



Counting and Accounting for Mental Health Related Deaths in England and Wales

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Abstract

This article examines how mental health related deaths (MHRDs) in England and Wales are counted and accounted for. Data collated by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) constructs such deaths as being predominantly the result of suicide. This article examines 221 Reports to Prevent Future Deaths (PFDs) issued by coroners' courts in relation to MHRDs. It establishes that in 49% of cases suicide is not recorded as the sole cause of death. The article also provides thematic findings that emerged from the qualitative analysis of these PFDs and identifies issues with errors or deficiencies in the provision of care (in 72% of cases), communication (55%) and policy (26%). The findings emphasise that organisational and structural issues contribute to deaths of people in connection with mental healthcare and that these deaths should not solely be considered suicides. The article raises significant questions about the accuracy of mortality data and the capacity of public organisations to learn lessons that might prevent future deaths.

Keywords: Mental health; mortality data; preventable deaths; suicide; coroners; learning lessons.

Data on Mental Health Related Deaths

There is no known national count of people who die in the context of mental healthcare provision in England and Wales (INQUEST 2015). The nearest approximate count is data on suicides connected with mental health services in England and Wales, which has been collated since 1996 by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Between 2007 and 2017, patient suicides totalled 18,024 representing 28% of all national suicides during that period (NCISH 2019). The NCISH gathers data confidentially to encourage mental healthcare providers to voluntarily disclose information about patient deaths (NCISH 2019). The underpinning rationale is that learning lessons which might prevent future deaths is most productively done in an environment where blame or liability is not ascribed (NCISH 2019). One significant limitation to this approach is that it frames such deaths as being caused solely by suicide; another is that it relies on providers to voluntarily supply information; a third is that there is no public record to ensure this disclosure occurs; a fourth is the lack of certainty that the current data is accurate due to the aforementioned reasons.

This article examines how we might gain an understanding of the factors that lead to mental health related deaths (hereafter 'MHRDs'). In doing so, it identifies some significant drawbacks in how MHRDs are counted and accounted for. The article challenges the received knowledge about MHRDs in relation to suicide by interrogating a database of 221 Reports to Prevent Future Deaths (hereafter PFDs) issued by coroners in England and Wales about such deaths. The rich qualitative data derived



from these reports provides a wealth of information that illustrates how and why many of these deaths can be linked to structural and organisational errors or failures in public services. The article considers what NCISH data and coroner data might reveal about MHRDs in terms of how they are investigated and counted and how lessons might be learnt that could prevent future deaths. It demonstrates that while there is institutional knowledge about how these deaths occur, our understanding of them is limited by lack of clarity in the mortality data.

Although the NCISH collects and collates data on MHRDs, it does not investigate such deaths. In England and Wales, MHRDs can be investigated in coroners' inquests before a jury if the death is unexplained or in some way contentious (Dorries 2014). Article 2 of the European Convention on Human Rights (ECHR) obliges coroners to independently investigate unexplained or contentious deaths that occur in or after being in the care of state and to establish that they could not have been prevented (Baker 2016b). An integral part of this process requires coroners to consider structural factors that might have contributed to a person's death (Matthews 2011). Coroners also aim to identify lessons that could prevent future deaths (Thomas et al. 2014). Since 2013, coroners have been obliged to complete a PFD and send it to any organisation that they believe should amend their policy or practice in respect of an individual's death (Baker 2016b). Organisations in receipt of a PFD are required to respond to coroners within 56 days, but they cannot be compelled to do so, nor can they be compelled to act on coroners' concerns (Thomas et al. 2014).

For the purposes of this article, the term MHRD adopts the tabulation wording from the Judiciary website on which PFDs are posted. This tabulation was used to gather the 221 PFDs used for the database in this article and comprises deaths in a variety of locations; for example, at National Health Service (NHS) sites, in custodial settings, in public places and in private homes. As such, the article considers the deaths of inpatients, outpatients, individuals in police and prison custody, and of people who had either been discharged from care or had never been connected to formal mental healthcare services. The authors argue that this provides a more holistic overview of such deaths, as the NCISH data predominantly captures MHRDs in terms of inpatients or people who had recently been discharged as inpatients. The authors further argue that suicide and MHRDs should not be conflated, as doing so produces inaccurate mortality data and hampers our understanding of how and why such deaths occur and consequently how we might learn lessons to prevent future deaths.

Literature on MHRDs

The majority of the literature on MHRDs before 2020 is quantitative and focuses on clinical settings, with the principal generator of research being the NCISH. An NCISH (2013) review on patient suicide stressed that establishing specific policies is key to reducing the number of suicides. It further asserted that NHS Trusts that adopt NCISH recommendations had lower suicide rates than those that did not. In particular, it focused on policies, such as the introduction of 24-hour crisis teams, the treatment of patients with drug and alcohol dependencies, patients absconding and improved information sharing with agencies in the criminal justice system (NCISH 2013). A common theme across the NCISH literature is that families of patients are insufficiently contacted or consulted about their relatives' care and/or condition. It also emphasises that risk management, which is described as a dynamic and person-centred approach, is not a simple 'tick-the-box exercise' (NCISH 2017; 2018). A further theme is limiting access to psychotropic medication due to the risk of it being used to cause suicide by overdosing (NCISH 2017; 2018). NCISH literature also identifies the need to follow up with patients post discharge (NCISH 2017), the importance of patient observation (NCISH 2013) and specific issues relating to the care of people with personality disorders (NCISH 2015). The focus of the NCISH data is suicide; however, it is evident that NCISH research also examines organisational issues that could prevent suicide.

Before 2020, academic literature on MHRDs focused almost exclusively on suicide, was predominantly quantitative in nature and typically considered clinical issues (see Kapur et al. 2013; Manu et al. 2011; Pirkis et al. 2002). Psychiatric patients were two to six times more likely to die than the general population and suicide was the most likely cause of death (Grigoletto et al. 2009; Pirkis et al. 2002). Research reports that contact with healthcare services can be a catalyst for suicide, and the overwhelming majority of suicides occurred within one year of such contact (NCISH 2017). Common causal factors involved in such deaths were a diagnosis of schizophrenia and/or a background of alcohol and drug use (Grigoletto et al. 2009; NCISH 2017; Pirkis et al. 2002). The link between physical and mental health has also been highlighted as a causal factor in severe depression, with cardiovascular and circulatory conditions being particularly relevant (Manu et al. 2011; NCISH 2017; Yim et al. 2004). Research has consistently shown that improved screening and risk assessments of inpatients and following up with patients post discharge could reduce the incidence of suicide (NCISH 2013; Pirkis et al. 2002; Yim et al. 2004).

Since 2020, qualitative literature, which typically uses PFDs as data sets, has emerged in relation to suicide and MHRDs. Most of this literature has been conducted by a 'webscraping' tool developed by multidisciplinary academics working under the banner of 'The Preventable Deaths Tracker' (2023) that allows data from PFDs to be gathered to create usable data sets (for an

example on how this tool works in practice, see Zhang and Richards 2023). Anthony et al.'s. (2023) research focused on suicides involving medicine and considered 100 PFDs between July 2013 and December 2019. They found that the most frequently expressed concerns by coroners could be grouped under the following themes: procedural inadequacies (in 14% of cases); inadequate documentation and communication (10%); and inappropriate prescription access (9%). Ferner et al. (2023) also examined the relevance of medicines in PFDs written in relation to deaths and noted that compared to Australia and New Zealand, there appeared to be little interest by either academics or journalists in England and Wales in analysing PFDs despite their capacity to improve public health outcomes. One exception to the webscraping approach was Leary et al. (2020) who examined 720 PFDs over a four-year period into healthcare deaths and found it unrealistic to analyse such data in a quantitative manner, instead focusing on thematic analysis. They identified five key concerns highlighted by coroners: deficits in skill or knowledge; missed, delayed or uncoordinated care; communication/cultural issues; systems issues; and a lack of resources.

Previous peer-reviewed academic research on MHRDs in clinical settings and on suicides and healthcare deaths has used PFDs to construct data sets to examine such deaths. Only limited research has examined MHRDs outside purely clinical settings. Indeed, to date, only The Guardian (Duncan 2018; Duncan et al. 2018) and the Office for National Statistics (ONS) (2023) have used PFDs as data sets for their analyses. The ONS (2023) undertook a qualitative analysis of 164 PFDs about suicide issued between January 2021 and October 2022 and considered organisational and structural errors or failures identified by coroners in relation to these deaths. They found that the four most frequently identified themes were errors or failures in processes (in 54% of cases), communication (34%), assessment and clinical judgement (34%) and access to services (32%). As the ONS research only examined suicides, it adopts – purposefully or otherwise – the NCISH counting mechanism that records MHRDs as suicides. The Guardian (Duncan 2018) examined 271 PFDs issued between 2012 and 2017 involving people receiving NHS care for mental health conditions. It used optical recognition software to scan 500 PFDs that were then checked manually to ensure each death involved an NHS patient or a person who had been recently discharged by the service. The review (Duncan et al. 2018) focused on institutional errors and identified 706 failings across the 271 deaths surveyed. The key findings were that in 72 cases (27%), poor or inappropriate care was identified; in 45 cases (17%), patients were discharged either too soon or without adequate support and in 41 cases (15%), treatment was delayed, which was potentially contributory to the death. This article adds to the extant literature by examining MHRDs holistically in terms of both non-suicides and suicides in community, outpatient, inpatient and custodial settings over a 10-year period. It provides a wealth of information from the rich, qualitative data provided by the PFDs in these cases that demonstrate systemic and organisational errors or failings in MHRDs.

A Note on the Method

The article uses a data set of 221 PFDs issued for deaths that occurred between October 2010 and March 2020. The PFDs were selected using the 'mental health related deaths' tab on the Judiciary website. These data are qualitative, as they document concerns resulting from investigations carried out in the aftermath of the deaths and provide valuable insights into the circumstances of each death. The data were analysed interpretatively using framework analysis (Ritchie & Spencer, 1994). First, the authors familiarised themselves with the data set to gain a better understanding of its contents. Second, a thematic framework was identified through the process of familiarisation and the construction of matrices (e.g., suicide/non-suicide as a key theme). Third, all of the data were systematically indexed, which involved breaking the matrices down in terms of the type and place of death, the type of death classification, age and gender. Fourth, the data were rearranged into charts to enable the identification of patterns between and within these issues; for example, the use of narrative conclusions to record multi-causal explanations of deaths was identified as a pattern. Finally, these charts enabled the systemic factors associated with MHRDs (e.g., a lack of provision, poor communication and poor or no adherence to policies) to be mapped and interpreted. Thus, the research findings emerged through an inductive, iterative process.

Findings: Causes of Death

In the data set, the most commonly recorded cause of death was suicide (which represented 51% of deaths), followed by 'narrative' (17%) and 'suicide with factors' (8%). Narrative conclusions record the jury's explanation of the circumstances leading to an individual's death and are one outcome of the obligations imposed by Article 2 of the ECHR that requires juries to consider structural factors when examining preventable deaths. Due to the requirements of Article 2, juries eschew choosing a cause of death and typically focus on the multi-causal factors that led to the death (Baker 2016b). 'Suicide with factors' is a term adopted by the authors to categorise coronial conclusions that found the cause of death to be suicide in addition to other specific factors; for example, neglect and/or failure, on the part of public services. This category covers cases in which neither a conclusion of suicide nor a narrative conclusion could be reached. Figure 1 provides a full breakdown of the causes of death.

Cause of death	Number of cases	Percentage of data set
Suicide	113	51
Narrative	37	17
Suicide 'with factors'	18	8
Drug related	13	6
Accident	10	5
Misadventure	9	4
Natural causes	6	2.5
Medical related	6	2.5
Open	5	2
Unlawful killing	2	1
Alcohol related	2	1

Figure 1. Recorded causes of death

As stated above, the extant literature on MHRDs predominantly focuses on suicide as the cause of death. Our data set supports a number of findings from the extant quantitative literature in terms of the potential causal factors relating to these deaths. Notably, in this data set, drug use was the most commonly recorded factor (32% of the cases recorded drug use as a factor related to the deaths in the PFDs) (see, for example, Grigoletto et al. 2009; NCISH 2017). The next most commonly recorded factor was schizophrenia (17% of the cases recorded schizophrenia as a factor related to the deaths), followed by alcohol (15% of the cases recorded alcohol as a factor related to the deaths) (see NCISH 2017; Pirkis et al. 2002), and then issues related to physical health (10% of the cases recorded issues related to physical health as a factor related to the deaths) (see, for example, Manu et al. 2011; Yim et al. 2004). These factors related specifically to the behaviours and/or characteristics of the deceased as distinct from organisational actions or omissions related to the deaths. An analysis of the data set identified that organisational factors related to the deaths of individuals were commonly recorded, irrespective of whether a conclusion of suicide was determined. In order of frequency, those factors were: provision (in 72% of cases), communication (55%) and policy (26%). These factors were typically recorded as a lack or absence of provision, communication and policy.

Provision

Provision was recorded as a factor related to the death in 72% of cases. Provision refers to material things or services that were not supplied or provided and were recorded as having potentially contributed to individuals' deaths. The analysis broke provision down into the following categories: provision related to practice/procedure and provision related to resources/funding. Between the two categories, the former was the most common issue under this theme. It refers to any duty, expectation or task that should have been completed but was not. Using the definition provided above, the category of provision appears to largely cover the thematic categories identified by the ONS (2023) in its research into deaths as a result of suicide of 'access to services' (identified in 32% of the PFDs analysed) and 'assessment and clinical judgement' (identified in 34% of the PFDs analysed). Compared with Anthony et al's. (2023) research into suicide and PFDs, our category of 'provision' appears to be similar to their category of 'procedural inadequacies' (identified in 14% of their analysis).

Examples of errors in practice/procedure identified in our analysis included:

Case 38: Delays in instigating resuscitation contributed to his death.

Case 135: The police system did not appear to have been correctly updated with markers to flag his vulnerability.

Case 210: The witness evidence heard and records consulted give the impression that those professionals involved in his care had discounted his symptoms as non-psychotic, without adequate investigation, underestimated his suicidality and had not addressed the concerns of the GP who referred him.

In the resourcing theme, the absence of provision tended to be cited as an issue more frequently than funding. Resourcing not only related to beds and places but also related to the number of qualified and experienced staff available. It was often used as a way of implicitly referring to funding, which reflected an unwillingness on the part of the coroners to explicitly identify

funding as a structural determinant in the provision of mental healthcare. It was identified implicitly as a key factor in the following cases:

Case 69: As there were no acute mental health beds available in [place redacted] at that time, he was transferred to [place redacted] for treatment (5 hours travel from his home).

Case 131: It is not difficult to imagine the despair and distress felt by [the deceased] to be told that it would be almost 6 months before she could even begin the help/treatment she was seeking on voluntary admission some 4 months previously.

Case 217: [The deceased] was offered counselling, but was told that there was an eight to ten week wait for counselling. By the time of his death counselling had not commenced.

Coroners rarely explicitly identified funding as an issue, but there were cases where this did occur. The following examples are illustrative of this:

Case 144: If funding is not sufficient to enable staff to fulfil their professional obligations to patients, lives are at risk.

Case 105: Chronic underfunding of mental health services is creating a risk to life.

Under the theme of provision, the data also identified the absence of physical things that could have prevented death. These ranged from potential ligature points to warning signs and barriers. For example:

Case 18: The wall surrounding the seventh floor of the car park has a metal barrier/bumper situated low down to prevent damage to the wall by parking cars. It equally provides a sturdy foothold allowing [people] to climb onto the wall.

Case 177: There used to be signs at the top of Culver Cliff akin to those which are found at Beachy Head in East Sussex which have wording such as “Suicidal? Despairing? Call Samaritans on [local number]”, these signs appear to no longer be present.

In the great majority of the data set, provision was identified as a factor in the deaths, usually recorded as an absence or omission in relation to organisational practice, physical things and funding. The next most common factor identified was communication.

Communication

Communication was recorded as a factor related to the death in 55% of the cases. This figure can be compared with the 34% reported by the ONS (2023) and 10% reported by Anthony et al. (2023) in their PFD research on suicide. In our analysis, communication refers to the sharing and recording of written and verbal information to ensure the continuity of care. Two overarching issues were identified: 1) the capacity of organisations or individuals to effectively share information; and 2) discrepancies in the information shared and/or recorded. In relation to information not being shared, it was repeatedly noted in the PFDs that the family members of individuals under the care of mental health services were often denied the opportunity to have any input into their loved one’s care (see also, Easton 2020; Duncan et al. 2018). The following examples are illustrative of this:

Case 55: Due to inadequate communication of potentially significant information between [the deceased’s] family and staff members, [the deceased] was put at risk.

Case 77: Information provided to visitors including close family was often short on detail and lacked helpful information.

Case 80: The ‘system’ made it difficult/impossible for information from the family to be shared and acted on by [the deceased’s] medical team.

According to best practice, a joined-up approach should be adopted to address the needs of individuals under the care of mental health services. This involves ensuring that mental healthcare services, the family and the individual being cared for all have

input into a recovery plan (NCISH 2017). The data set showed that information was often not shared effectively between organisations. At the micro level, information was not shared between staff about patients. At the macro level, information was not shared between organisations such as Mental Health Trusts, emergency services and private sector companies. The following examples are illustrative of this:

Case 35: Due to the non-receipt of notes and records that had been requested in other cases [the NHS Trust] no longer routinely requested such information from the CMHT [Community Mental Health Team].

Case 191: It appears that the police Safeguarding team have no established links with [the] NHS [Mental Health] team and that referral to a Crisis Resolution and Home Treatment Team depends on an officer recognising the need was urgent.

As the following two examples demonstrate, a lack of communication was also observed at the micro level:

Case 68: There was no contemporaneous notification to her GP [general practitioner] of the discharge or the assessment leading to discharge, in fact the GP had still not received notification by the time of discovery of [the deceased's] body.

Case 89: The deceased's Key Worker did not receive a report that the deceased had not collected his methadone on the above dates and only became aware of his non-collection of methadone by her own enquiry.

The second overarching issue in the communication theme refers to discrepancies in the information recorded. This included: miscommunication between mental health professionals and/or families; insufficient information being recorded; and on occasion, information simply not being documented. The examples set out below can affect how cases are rated in terms of urgency:

Case 58: The receptionist was told that [the deceased] was feeling suicidal and suffering auditory hallucinations, although [the receptionist] only recorded that he was hearing voices.

Case 122: Inaccurate information was communicated to liaison psychiatry: they were told that [the deceased] had taken 2 tablets, when she had taken 20.

Case 200: It is possible that, had accurate up to date information been recorded, a Grade 1 police response might have been dispatched, despite [the deceased's] assurances to the police call handler that she was now ok.

Case 220: [There are] concerns about the dissemination of information relating to risk of choking, particularly ensuring that hospital records are full, accurate and up to date.

Similar to the theme of provision, communication was sometimes marked by its absence, but it was more often marked by errors in recording. Either way, communication was identified as a structural factor relating to a person's preventable death.

Policy

Policy was identified as a theme in 26% of the cases in the data set. Policy refers to absences, lacks or inconsistencies in guidance adopted by organisations to minimise risks to individuals. Using our definition, it appears to be analogous to the ONS (2023) category of 'policy' (identified in 27% of their analysis). Policy can differ nationally between NHS trusts and between the public and private sectors. These inconsistencies were highlighted within some of the PFDs:

Case 38: The [place redacted] now have a crisis team that work with people who are in a mental health crisis. This involves a mental health worker and ambulance crew working together with the Police to try and help patients with acute mental health disorders. My concern is that this is not a national system.

Case 94: The evidence at inquest was that private providers of "Locked Rehabilitation Units" were not subject to such a National NHS England framework.

Absence of policy was also noted about a number of deaths, for example:

Case 20: [The deceased] acquired non-prescribed medication from the internet. She took an overdose of the drugs so acquired and died...I am deeply concerned regarding the ease with which [the deceased] managed to acquire Pentobarbital (and other medication) from the internet.

Case 67: There is no ability to admit [a patient with addiction issues] into a “safe space” when in crisis for care and supervision. Essentially patients with dependence are thus discriminated against by psychiatric services, with addiction being regarded as a personal choice.

Case 216: Opiate drugs are classed as non-controlled and are therefore not audited. There is a real risk that potent medication could go unaccounted for and could end up in the possession of patients.

Two other issues were identified under the policy theme. The first being where policies lacked specificity or relevance; the latter being staff non-adherence to policies. The examples below illustrate the former issue:

Case 24: [There is] no detailed guidance with regard to either access or the type of ligature cutter to be used.

Case 90: There should be a review of [the mental health trust’s] policy that currently appears to fail to accommodate the needs of service users leaving the UK for longer periods than the protocol provides for their prescription of maintenance medication.

Case 153: The Mental Health Act is out of date in that it does not recognise or accept responsibility for providing a plan of action to deal with people such as [the deceased].

Failures to adhere to the relevant policy was also identified as being potentially causal in an individual’s death, for example:

Case 33: The Partnerships in Care Policies in place at the time of [the deceased’s] death, if followed, are likely to have prevented his death.

Case 46: The procedure for removing items of property which could be used for the purposes of self-harm was undertaken incorrectly.

Case 221: There was insufficient knowledge and understanding amongst members of the psychiatric liaison service and the [place redacted] Hospital as regards the ‘Interagency Joint Working Protocol for the Management of Mental Health [place redacted] Area’.

Similarities across the three themes of provision, communication and policy are organisational absences, omissions and inconsistencies. Each theme also had macro and micro issues in the illustrative examples. Having established that there is a rich wealth of coronial findings that can inform our understanding of MHRDs, the article now turns to examine what might be gleaned from these findings in the context of those provided by the NCISH data and extant literature on deaths by suicide.

Discussion

The findings of this study demonstrate that people who die in MHRDs do not, by any means, all die by suicide. Thus, to conflate – purposefully or otherwise – MHRDs with suicide is reductive and unhelpful, as it necessarily limits our capacity to understand the multifarious issues surrounding MHRDs. The findings further demonstrate that such deaths occur in a variety of locations outside inpatient settings and are thus beyond the purview of the NCISH. Structural issues relating to public services are commonly identified as being causal in relation to these deaths, irrespective of whether a finding of suicide has been recorded by the coroner.

The current counting of MHRDs is based on the principles and parameters used by the individual counting organisations. As an objective of the NCISH was to count the number of suicides in mental healthcare it is unsurprising this is what it counts. That there are issues with transparency and accuracy in the way the NCISH collects data has been established. As the principal national collector and collator of data on such deaths, the NCISH represents the primary reference point from which these deaths might be considered. The predominant narrative that emerges from this is that healthcare agencies should adopt preventive risk models in relation to potentially vulnerable people (NCISH 2019). Under this approach, causal factors are

identified about specific population groups or individuals, and it becomes incumbent on those agencies to manage the risk of suicide as best as they are able.

Consequently, the focus of the great majority of NCISH literature is on minimising opportunities for individuals to die by suicide (NCISH 2013; 2017; 2019). This appears to be somewhat at odds with Article 2 of the ECHR, which is intended to be applied in a proactive way by public services. This means that rather than focusing merely on the prevention of death, public services should focus on proactively protecting life (INQUEST 2015; Thomas et al. 2014). The approach of the NCISH appears to focus more on a prevention of death paradigm, as emphasised by its focus on suicide. The findings from this study demonstrate that structural issues are commonly identified as absences regarding provision, communication and policy in relation to MHRDs. These absences point to instances in which life was not proactively protected by public services, and if lessons are not learnt in the aftermath of these deaths, the failure to learn lessons becomes a further systemic and structural failing of the public services charged with the care of vulnerable citizens. The lack of any independent investigation into these deaths (Equality and Human Rights Commission 2014; INQUEST 2015) is one possible reason why the narrative of the NCISH on MHRDs might have persisted.

As has been evidenced throughout this article, it is unsurprising that systemic organisational factors are examined by coroners. The finding that 49% of deaths are not classified as suicides is significant. Deaths might not be recorded as suicides for a number of reasons. The first factor might be related to the legal requirements for recording such a conclusion. To record a conclusion of suicide in England and Wales, coroners must be satisfied that: 1) the deceased intended the act; and 2) the deceased intended that specific act to end their life (Mumford 2016). This two-stage legal standard might prevent coroners from reaching a conclusion of suicide and cause them to seek alternative ways of recording their conclusions in these cases (see, for example, Tait and Carpenter 2016). Until 2020, a finding of suicide needed to meet the criminal standard of proof (i.e., 'beyond reasonable doubt'); however, this requirement was overturned by a Supreme Court ruling (in *R (Maughan) v HM Coroner for Oxfordshire* [2020] UKSC 46) that changed the standard to the civil standard (i.e., 'on the balance of probabilities'). In its decision, the Supreme Court noted changing societal attitudes to suicide and that identifying factors that might prevent suicides required a more accurate count of such deaths, observing that the previous burden of proof led to undercounting (Graham 2020).

The pastoral aspect of coronial work might represent a second factor that leads coroners to record conclusions in ways other than suicide out of respect to grieving families (Moore 2016; Tait and Carpenter 2016). The third factor might be related to the fact that coroners, as autonomous legal officers based within specific geographic areas, execute an atypical regulatory function in relation to public services. They can assess patterns and trends based on surveying cases brought before them after sitting for years (in some cases decades) in the same district (Baker 2016a). Consequently, they can monitor specific hospitals, custody suites, prisons and psychiatric detention units within their purview and provide critical insights into structural issues at a local level in a way that perhaps no other regulatory officer can (Coles & Shaw 2012). In combination, these three factors reveal that wider socio-legal contexts are used to socially construct how MHRDs occur and the conclusions recorded as a result; however, these conclusions can be subject to fierce contestation (Easton 2020; Thomas et al. 2014).

Much of this contestation derives from how subjective decisions made by medico-legal professionals ultimately determine a citizen's cause of death. Suicide represents a classification of how an individual met their death; however, the factors affecting how that determination is reached are subject to 'contextual constructionism' (Bourke 2003: 2,355). It has been noted that death investigations and classifications tend to impose order and impute meaning on events that are often complex, uncertain and disputed (Baker 2016a; Prior 1985). Thus, to record a conclusion of suicide, the causal reasons for the suicide need to be understood. In this way, coronial PFDs and the NCISH data are perhaps not as different as they might first be thought, as the latter, while exclusively focusing on suicide as a conclusion, does not necessarily overlook some of the structural factors that might have contributed to the act of suicide (see, for example, NCISH 2017; 2018; 2019).

However, the public health policy focus on suicide prevention tends to lead to a search for causal factors that can be assessed by risk models (White and Stoneman 2012). This can result in an overly reductive approach to understanding suicide and thus overlook the multi-causality that often exists in cases of unexplained deaths (Dorries 2014; Matthews 2011), which in turn can lead to the focus on the deceased as being engaged in an act of agency that leads to self-destruction rather than a consideration of the structural circumstances that might have led them to commit such an act (White and Stoneman 2012). Arguably, a focus on individual agency could not only lead to structural factors being overlooked but also to a belief that the suicide could not be prevented due to individuals being determined to assert their will. As the Supreme Court noted in its decision to change the evidential bar for a conclusion of suicide from the criminal standard to the civil standard in 2020 (Graham 2020), researchers have observed that coroners significantly under-report the number of suicides (Pescosolido and Mendelsohn 1986). In Australia, the under-reporting of suicides by coroners led to the National Bureau of Statistics applying post-facto calculations in an attempt to estimate a more accurate figure (Tait and Carpenter 2016). Thus, the finding that 51% of MHRDs were suicides in this article should be viewed with a degree of caution for two reasons. First, the number of suicides in the period examined by this article

are likely under-reported. Second, the balance of proof when recording a conclusion has now changed, and this could increase the annual number of deaths considered suicides. The latest available coronial data states that 4,904 suicide conclusions were recorded in 2022, a figure which represents the highest recorded number since reporting began (Ministry of Justice 2023).

A key difference between the NCISH and the coronial system is that the latter *investigates* deaths in a *public* setting while the former effectively *reports* on them based on information *confidentially* disclosed. This could lead coroners to be more critical of organisations and consequently focus on structural factors when examining such deaths (Baker 2016a; Thomas et al. 2014). However, there are some similarities between the approaches of the NCISH and the coronial system. First, the focus on individual deaths means that wider patterns of systemic issues largely remain under-considered by the NCISH because it does not collate data based on those principles and by the coronial system because while it does collect such data, it does not examine it at a meta level. This is because coroners effectively operate within a regional (rather than a national) service (Baker 2016b). Second, both systems are characterised by their relative opacity in terms of evidence collection and data publication. Third, neither coroners nor the NCISH can enforce recommendations that might prevent future deaths.

A review of the literature on suicide in relation to data gathering, death investigation and social construction revealed themes that could aid our understanding of MHRDs. First, discretion typifies the gathering of data by the NCISH, decisions about how and the way in which deaths should be investigated by coroners and the classification of death by coroners. Second, for the reasons stated above, ambiguity exists about these issues, as a lack of standardisation exists both within and across counting systems in relation to the protocols and processes that might provide clarity in data gathering and death investigation. Third, and linked to the first two issues, there is no national audit framework that might be applied to better understand the issue of MHRDs. As a result, there is no national system of oversight for data gathering or death classification. This article surveyed the available data and investigated knowledge of an issue characterised by uncertainty, discretion and opacity. It established that different data sources can portray the issue of MHRDs in different ways and that there can thus be no realistic claim to objectivity in the recording of MHRDs. Just as the data about MHRDs are contested, so too are the factors that lead to MHRDs, which affects our capacity to learn lessons that might prevent future deaths.

Extraneous factors placed limitations on the data set used in this study. The authors cannot be sure that all the PFDs about these deaths are forwarded to the relevant section in the Ministry of Justice, which is charged with posting them onto the Judiciary website, nor can the authors be certain that all of those that are forwarded are posted on the website or that they are posted to the correct tab on that website. It is also not known how many of these cases are investigated at inquest where a PFD is subsequently not issued by coroners, because they did not believe that organisational lessons could have been learnt. The utility of PFDs is further complicated by absences in each report; for example, the ethnicity of the deceased is not recorded in any PFDs. In the data set examined by the authors, 27% of the PFDs did not record the age of the deceased, which is similar to the amount of 39% recorded by Anthony et al. (2023). Further, in the process of gathering data, the authors identified 26 coronial districts (out of a total of 83 in England and Wales) in which no PFDs under the ‘mental health’ tab on the Judiciary website had been recorded. The lack of PFDs from coroner districts has also been referenced in other research into PFDs (see, for example, Ferner et al. 2023; Zhang and Richards 2023). King and Benbow (2022) examined 150 PFDs in relation to hospital and emergency-related deaths and found that only half of the coronial districts in England and Wales had produced PFDs. There could be numerous reasons for this, not least that the PFDs might not have been posted onto the relevant website or that the PFDs might have been posted under an incorrect tab (see also Anthony et al. 2023). Despite these limitations, it is clear that PFDs represent a valuable source of data about preventable deaths, particularly in relation to MHRDs, due to the limitations of the NCISH data on this issue.

Future research on MHRDs could be fruitfully undertaken in a number of ways. From a qualitative perspective, the use of a combination of semi-structured interviews and focus groups with key participants could provide a more holistic understanding of how such deaths are recorded, investigated and classified. Participants could include coroners, members of bereaved families and their lawyers, in addition to staff and managers from mental healthcare providers. More focused research could be undertaken by considering MHRDs in custodial settings; for example, in prison or police custody, using independent investigation reports by regulators into those deaths as a further source of data.

Conclusion

When considering MHRDs, it is evident that there is a lack of accurate data, a lack of understanding and a lack of lesson learning that might prevent future deaths. At the time of writing this article, the NHS Essex Partnership University Trust is subject to a public inquiry into 1,500 MHRDs that was set up in the aftermath of the trust pleading guilty in court to failures relating to the preventable deaths of 11 patients. In addition, numerous NHS mental health trusts in England and Wales are facing calls for inquiries due to concerns over preventable deaths (Precey and Fox 2022). A recent independent audit into

MHRDs related to services provided by the NHS Norfolk and Suffolk Foundation Trust found significant errors in the accuracy of mortality data and that a cause of death was not established in more than 75% of the 11,379 deaths examined over a five-year period. It concluded, ‘more should be done to understand the causes of death and contributing factors’ (Precey and Fox 2023). There are clearly very significant and widespread concerns about counting and accounting for MHRDs in England and Wales, and this article demonstrates how and why there are problems with the interpretation of mortality data in these cases.

This study found that suicide was by no means the only recorded cause of death in these cases; however, that does not necessarily invalidate findings derived from data gathered by the NCISH. The article demonstrates that there are a wide variety of factors that could be considered about MHRDs, not least the fact that they occur in healthcare, community and custodial settings and to people who are outpatients as well as inpatients. Social constructions mean that subjective interpretations can be applied to factors related to MHRDs, and thus different meanings can be applied to the objective recording of them (Prior 1985). This leads to limitations in our understanding due to inconsistencies, gaps, absences and omissions in the counting of and accounting for these deaths, as has been demonstrated in this article. It is evident that the findings in this article have implications for public health policy in relation to preventable deaths in England and Wales.

The provision of care is highlighted as a key finding in this article, and there are increasing concerns about the budgets available to provide appropriate mental healthcare (McCartan et al. 2021). In England and Wales, there are significant questions about the capacity and quality of care that the NHS is able to deliver (Care Quality Commission [CQC] 2022). Additionally, serious concerns arose about patient safety in numerous inpatient facilities in England and Wales that led the government to commission a ‘rapid review into mental health inpatient settings’ (GOV.UK 2023). The CQC (2022: 7) has made a stark assessment of the current state of mental health inpatient care: ‘Workforce issues and staff shortages mean that people are not getting the level or quality of care they have a right to expect, and the safety of patients and staff is being put at risk’.

As McCartan et al. (2021) noted, mental health conditions co-exist within social, political and economic contexts. A National Audit Office (NAO) report noted that while the capacity of the NHS for the delivery of mental health services increased by 22% from 2016–17 to 2021–22, during the same period, demand also increased by 44%. It further stated that ‘many people using services are reporting poor experiences’ (NAO 2023: 8). The CQC (2022) noted a lack of inpatient beds, a lack of community mental health provision and that despite a record high of 4.3 million referrals for mental health treatment in 2022, there remains grave uncertainty as to how the national lack of staffing will be addressed in terms of strategic plans. This article identified provision as a principal finding and underlined the singular capacity of coroners to highlight issues relating to MHRDs; however, there is currently no national oversight body to analyse coroner findings and promote lesson learning to better prevent future deaths.

The article identified that governmental and societal understandings of how and why MHRDs occur are limited, and that the data that exists is open to contestation. The authors believe the article provides a touchpoint from which further research can be undertaken into the contentious and under-researched area of MHRDs. The number of PFDs produced by coroners will continue to increase, and they represent an excellent source of publicly available data for researchers in an area which is significantly under-researched.

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