

# Unaddressed System Failures in Inpatient Suicide: Lessons from Coroners' Prevention of Future Deaths Reports

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## Background

- Persistent problem: Suicide rates in England and Wales remain ~10–11 per 100,000, with inpatient suicides offering critical but underused learning opportunities.
- System failures identified: Coroners' PFD reports consistently highlight multi-level system weaknesses (organisational, environmental, task, people, and technology factors).
- Dominant issues: Most failures relate to organisational governance, policies, communication, escalation processes, and wider workforce and capacity pressures.
- Mismatch in responses: Organisational responses to PFDs mainly focus on training, reminders, and procedural changes, rather than addressing broader system vulnerabilities.
- Limited learning spread: Learning from PFDs is fragmented, locally contained, and inconsistently acted upon, allowing recurrent failures to persist.
- Implication for prevention: Effective inpatient suicide prevention requires coordinated, national, systems-based redesign across all care domains, not narrow organisational fixes.

## Results

Applying the SEIPS model showed that inpatient suicide is driven by unevenly addressed, multi-level system failures.

Organisational and external-environment factors dominated coroners' reports, particularly governance gaps, unclear policies, poor communication, and workforce pressures. People, task, environmental, and technology issues were less frequently identified, despite their contribution to risk. Overall, findings indicate that inpatient suicides result from interconnected system weaknesses rather than single clinical or individual failures.

Reference 4 – 2.10% Coverage

DfE is aware of the long-standing difficulties faced by local authorities in fulfilling their obligations to provide suitable placements for looked after children with complex needs.

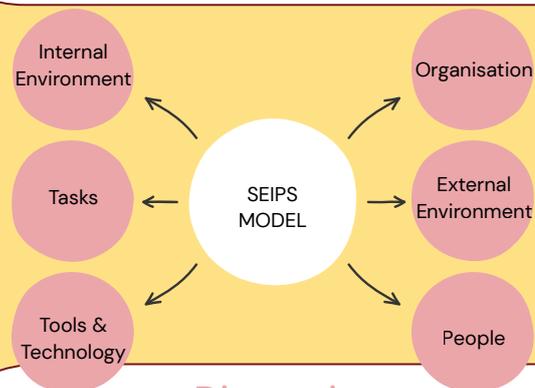
Reference 12 – 0.26% Coverage

This is to reduce the risk of patients being able to access such rooms which contain high risk items within.

## Method

We conducted a qualitative systems analysis of PFD reports and associated organisational responses relating to inpatient suicides. Using the Systems Engineering Initiative for Patient Safety (SEIPS) model, we coded extracts across six domains: organisation, people, tasks, internal environment, external environment, and tools/technology.

We examined the distribution of contributory factors across domains and evaluated the alignment between coroners' findings and organisational actions.



## Discussion

Coroners highlight systemic causes of inpatient suicide, but organisational responses often focus on individual-level actions that fail to address root causes. This mismatch allows risks to persist, underscoring the need for system-level solutions rather than procedural fixes.

Given workforce constraints, optimising shift patterns and handovers is a pragmatic approach to reducing fatigue and patient safety risk.

## Conclusion

In conclusion, coroner's Prevention of Future Deaths reports reveal ingrained, system-level weaknesses contributing to inpatient suicide, but organisational responses often remain narrowly focused on organisational interventions, overlooking environmental, task-related, and technological factors. Effective prevention requires a comprehensive system-level redesign that strengthens all relevant components of care, supported by a national mechanism for coordinated learning from PFDs through a systems-based approach.

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