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# Thematic analysis of Prevention of Future Death reports for suicide: January 2021 to October 2022

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## ABSTRACT

**Background** Suicide prevention remains a high priority topic across government and the National Health Service (NHS). Prevention of Future Death (PFD) reports are produced by coroners to highlight concerns that should be addressed by organisations to prevent future deaths in similar circumstances.

**Objective** This research aimed to understand themes from concerns raised in PFD reports for deaths from suicide to inform future policies and strategies for preventing suicide.

**Methods** We employed a retrospective case series design to analyse PFD reports categorised as suicide using qualitative inductive thematic analysis. Primary themes and subthemes were extracted from coroners' concerns. Following theme extraction, the number of concerns coded to these themes across reports and the frequency of recipient organisation being named as addressee on these reports were assessed as primary outcomes.

**Findings** 12 primary themes and 83 subthemes were identified from 164 reports (4% of all available reports). The NHS was the most frequent recipient of these reports, followed by government departments. Coroners raised issues around processes within or between organisations and difficulties accessing services. The most common concerns fell under the primary theme 'processes' (142 mentions), followed by 'access to services' (84 mentions). The most frequent subthemes were 'current training not adequate' (38 mentions) and 'inadequate communication between services' (35 mentions).

**Conclusions** Our results specify areas where review, improvement and policy development are required to prevent future suicide deaths occurring in similar circumstances.

**Clinical implications** These themes highlight concerns across current care and service provision where reform is required for suicide prevention.


### WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ This is the first report analysing Prevention of Future Death (PFD) reports to identify key themes contributing to all deaths that occurred by suicide to explore concerns raised by coroners.

### WHAT THIS STUDY ADDS

⇒ This study provides insight into deaths occurring by suicide and explores coroners' concerns to highlight areas where improvements are needed to prevent future deaths occurring in a similar manner.

### HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study can be used to help inform future suicide prevention policies and by organisations to help make improvements in service. This study also promotes using PFD reports to explore themes in suicide further.

## INTRODUCTION

In the last three decades in England and Wales, approximately 5000 suicides are typically registered each year.[1] Suicide is a key patient safety concern, with 17 931 patients in contact with mental health services in the UK dying by suicide between 2006 and 2016.[2] Changes in the economic, health, societal and digital landscapes continue to present new challenges; therefore, suicide prevention continues to be a National Health Service (NHS) priority for the next decade.[3] Understanding the critical context surrounding suicide and mental healthcare is a key aspect in developing quality improvement.[4]

All suspected suicides in England and Wales are subject to a coroner inquest to conclude the cause of death prior to official registration. In cases where concerns surrounding circumstances of death are raised, coroners have a duty (under paragraph 7 of Schedule 5, Coroners and Justice Act 2009) to make a Prevention of Future Death (PFD) report detailing these and actions which should be taken to prevent future deaths.[5] Despite the valuable information that PFD reports contain, to date there have been no published papers focusing solely on extracting themes from PFD reports for all suicide deaths in the UK. Previous investigations which have analysed PFD reports to extract themes have focused on broader 'mental health related deaths' (of which around 50% are suicide deaths),[6 7] suicides resulting in a claim for compensation[8] or suicides specifically involving medicines.[9] Analysing the concerns from reports for all suicide deaths is important, as they provide crucial information surrounding care and service provision which can be used to inform suicide prevention strategies. An aggregate analysis of PFD reports helps in identifying repeating concerns surrounding suicide deaths.

Research on PFD reports indicated their potential for learning, recommended wider dissemination of learning and increased utilisation of reports.[10 11]

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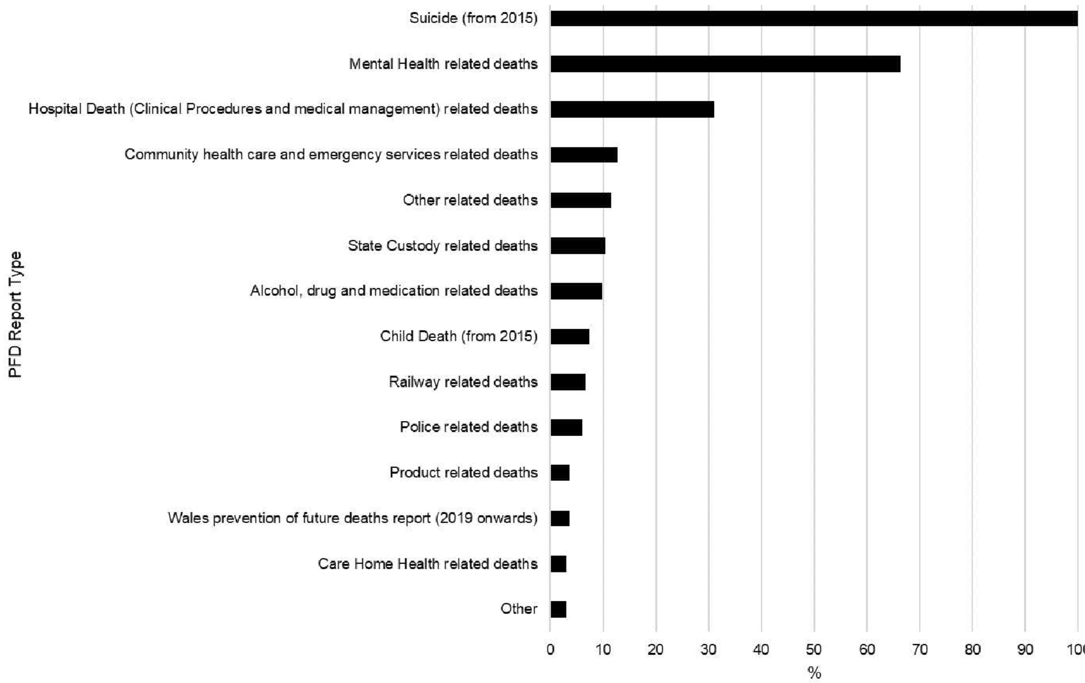


**Figure 1** Percentage of secondary categories in addition to 'Suicide' assigned to the Prevention of Future Death (PFD) reports analysed in this study. 'Other' includes reports categorised as 'emergency service related deaths' and 'service personnel', in addition to 'suicide' on the Courts and Tribunals Judiciary website.

The Preventing Suicide in England fifth progress report also identifies an ongoing workstream to analyse PFD reports to inform future policies and practices for deaths in prison custody, highlighting that PFD reports contain important information that can be used to help understand trends and inform suicide prevention.[12] The Preventing Suicide in England report includes data and evidence on suicide and self-harm and updates on the progress made on existing commitments of prevention, as well as providing further actions to be taken.

One paper examining PFD reports in England and Wales (years 2016–2019) for feasibility of analysis examined themes surrounding deaths from all causes.[10] One of the key themes was regarding missed, delayed or uncoordinated care; however, prominence of this theme varied across different categories of death. This emphasises the usefulness of focusing analysis on suicide deaths, to establish specific themes which may be unique to the context of suicide. There has been one study, to the authors' knowledge, examining coroners' investigations into deaths by suspected suicide in New Zealand where reports are provided to mental health services.[13] Findings showed that communication, risk containment, service delivery and family involvement were common themes, and therefore suicide prevention strategies focusing on improvements in these areas should be implemented.[13] This paper highlights that coroners' reports can play an important role in synthesising concerns to be used to guide future suicide prevention strategies within mental healthcare.

In this study, we conducted a qualitative thematic analysis of the concerns raised in PFD reports categorised as suicide published on the coroners' court website between January 2021 and October 2022. The aim of this research was to identify themes which may inform future research or policy into suicide prevention.

## METHOD

### Study design

This study used a retrospective case series design using PFD reports which are publicly available on the Courts and Tribunals Judiciary website as PDF files and cover England and Wales. PFD reports are categorised by type, for example, suicide (from 2015), emergency service-related deaths, care home-related deaths or accident at work and health and safety-related deaths.

Reports typically have a standard structure with the following sections: This Report is Being Sent To, Coroner details, Coroner's Legal Powers, Investigation and Inquest, Circumstances of Death, Coroner's Concerns–The Matters of Concern, Action Should be Taken, Your Response and Copies and Publication. Some parts of the report texts are redacted and therefore could not be included in the analysis.

### Procedure

PFD reports classified under the 'Suicide (from 2015)' category and uploaded to the Courts and Tribunals website between 1 January 2021 and 31 October 2022 were manually downloaded (n=164). At the time of analysis, a total of 371 PFD reports were classified as suicide (from 12 February 2015 to 31 October 2022) and 4149 total PFD reports were available (from 30 July 2013 to 31 October 2022); therefore, the analysis period included 44% of total PFDs classified as 'Suicide' and 4% of total PFD reports on the Courts and Tribunals website. However, it should be noted that some studies have highlighted assignment of suicide-related PFD reports to categories not including suicide[9] and therefore may exclude relevant reports otherwise categorised. As every suicide is subject to a coroner inquest, there is a delay between date of death occurrence, date of death registration and compilation and upload of the coroner's report. The date of the report being uploaded is typically considerably later than the date of death occurrence. The median registration delay for

England was 190 days in 2021 and 291 days for Wales.[1] For the reports included in our analysis, the earliest date of death was September 2016, and the most recent date of death was July 2022.

We conducted descriptive analysis including a count of the number of concerns per report and summed these to calculate the mean number of concerns per report and range.[10] Each concern could be coded to multiple primary themes and subthemes if it fits into multiple categories. All concerns were coded into primary themes, and then coded into subthemes to provide more detail around the concerns. Additional counts for demographic analysis including sex, age, place of death and organisations who were recipients of the reports were also collected, and proportions calculated.

Reports were then imported into QSR NVivo V.14 qualitative analysis software for inductive thematic analysis to identify common themes of coroners' concerns. The other sections of the reports were not included in the inductive analysis. Researchers who conduct inductive analysis have no preconceptions of themes and have not preset any themes, which allows for the generation of new ideas and themes.[14] All reports (100%, n=164) were manually coded by a single researcher initially, and then this same researcher reviewed the coding structure to refine the codes further to produce primary themes and subthemes. Following this, a second naive researcher quality assured the coding structure by reanalysing 40% (n=65) of the PFD reports. Initial agreement between the two researchers was 82% (*Agreement = Agreed codes ÷ Total number of codes*). Where researchers disagreed with codes created, these researchers discussed their views and came to a consensus (agreement after review=97%). For the remaining 3% of codes the lead researcher decisions were used.

## RESULTS

### Data

A total of 164 reports were available for descriptive and thematic analyses (2021=96 (59%); 2022=68 (41%)). Across these reports, a total of 485 concerns were raised with an average of three concerns per report (range 1–12).

### Descriptive statistics

All reports in this paper were categorised as 'Suicide (from 2015)' on the Courts and Tribunals website. Reports labelled as 'Suicide' are available on the website from 2015 onwards. Reports can be assigned to multiple categories on the website, and figure 1 shows the breakdown of categories assigned to the reports used in this analysis.

Of the 164 reports analysed, where sex was reported, 62% of the deceased were male, and 37% were female. The sex of the deceased is not always provided in the PFD reports, and therefore could not be confirmed for a small proportion of the reports (1%). Where the age of the deceased was provided in the report, the average age at death was 36.4 years for both sexes and ranged from 14 years to 81 years. Of the 164 reports, 56 (34%) did not mention the age of the deceased.

Across the reports analysed, 27 deaths occurred in an inpatient setting (general inpatient n=17, psychiatric inpatient n=10). A further 86 deaths occurred in a community setting (home=46, railway=10, other=25) and 17 deaths occurred in a prison. Finally, a small number of remaining reports reported the death as occurring in a care home.

Where the report mentioned the deceased having a specific diagnosis, this was recorded and summarised (figure 2). It should be noted that only reports where a specific known clinical diagnosis was mentioned were included in this summary. Instances where symptoms of a disorder were noted in the report but no diagnosis was specified were not included.

The recipient(s) of a PFD report are the (one or more) organisations to which the concerns relate to and should act on suggested actions in the report. PFD reports were addressed to a variety of organisations, with NHS organisations (including health boards, trusts and ambulance services) being the most frequent recipient (n=69, 42%), followed by government departments (n=40, 24%)(table 1).

### Thematic analysis

The inductive thematic analysis on the concerns sections of the PFD reports resulted in 12 primary themes and 83 subthemes (online supplemental table 1). Definitions of each primary theme

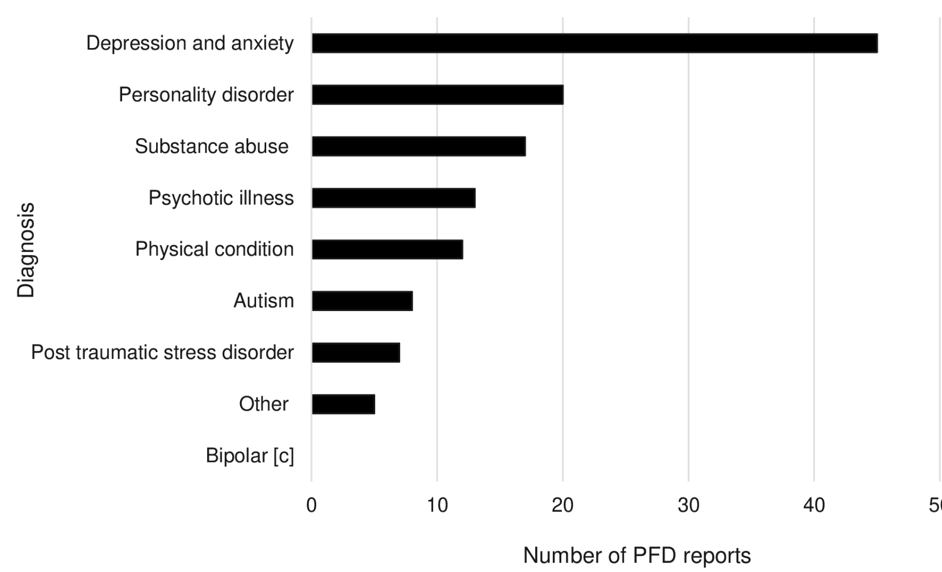


**Figure 2** Number of reports where the specific diagnosis of the deceased is mentioned, by category. Where number of mentions shows confidential [c], this result is below 3 and therefore potentially disclosive. PFD, Prevention of Future Deaths.

**Table 1** The number of reports categorised as 'Suicide' and included in the analysis that were addressed to different organisations

| Organisation | Reports* (n) |
|---|---|
| NHS† | 69 |
| Government department | 40 |
| Regulator or professional body | 21 |
| Prison and probation service | 15 |
| Police force | 14 |
| Council | 12 |
| Private company (medical) | 10 |
| General Practitioner (GP) | 8 |
| Safeguarding agency | 7 |
| Rail network and highways | 5 |
| Other‡ | 14 |

*PFD reports can be addressed to multiple organisations so total will not equal 164.
†'NHS' indicates that the recipient was part of the NHS including: NHS trusts, health boards, clinical commissioning groups, primary care services (other than GP), health and care partnerships and the ambulance service.
‡'Other' is used where numbers are less than 3 and are therefore disclosive. 'Other' includes: private company (prison), university, army, care home, charity, private company (internet and social media), private company (care home) and solicitors.
NHS, National Health Service; PFD, Prevention of Future Deaths.

and subtheme are included as online supplemental materials. The most common primary themes and cross-cutting subthemes are explained below.

## Processes

The most common primary theme identified across all PFD reports related to processes (n=142) (figure 3), with one of the main subthemes relating to concerns around the inadequacy of monitoring and documenting processes (n=32). These concerns largely referred to processes or standard operating procedures within or between organisations not being recorded or being incomplete, with the consequence that compliance could not be monitored, and therefore potentially contributing to a death.

Additionally, in this primary theme, all concerns being raised where there were no processes or standard operating procedures in place, and coroners judged that if they had been in place, a death may have been prevented (subtheme 'no processes in place', n=29). Examples include processes involved in permitting leave if the person was detained, carrying out and documenting observations and clinical record keeping.

## Staffing (cross-cutting)

Within the primary themes, there were many concerns coded as subthemes, which related to issues raised with staffing (figure 4). One theme where staffing concerns were prominent was training, with concerns ranging from staff training not being mandatory, knowledge gaps due to inadequate training, training not being applied in practice and materials from training not being updated following lessons learnt from specific incidences. A prominent concern across reports related to staff shortages resulting in processes not being followed (n=18). Concerns were also reported relating to a culture within a service that led to a negative impact on the care of the deceased because of staff shortages (n=17) and delays in accessing services for the deceased because of a general shortage of staff or a lack of qualified or specialist staff resulting in long waiting times (n=17). Moreover, staffing-related concerns were included in the theme of assessment and clinical judgement where a lack of qualified staff and staff shortages resulted in issues in the accurate assessment of a patient, potentially contributing to a death (n=10).

## Communication

Across reports, concerns related to the primary theme of communication were identified (figure 5). The most common subtheme

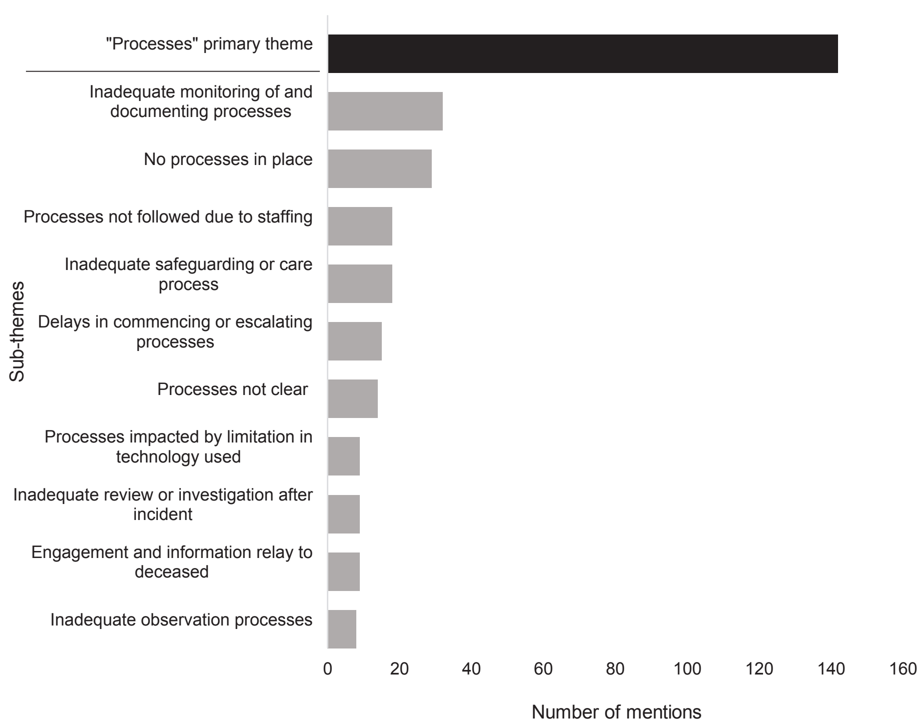


**Figure 3** Number of mentions in PFD reports related to the 'processes' primary theme and subthemes of 'processes'.

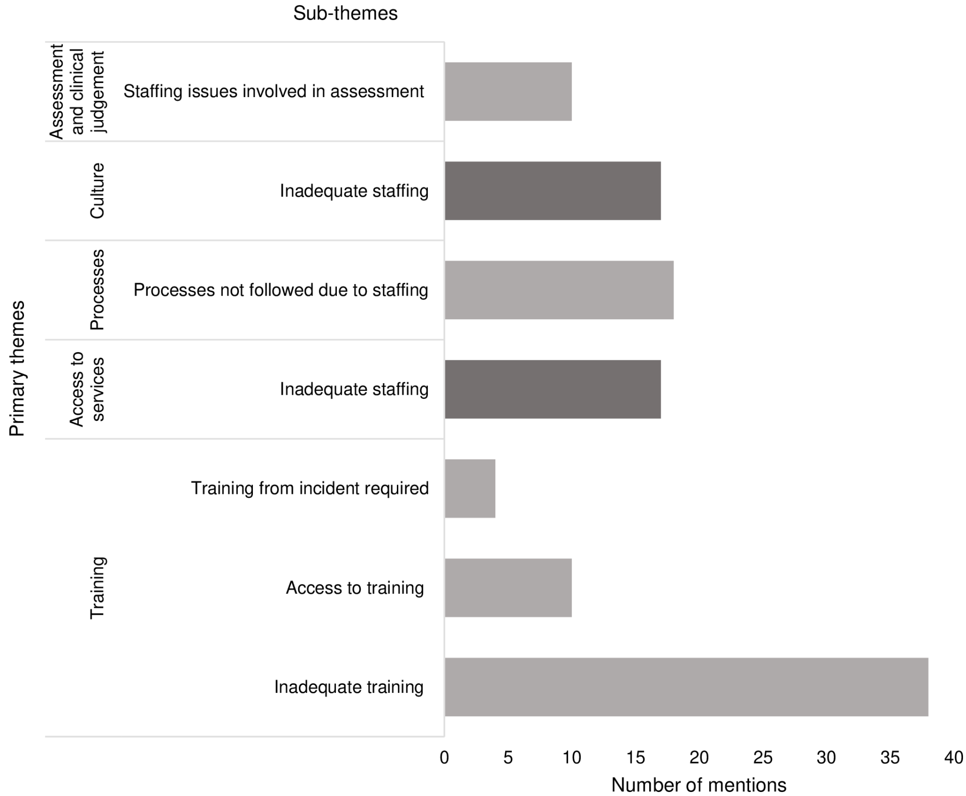


**Figure 4** Number of mentions relating to primary themes and subthemes that involved staffing concerns.

in the communication theme was concerns with inadequate communication between services (n=35). This related to reports where care was provided to the deceased by multiple services and that these services had not communicated correctly or efficiently between each other (eg, inadequate relaying of medical information or lack of communication resulting in gaps in care). This consequently negatively impacted the care of the person and may have contributed to their death.

Another subtheme within the communication was coroners' concerns related to the family of the deceased not being involved in the care process (n=12). This includes instances where processes which specifically require the engagement of the family, including information sharing and care planning, were not considered or carried out. This resulted in gaps in the deceased's care and support. In addition, this lack of involvement may have resulted in important information being missed

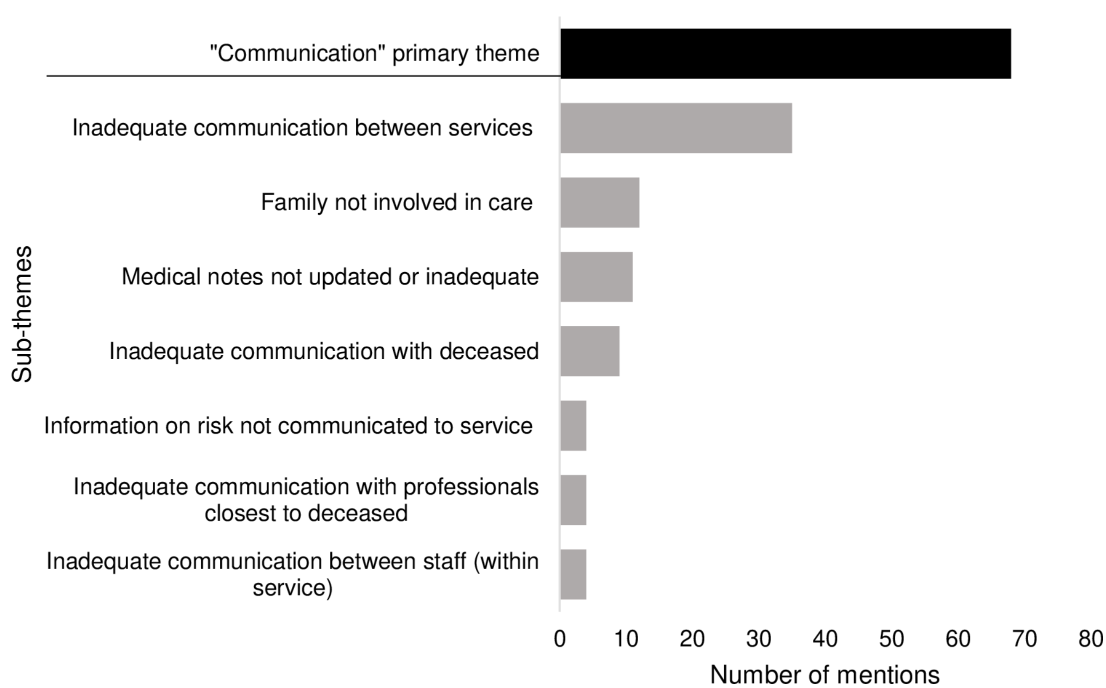


**Figure 5** Number of mentions for concerns relating to the primary theme 'communication' and subthemes of 'communication'.

or not considered, which could be crucial in care decisions. Moreover, coroners raised concerns surrounding the adequacy of medical notes (n=11), resulting in a lack of clarity between staff and services involved in care when accessing the deceased's notes leads to gaps in the care process.

### Access to services

In the PFD reports analysed, coroners' reported concerns related to access to services (n=84). The most common subtheme within this was delays in accessing specific services (n=21), for example, due to issues in referrals, delays in action being taken for the deceased to access a service and/or waiting times for accessing services. Inadequate staffing (n=17), as previously discussed, has also an impact on access to services. In some instances, the only services available to the deceased were not appropriate due to their requirement for specialist care (n=16). In these cases, access to services was delayed due to increased demand and/or too few staff or not enough qualified staff members, resulting in long waiting times.

## DISCUSSION

Our analysis highlighted that many concerns raised by coroners in PFD reports for suicide deaths were related to processes, including standard processes within services being unclear, delayed and no standard operating procedures. Additional findings highlighted issues with staffing and communication between services and that most of the PFD reports analysed were addressed to the NHS.

To our knowledge, this is the first qualitative analysis to report themes from suicide-specific PFD reports within the UK, as opposed to broader mental health-related deaths or a narrower subset of suicide deaths. Previous research on PFD reports between 2016 and 2019 in general contexts identified similar themes relating to lack of knowledge or skill, delays, and lack of coordination in care, communication and culture issues, issues in systems and lack of resources.[10] In addition, similar themes such as communication, family involvement and service delivery were highlighted in a report examining coroners' investigations in New Zealand in suspected suicides and were also found within this study.[13] Although similar themes emerged in both analyses, the proportion of mentions between themes differs between deaths in other contexts, and suicide-specific deaths. One of the least mentioned themes for hospital and care home deaths was resources, including staffing concerns; however, we identified numerous staffing issues raised across several themes for suicide-specific deaths. This emphasises a well-established issue within mental healthcare, which received the smallest increase in staffing across all departments within the NHS[15] despite it being identified as a priority in the NHS Five Year Forward View.[16] Communication between services was also a frequently raised theme in this study, and previous research has also highlighted the importance of effective communication including when patients are transitioned between and discharged from services by making sure care plans were up to date, shared and accessible.[4]

Our findings highlight concerns specifically about services being accessed by those vulnerable to suicide, for example, mental health services.[17 18] Recently, a rapid review into patient safety in mental health inpatient settings in England[19] identified recommendations including sharing good practice across organisations, exploring a full range of deaths data and actions providers should take to prevent and respond to patient safety risks (including staffing, processes for visiting patients and processes in care). Our results provide an additional timely insight into the themes which provides focus areas for review and reform in this context, as well as providing additional support for recommendations that have been highlighted in the review.

Our study has limitations which must be acknowledged. First, our findings relate to individual circumstances for PFD reports published over a 22-month period, representing a small minority of cases as approximately 5000 suicides are registered annually.[1] Second, due to the length of time to conduct inquests and registration delays, the date of death may be several months, or years, prior to the report being published. Therefore, some concerns highlighted in these reports may not reflect more recent situations. In addition, this analysis was carried out on PFD reports that had been categorised as suicide on the Courts and Tribunals Judiciary website. While improvements have been made to categorisation of PFD reports, in 2021, 33% of PFD reports on the website were not categorised and there is currently no guidance or criteria for the process to categorise PFD reports.[20] Therefore, it is possible that some PFD reports relating to death by suicide have not been included in this analysis.

Due to the small number of reports available within the analysis period, we were unable to reliably investigate concerns associated with specific services within organisations. Future research could identify services which are vulnerable to frequently mentioned concerns. In addition, we could not reliably provide an analysis of regional patterns. In addition, the current analysis focused on those reports categorised as Suicide on the Courts and Tribunals website; however, this may exclude suicide-related PFDs which were otherwise classified, as highlighted in previous research.[9] Healthcare inequalities[21] and sociodemographic risk factors for suicide[22] based on geography are apparent; therefore, establishing concerns by region would highlight areas where services require additional support. Future research could also look to examine the role that the coronavirus pandemic played in suicides; due to the length of time inquests take to conduct, around half of the reports analysed in this paper occurred prior to the pandemic with some dating back to 2016.

Previous work from over 20 years ago highlighted issues with communication and processes within mental health services contributing to suicides,[23] indicating consistent concerns over time. As such, it would be beneficial to analyse PFDs over time to determine consistent themes and concerns for suicides, highlighting systemic and enduring issues. In addition, due to the time taken for the inquest of suicides, PFD reports compiled in the coming months may shed light on concerns arising specifically from societal events such as the global coronavirus (COVID-19) pandemic,[24] the cost-of-living crises[25] and social media and internet development.[26] Analysis of more recent PFD reports is important to identify new themes, and work underway which aims to conduct 'real-time' analysis of PFDs provides a crucial database from which further thematic analysis can be conducted.[20]

In conclusion, our analysis of PFD reports categorised as suicides highlights key concerns where improvement is required. Inadequate processes and documentation, communication between services and access to services were major themes for these reports, with issues surrounding staffing spanning across reports. This supports previous literature indicating disproportionate staffing issues in services where suicide is a patient safety concern and provides specific direction for service reform to prevent future suicides.

**Contributors** ES, EW, DM and DS conceived and designed the study. EW and LR analysed and quality assured the data. LR, ES, EW, DM and DS wrote the manuscript. ES is acting as the guarantor for this study

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**Competing interests** None declared.

**Patient consent for publication** Not applicable.

**Ethics approval** This study was ethically self-assessed against the ethical principles of the National Statistician's Data Ethics Advisory Committee (NSDEC) using NSDEC's ethics self-assessment tool.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** Data are available in a public, open access repository. PFD reports are freely available on the UK Courts and Tribunals Judiciary. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/datasets/preventionoffuturedeathreportsforsuicidesubmittedbycoronersinenglandandwales



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