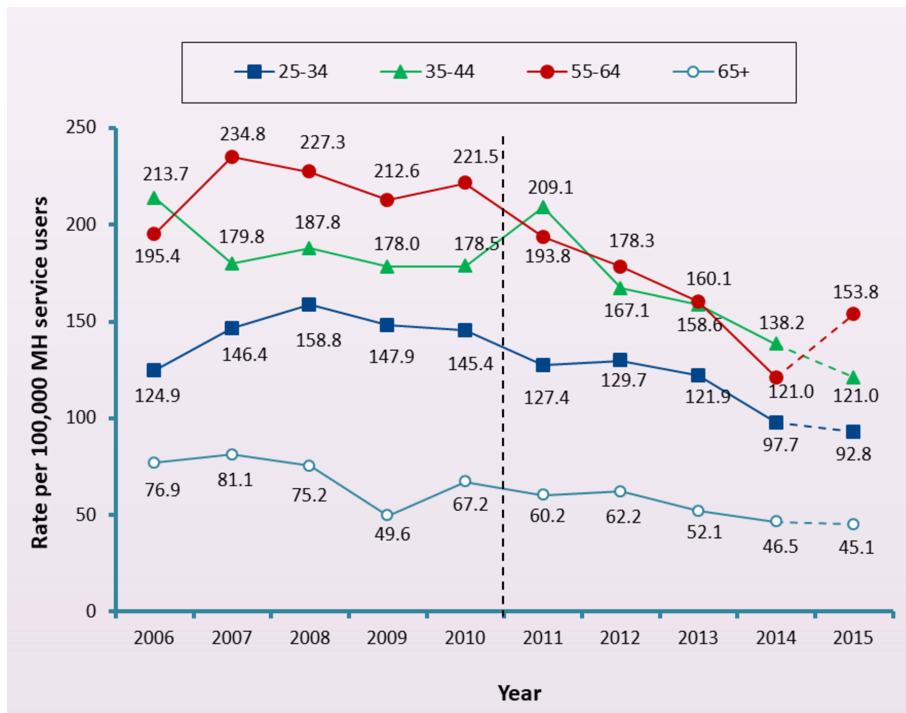


Figure 3 - Patient suicide rates in males by age, England (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017)

4.3 Nationally, the rate of unexpected deaths in patients under 25 decreased until 2007 – since then figures have been higher, though with no consistent pattern (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017); however, the number of unexpected deaths in this age range within Luton Mental Health Services, should a decrease from 2016/17 (n=3) to 2017/18 (n=1).

5.0 CAUSES OF DEATH

5.1 Fatal toxicity or overdose of some kind featured in four cases. In one case, the patient had ingested excessive amounts of pentobarbital. There were two cases of drug overdose and one of heroine/morphine toxicity. These four cases equate to 57.14% of the total number of unexpected deaths in Luton Mental Services in 2017/18, which is an increase from 50% in 2016/17.

5.2 One patient died from a large chronic subdural haematoma at the Luton and Dunstable Hospital.

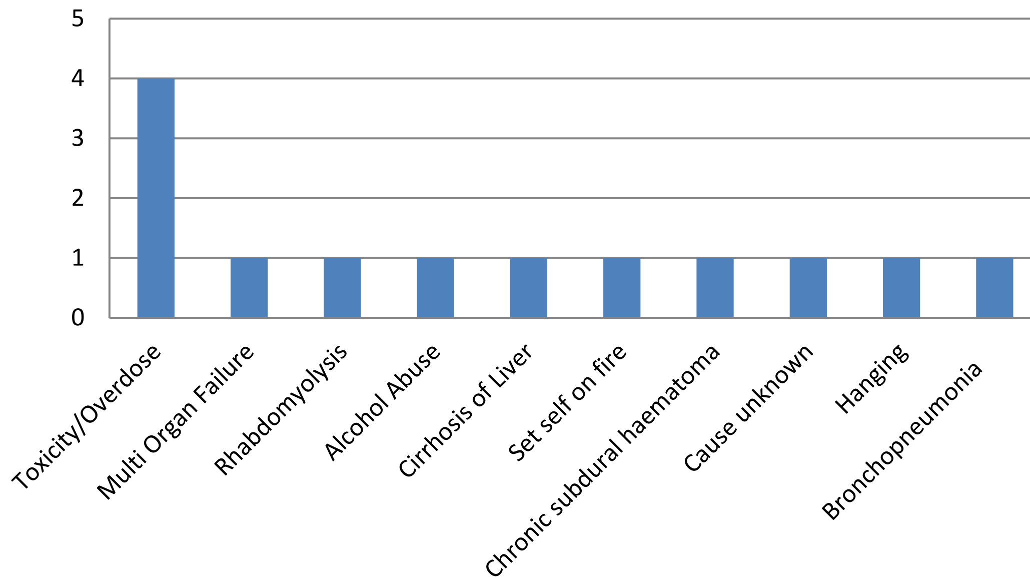


Figure 4 - Causes of Unexpected Death

5.3 According to the NCISH 2017 Report, the most common method of suicide by patients in the UK is hanging; which equated to almost half of all suicide deaths. The next most common method is self-poisoning: opiates (and opiate-containing compounds) remain the main type of drug taken in fatal overdose in the UK, including both prescribed and illicit drugs (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017).

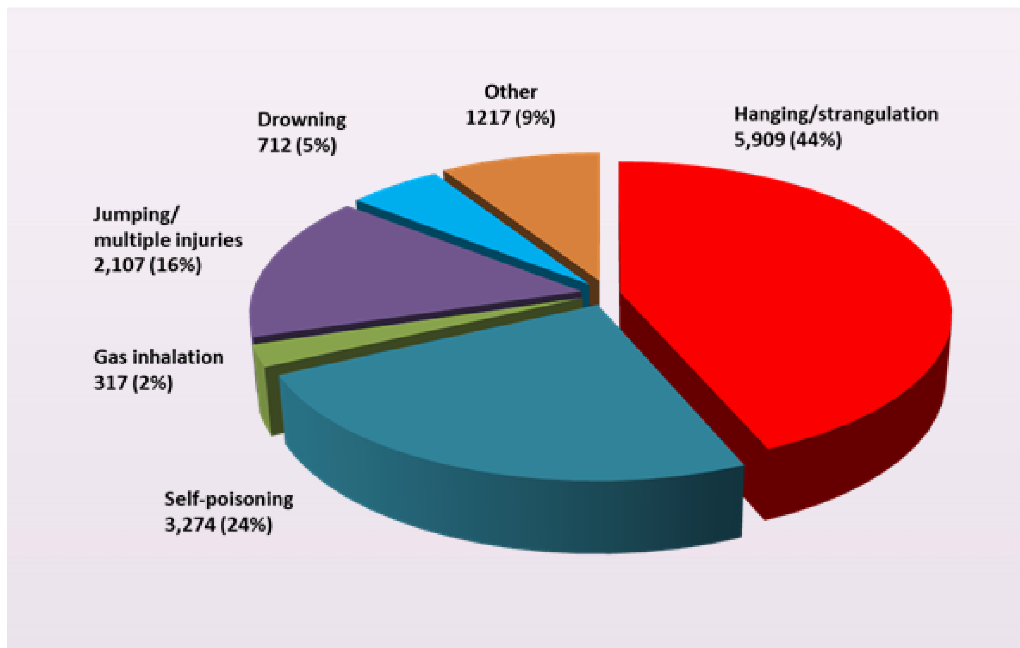


Figure 5 - Patient suicide: main causes of death, England (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017)

5.4 The above is not consistent with the figures in Figure 4 above, which is showing self-poisoning/toxicity as the primary cause of death, with the numbers of unexpected deaths by hanging have reduced from the previous year (three in 2016/17 and one in 2017/18).

6.0 SOCIAL AND CLINICAL CHARACTERISTICS

6.1 It is important to refer to the ethnic makeup of patients who died unexpectedly to ensure that where certain groups are perhaps being over-represented in terms of unexpected deaths, this information can be factored into service design and redesign. This cannot be done in isolation, but in synergy with other clinical and social factors.

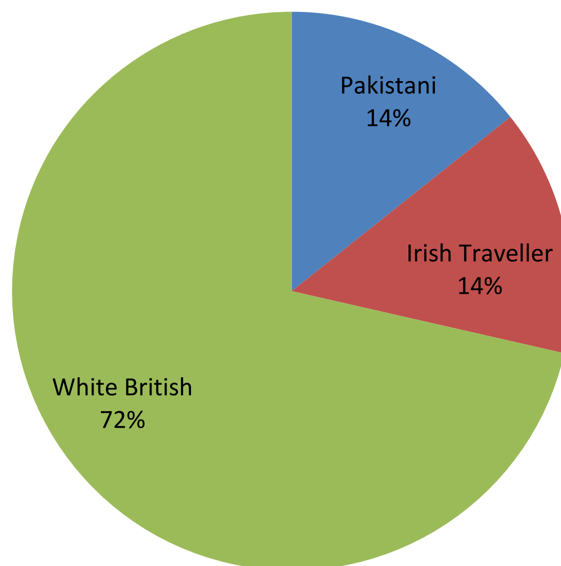


Figure 6 - Unexpected Deaths by Ethnicity

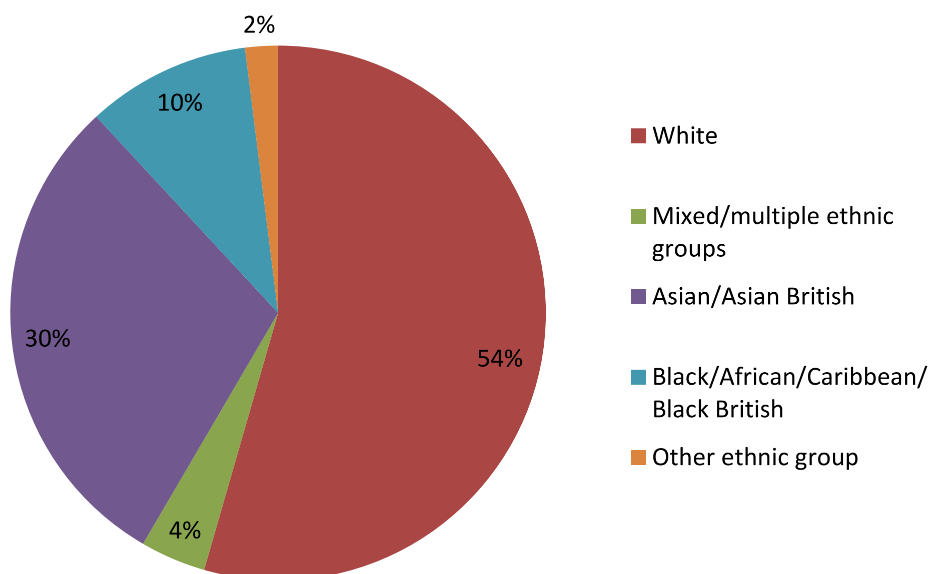


Figure 7 - Luton Ethnicity Breakdown*

Source: Office of National Statistics: National Census 2011

6.2 Considering our frequencies in the context of the Luton ethnicity breakdown (Figure 7), the presenting demographic appears to show an over-representation of White British, while Mixed/multiple ethnic and Black/African/Caribbean/Black British are not represented at all.

7.0 DIAGNOSIS

7.1 The most common primary diagnoses were depressive illness, emotionally unstable personality disorder (EUPD) and mental and behavioural disorders due to drug use (Figure 8). Affective disorders (such as depressive illness, PTSD, bipolar disorder and general anxiety) made up 50% of the primary diagnoses of patients who died unexpectedly in 2016/17. This fell substantially in 2017/18

7.2 The finding above is in keeping with the national picture as suicides in patients with affective disorders has fallen since 2012 (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017). However, affective disorders remain the most common diagnosis of those patients who die unexpectedly.

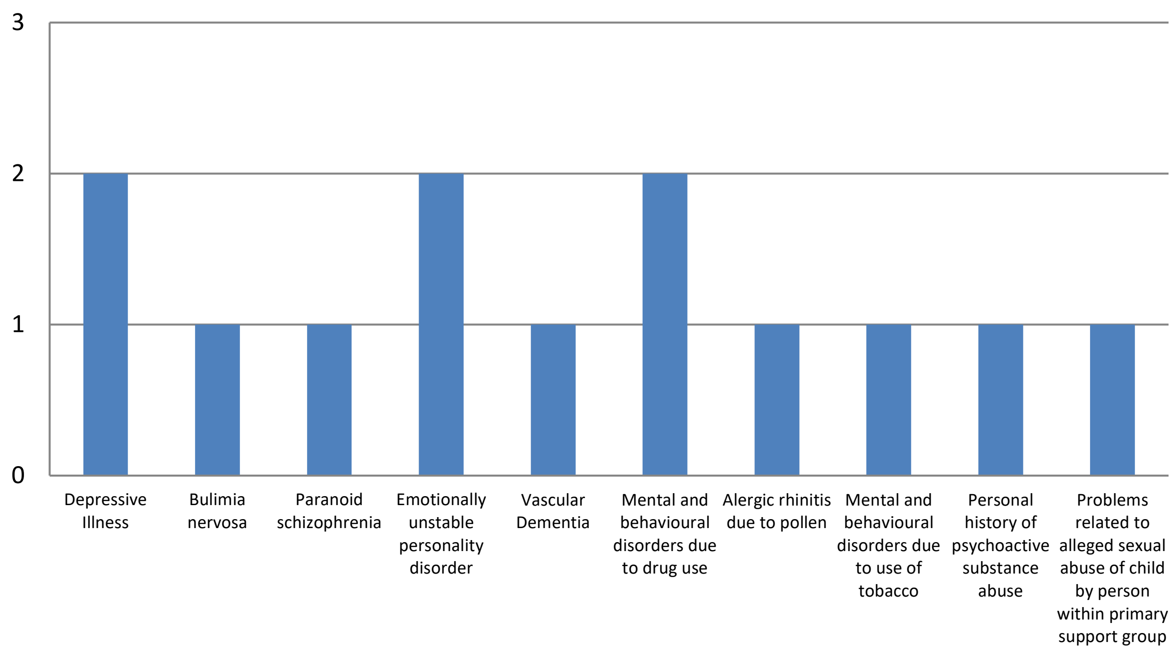
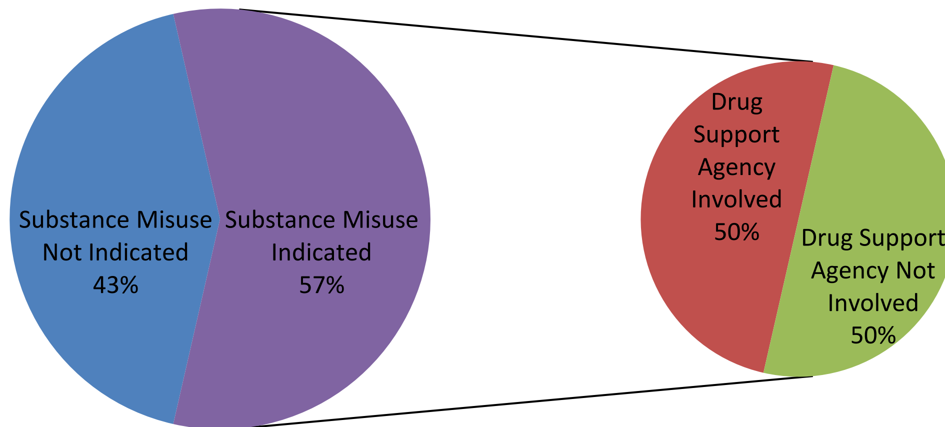


Figure 8 - Primary Psychiatric Diagnoses

8.0 SUBSTANCE MISUSE AND CONTACT WITH SPECIALIST SUBSTANCE MISUSE SERVICES



8.1 Poly -Substance misuse was indicated in 57% (n=4) of the cases, but the ResoLUTiONs Alcohol and Drug Recovery Service was only involved in two of those cases. It is important to note that in the other two of cases where substance misuse was indicated, the ResoLUTiONs was not involved because in one case, the patient denied use of drugs and had a negative screening on admission, which resulted in acute intoxication with opiates going unrecognised. In another case, the patient was seen by the service and asked the staff to leave and disengaged from the ResoLUTiONs service.

8.2 This would indicate the stronger links have been made with ResoLUTiONs than were in place the previous year when the lack of patient engagement with the drug and alcohol service was a direct result of the fact that there was no single agency contracted to provide this service within Luton. CGL was awarded the new contract for the ResoLUTiONs Alcohol and Drug Recovery Service on 1st April 2017 and there have been positive links made between CGL and ELFT.

8.3 It is also important to note that the Luton Mental Health Directorate have been working QI Team to adopt the Violence Collaborative methodology which has been show to support management of co-morbid substance misuse on inpatient wards.

9.0 CLINICAL SETTINGS

9.1 Figure 9 below shows that Brantwood CMHT experienced the larger proportion of unexpected deaths and was also the only Adult CMHT to record unexpected deaths in 2017/18. In both of these cases, the follow-up appointments were not booked by the administrators and in one case, not until 17 months after the last appointment. Since these

incidents, a policy for administration standards was developed and the procedure has been improved and strengthened.

9.2 Of the seven patients who died unexpectedly in 2017/18, two were inpatients at the time of their death, although only one died while physically on the ward. One of the antecedents of this case was that the design and size of the ward made it difficult for staff to apply the ELFT observation policy effectively as staff needed to cover considerable distances during observations. At the time, the ward was consisted of 26 beds and at the time of writing there are plans in place to reduce the maximum capacity to 24 in the first instance, working towards not having more than 18 beds, in line with guidance from the Royal College of Psychiatry[1].

Also when patients were asleep in their bedrooms, staff needed to open a patient's bedroom door to carry out general observations, however this practice was not supported by patients who felt it was an invasion of privacy. At the time of writing, the ward is installing mirrors at critical points to aid staff in carrying out observations without compromising the privacy and dignity of patients.

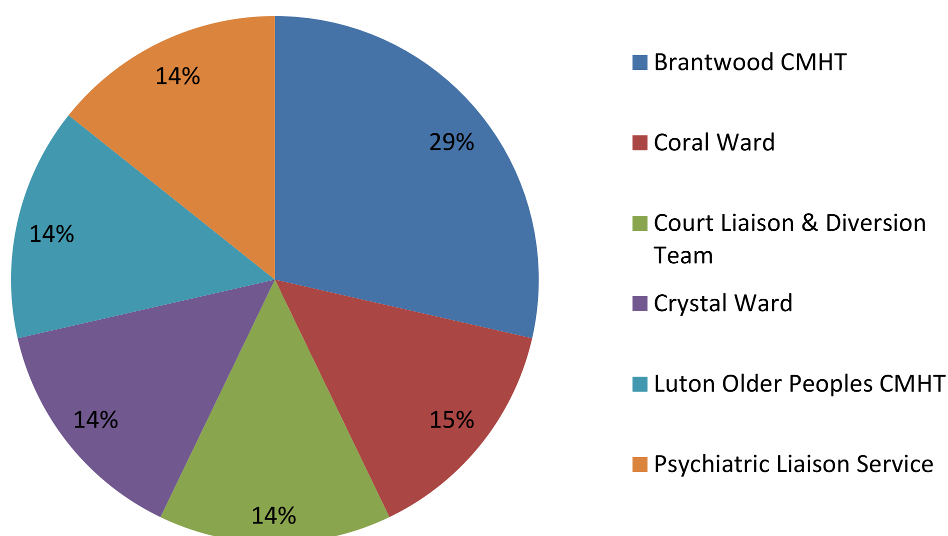


Figure 9 - Service Involved at the time of Unexpected Death

9.3 There is no difference in the number of inpatient unexpected deaths from 2016/17 to 2017/18. This is in-keeping with the national picture as though the numbers of inpatient unexpected deaths has fallen since 2011, the numbers have been falling much slower in recent years. It is also important to note that nationally, 78% of inpatient unexpected deaths take place while the patient is on agreed leave or had left with staff agreement[2]. This was the case in the one incident regarding Crystal Ward.

[1] Do the right thing: how to judge a good ward – Royal College of Psychiatry (June 2011) https://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf
[2] (National Confidential Inquiry into Suicide and Homicide by people with Mental Illness, 2017)

9.4 It is interesting to note, the number of unexpected deaths or suicides involving Crisis Resolution Home Treatment Team (CRHTT) nationally has been increasing in recent years, however there were no unexpected deaths or suicides recorded against the Luton & South Beds CRHTT in 2017/18.

10.0 UNEXPECTED DEATHS FOLLOWING DISCHARGE

10.1 Of the seven unexpected deaths covered in this report, two patients had never been admitted to a ward, one patient while physically present on the ward and one while on agreed leave.

10.2 Figure 10 below shows that of the remaining unexpected deaths, two had been inpatients over one year prior to the incident and one patient died unexpectedly 10 days following discharge from Townsend Court. It is important to note however, that the patient was discharged to a care home and was subsequently admitted to the Luton & Dunstable Hospital four days later. The patient died in hospital six days later of a large acute chronic subdural haematoma.

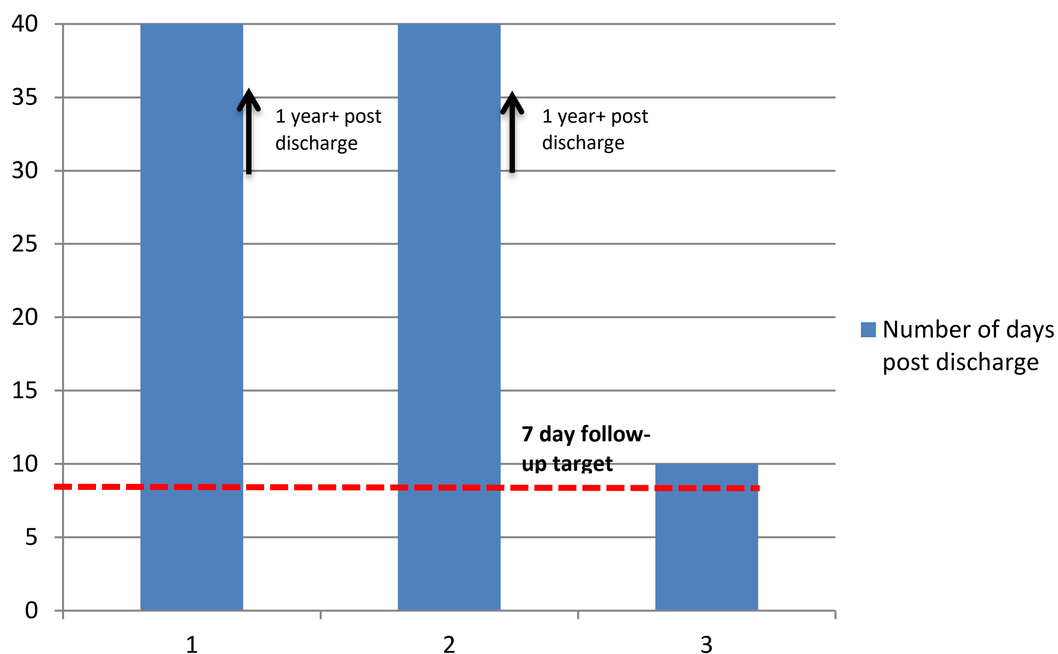


Figure 10 - Unexpected deaths following Discharge from Inpatient Services

10.3 It is therefore evident in the cases above, that 7-day follow-up procedures played little part in the preventability or predictability of the unexpected deaths.

11.0 THEMES FROM ACTION PLANS

11.1 A number of recurrent themes were picked up from analysis of action plans resulting from Serious Incident Investigations. The value in analysing the action plans is in highlighting recurrent issues which may be wider spread than identified within an individual SI investigation.

This analysis is clustered into three broad headings. These are:

- Standard Operating Procedures and Guidelines
- Ensuring Valid and Up-to-Date Training
- Communication

11.2 ***Standard Operating Procedures and Guidelines:***

There were a number of operational policies which were recommended for review or strengthening, including:

- Slips, trips and falls management (inpatient) policy
- Local procedures for managing patient records
- Luton CRHTT Operational Policy
- Guidelines for the inpatient treatment of opiate addiction
- OPMHS Operational Policy
- Observation Policy
- Luton CMHT Operational Policy

11.3 ***Ensuring Valid and Up-to-Date Training***

In several action plans there were calls for training to be given to staff or awareness raised on various subjects including:

- Updated training in risk assessment for all CMHT staff
- DBT skills training for CMHT staff
- Training on managing bookings on RiO for CMHT admin staff

11.4 ***Communication***

SI Action plans across 2017/18, identified on a consistent basis, a number of key areas of improvement with regard to communication. These were are follows:

- Transmission of referrals between teams within in the directorate
- Uniform booking management solution across all CMHTs
- Documentation of all decisions and communication on RiO by all staff involved in the patient's care
- Recording of Next of Kin details
- Recording of physical observations using the physical health pages of RiO
- Communication with Drug & Alcohol Recovery Service
- Communication of Crisis Numbers to Service Users
- Communication with GPs

11.5 At the time of writing, most of the above actions had been implemented however, it important that regular reviews are carried out to ensure that standards are maintained and all future learning is incorporated going forward.

12.0 CLINICAL MESSAGES

12.1 Clinicians and pharmacists should be aware of the potential risks of opiate and opiate-containing analgesics. Safer prescribing in primary and secondary care remains crucial,

particularly for patients with long-term pain, a group at high suicide risk. This should include prescribing only short-term supplies and enquiring about opiate-containing painkillers kept at home.

12.2 A greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together as reflected in published guidance

12.3 Consideration should be given to how to action as many of the National Confidential Inquiry's '10 ways to improve safety'

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