*Extract from a newsletter sent by the Chief Coroner to all coroners, summer 2022:*

**Focus on Assessment of Suicide Risk**

I am often asked to highlight matters that it would be worth coroners considering when they are investigating particular types of death, so share these through a regular 'focus' item in my newsletters to raise awareness. In this newsletter, I am going to focus on the assessment of suicide risk.

Many families bereaved by suicide, search for reasons why their loved one took their own life and question whether there were any services involved that might have been able to change the outcome. Where the deceased was under the care of mental health services, one of the issues that is often relevant is whether there was an appropriate assessment of suicide risk.

I have been made aware of the findings of various reports that suggest coroners should carefully consider the quality of suicide risk assessments, particularly if risk assessment tools have been used. These reports are as follows:

1. NICE guidance (guidance 2011) on the long-term management of self-harm state in section 1.3 that risk assessment tools and scales should not be used to predict future suicide.

2. The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022 commissioned by the Healthcare Quality Improvement Partnership ('HQIP') on suicides between 2009 and 2019 (link: HQIP report 2022) noted (see page 18):

a. in 46% of cases, the deceased had been in contact with mental health services in the week before their death; and
b. The immediate risk of suicide at the time of final service contact was judged by clinicians to be low or not present for the majority of patients who died by suicide.

3. A HQIP report relating to the assessment of clinical risk in mental health services that was published in 2018 (link: HQIP report on risk assessment) and informed a recently updated toolkit for practitioners (link: toolkit), which states (see page 14):

a. Most risk assessment tools seek to predict future suicidal behaviour. Tools, if they are used, should be simple, accessible, and considered part of a wider assessment process.
b. Treatment decisions should not be determined by a score. Risk tools and scales have a positive predictive value of less than 5%, meaning they are wrong 95% of the time, and miss suicide deaths in the large 'low risk' group.
c. In a sample of patient suicides, the quality of assessment of risks and management was considered by clinicians to be unsatisfactory in 36%.

4. The Royal College of Psychiatrists report on self-harm and suicide in July 2020 (link: RCP report . That report stated (see page 46):

a. the approach to risk assessment and responding only to those identified as 'high risk' was fundamentally flawed; and
b. the use of terms such as 'low risk' or 'high risk' was unreliable, open to misinterpretation and potentially unsafe.

Coroners should be aware of these concerns around the quality of suicide risk assessments and, within the context of their own independent judicial decision-making in an individual case, consider their relevance to investigations into suicide deaths.