Audit of Suicides in Calderdale 2012-2014

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Contents

Foreword

Every suicide is a tragedy for both the individual and their family and friends which can have long term and lasting effects on peoples' emotional well-being. I, therefore, really welcome this important report as it is the first time, since 2010, that we have been able to get a detailed picture of suicides in Calderdale.

In our society, no one should have to take their own life by ending up in a situation where their only perceived way out is suicide. It is our responsibility, collectively and individually, to address the reasons why people are driven to this action and ensure that we put measures in place to end this situation – from preventative measures to timely access to crisis support. However, we know from evidence that the majority of people who commit suicide are not in touch with services so we need to start early – in schools – to give our children and young people the skills and support to be able to talk about how they feel and, in turn, become more able and resilient to deal with what life throws at them.

The recently re-established Calderdale Suicide Prevention group, a multiagency partnership group, is committed to the aim of zero suicides and this report will help inform their future strategy and action plan.

Caron Walker
Consultant in Public Health, Calderdale Council

Acknowledgments

The audit team were given access to the records by the HM Coroner's Office in Bradford and are mindful of the privileged position of reading through the events leading to the last intimate moments of a person's life and the sensitivities therein. We would like to thank the staff at HM Coroner's Office Bradford for their help and support.

Executive Summary

Background

Suicide remains a major gender and social inequality and this can be seen not only in the UK but also worldwide. In 2013, 6,233 suicides were registered in the UK[1].

The Public Health Outcomes Framework 2012-2014 indicates that the suicide rate in Calderdale is 11.7 per 100,000, higher than the national average at 10 per 100,000, with the highest rate being in men at 20.1 per 100,000 compared to the national average at 15.8 per 100,000[2].

This audit will look at the data from both national and local sources and in doing so it will consider the scope of the problem in Calderdale and compare it to national results. From these results from the suicide audit, it will be possible to use policy and strategy to work towards reducing suicides in Calderdale.

Methods

Records at HM Coroner's Bradford contain all paper records for deaths occurring within Calderdale, Bradford and Kirklees. They are not currently kept on an electronic database so the court staff helpfully pulled all records from our reference years given a verdict of suicide for us to review.

When reviewing a death the coroner will give a verdict based on the evidence that they have available to them. They have to be sure beyond all doubt to give a verdict of suicide. There is therefore the potential for underreporting of deaths by suicide that have been given an alternative verdict such as accidental death or misadventure.

Using the audit proforma found in Appendix A, the audit team reviewed the records and obtained the necessary information. The process was as follows:

- Inquest records were obtained
- The audit team read through the inquests and identified the data required on the proforma (appendix A)
- The team discussed unclear information and came to agreed decisions on what to record
- The data was collected and recorded in an anonymised format on paper proforma forms. The data was thereafter stored securely.
- The data was logged on to an encrypted database and analysed.
- Further analysis of the narrative fields was undertaken to pull out additional themes and recommendations.

Findings

We identified 45 suicides (for which we had access to records for)

- 80% of recorded suicides were males
- The average age was 49, the range of ages in recorded data was 19-88
- The suicides took place across all wards and among those with differing marital and employment statuses
- 87% of the deceased were White British and 48% were living alone
- 49% of deaths were by hanging
- 31% took place on a Sunday, more than any other day of the week
- The suicides happened across a range of times of day – but with 40% at around midday or early evening;
- 51% of the deceased suffered with depression and 49% faced some sort of acute family or relationship issue around the time of death

Background

It is estimated that about 800,000 people take their own life each year worldwide with many more who attempt suicide. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. It was the second leading cause of death among 15–29-year-olds globally in 2012[1].

Suicide remains a major gender and social inequality and this can be seen not only in the UK but also worldwide. In 2013, 6,233 suicides were registered in the UK. This corresponds to a rate of 11.9 per 100,000 (19.0 per 100,000 for men and 5.1 per 100,000 for women). The male suicide rate is the highest since 2001. The suicide rate among men aged 45-59, 25.1 per 100,000, is the highest for this group since 1981.[2]

Evidence suggests that periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide[3,4]. This has been the case in the UK over the last few years and the economic outlook remains uncertain[4]. It is therefore important to ascertain the scope of the problem locally and work to having a strategy and plan in place to help reduce suicides locally.

This audit will look at the data from both national and local sources and in doing so it will consider the scope of the problem in Calderdale and compare it to national results. Once the results from the suicide audit have been obtained and analysed, it will then be possible to use policy and strategy to work towards the reducing suicides in Calderdale.

Zero Suicides Aspiration

The 'Detroit model' for suicide prevention has been particularly successful in the United States (US) by creating a cultural shift in how patients with mental health problems are cared for by screening every patient for suicide risk. The patient's care is then tailored depending on their level of risk. There is also a big emphasis on promoting communication between patient and healthcare professionals, as well as among the healthcare professionals themselves to prevent suicide[5]. In the first ten years of this programme suicide rates in Detroit, which were amongst the highest in

[1] Suicide. World Health Organisation (WHO). http://www.who.int/topics/suicide/en/ (accessed 20/06/16)
[2] Samaritans. http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf (accessed 20/06/16)
[3] Antonakakis N, Collins A. The impact of fiscal austerity on suicide mortality: Evidence across the 'Eurozone periphery'. Social Science & Medicine. 2015 Nov 30;145:63-78.
[4] Gunnell D, Lopatatzidis A, Dorling D et al. (1999) Suicide and unemployment in young people. Analysis of trends in England and Wales, 1921–1995. British Journal of Psychiatry 175: 263–270
[5] Detroit Model Suicide Prevention. Henry Ford Clinic http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1104 (accessed 20/06/16)

the US, saw a steady decline until zero suicides were achieved in the final two years[6].

Using the Detroit model as evidence, with a standard of zero suicides, the Zero Suicide Collaborative in the South West of England has adopted the same approach and Mersey Care, a NHS mental health trust in Liverpool, has also committed to a zero-suicide model. Although the aim is ambitious it has proven not to be unrealistic and therefore this audit would take the same approach and set the standard for zero suicides.

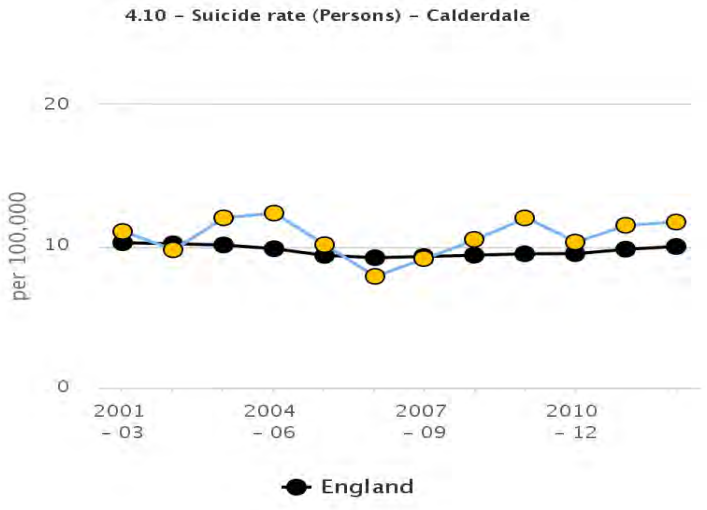
The Calderdale Suicide Prevention group, a multiagency partnership group, has committed to the aim of zero suicides in their recent suicide prevention action plan and strategy.

Local, Regional and National Context

The Public Health Outcomes Framework 2012-2014 indicates that the suicide rate in Calderdale is 11.7 per 100,000, higher than the national average at 10 per 100,000,[7] with the highest rate being in men at 20.1 per 100,000 compared to the national average at 15.8 per 100,000.

In 2010, a five-year retrospective suicide audit was undertaken for Calderdale and concluded that although Calderdale was on target to achieve a reduction in the rates of suicide there was scope for some prioritisation in services. Since the data from this audit was collected national rates have increased significantly as shown in Fig 1. With austerity measures set to continue in the UK it is important that this audit is repeated to gain a more up to date measure of the scale of the problem in Calderdale to discuss measures to improve it.

Fig 1[7]



[6] Depression Care. Royal College of Psychiatrists 2015 (accessed 28/07/16) http://www.rcpsych.ac.uk/pdf/Pursuing%20Perfect%20Depression%20Care-1-2.pdf

[7] Suicide Rate Calderdale. Public Health Outcomes Framework 2001-2012 http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000044/pat/6/par/E12000003/ati/102/are/E08000033 (accessed 15/0816)

National Policy

The national suicide prevention strategy outlines seven key areas for action[8]. These are:

1: Reduce the risk of suicide in key high-risk groups
2: Tailor approaches to improve mental health in specific groups
3: Reduce access to the means of suicide
4: Provide better information and support to those bereaved or affected by suicide
5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6: Support research, data collection and monitoring.
7. Making it happen locally

Within each of these areas, the national strategy provides key approaches and evidence to support local programmes. This audit will provide the supporting evidence needed to implement the local programmes that the strategy recommends. A key recommendation from the national strategy outlines that local authorities should undertake frequent audits of suicides and develop a multi-agency action plan to reduce suicides locally. Key resources are outlined in the guidance for producing an action plan available to all partners[9].

Local Policy

Locally, the Calderdale Suicide Prevention group has been restarted and are beginning to develop an action plan and strategy. This audit is part of this work and recommendations from this will inform the action plan in terms of local statistics and also as part of the national area for action- 'make it happen locally.' Information and recommendations formed within this group will feed into other groups within Calderdale whose focus is emotional health and wellbeing. In addition to this local work a regional suicide prevention network meets quarterly, led by Public Health England. Our local audit and subsequent strategy will feed into and inform this regional work.

Aside from active data collection such as conducting this audit, other sources of information may be found in the public health outcomes framework and also the local joint strategic needs assessment.[10]

[8] National Suicide Prevention Strategy. Department of Health 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[9] Local Suicide Prevention Action Plan. Department of Health 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359993/Guidance_for_developing_a_local_suicide_prevention_action_plan__2_.pdf
[10] Calderdale.Health and Premature Mortality Statistics 2012-2014 http://www.phoutcomes.info/ (accessed 16/08/16)

Methods

An audit of this kind deals with particularly sensitive and complex information. Access to the data and information in the records used was a privilege and all information was read and analysed in a delicate and sensitive manner.

Initially, it was aimed that this audit would focus on five years' data. However due to difficulties with access, only three years data could be obtained. They were from the calendar years 2012-2014 inclusive.

A scoping audit of primary care mortality data was done previously whilst waiting for access to HM Coroner's records. This enabled the audit team to analyse baseline data and obtain basic demographics. This information could then be built upon in the audit. Although regionally, the Leeds Suicide audit is viewed as the 'gold standard' we were unable to follow their methods fully. Due to restrictions in time and staff at HM Coroner's office, currently only those cases with suicide verdicts were able to be included. This has implications for completeness and validity.

Records at HM Coroner's Bradford contain all paper records for deaths occurring within Calderdale, Bradford and Kirklees. They are not currently kept on an electronic database so therefore the court staff pulled all records from our reference years for us to review that had been given a verdict of suicide.

Using the audit proforma found in Appendix A, the audit team reviewed the records and obtained the necessary information. The process was as follows:

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- The audit team read through the inquests and identified the data required on the proforma (appendix A)
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- Further analysis of the narrative fields was undertaken to pull out additional themes and recommendations.

Results

What follows is a basic overview of the suicide audit findings. Where possible, data are presented graphically and in tables. Where necessary – caveats around the data are mentioned. Further discussion of key themes and potential recommendations can be found in the following section. One thing to keep in mind when interpreting the statistics is the relatively small numbers; particularly in the more detailed subcategory analysis. Such small numbers are prone to natural variation by chance and should be interpreted with caution.

In summary: between 2012-2014 in Calderdale:

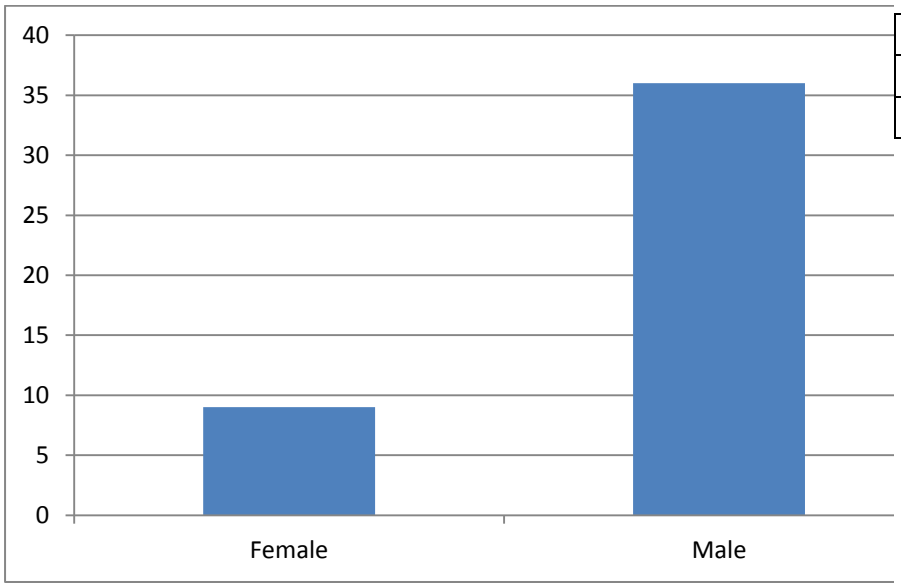
- We identified 45 suicides (for which we had access to records for)
  - Note: this will not be representative of all suicides which took place in 2012-2014 and may not mirror other analysis such as the public health outcomes framework.
- 80% of recorded suicides were males
- The average age was 49, the range of ages in recorded data was 19-88
- The suicides took place across all wards and among those with differing marital and employment statuses
- 87% of the deceased were White British and 48% were living alone
- 49% of deaths were by hanging
- 31% took place on a Sunday, more than any other day of the week
- The suicides happened across a range of times of day – but with 40% at around midday or early evening;
- 51% of the deceased suffered with depression and 49% faced some sort of acute family or relationship issue around the time of death

Statistics

Gender

Gender was recorded for all suicides included in the audit. The distribution closely matches the national picture:

Fig 2 - Bar chart by gender

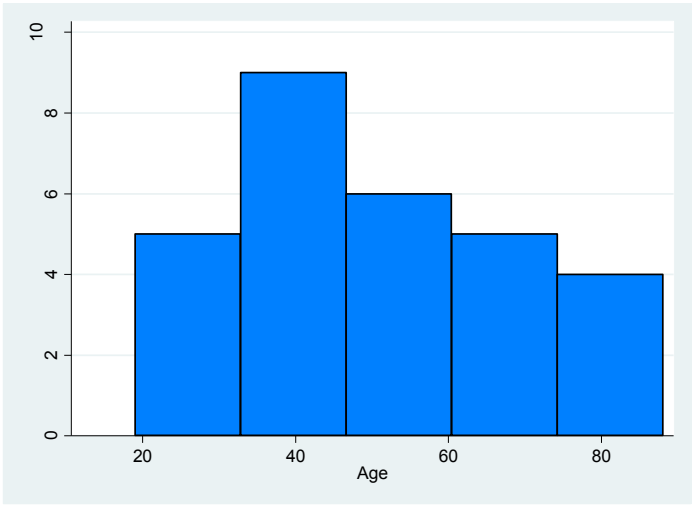


Female	9
Male	36
Grand Total	**45**

Age

The age at time of death was recorded for all cases in the audit. As with gender the distribution mirrors that of national statistics. Although no child deaths in the inquest records were classified as suicide, there were child deaths registered between 2012-2014. This means the registered deaths either did not happen in 2012-2014 or the deaths were categorised as a verdict other than suicide – which is more common for child deaths because of sensitivities towards the families. Indeed, the views of the chid death overview panel (CDOP) commented that there have been deaths over this time that were classified as misadventure that if occurred in an adult may not have been and been classified as suicide. anecdotally it is understood that there have been child deaths that took place in recent years for which we did not have access to information on. This means we could not include them in the current analysis.

Fig 3 - histogram by age

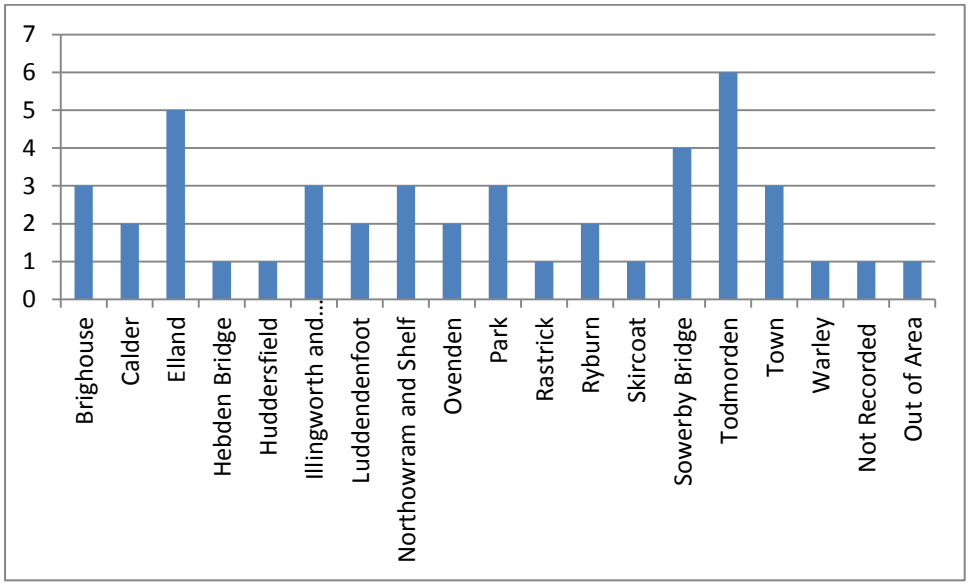


	Age
Mean	51
Median	49
Range	19-88

Location (Residence)

Location data was based mainly on the post code of the deceased's residence. An Excel look up file was used to match this to wards. With small numbers it would be unlikely that the slightly higher numbers in certain wards would be statistically significant.

Fig 4 - Bar chart by residence postcode

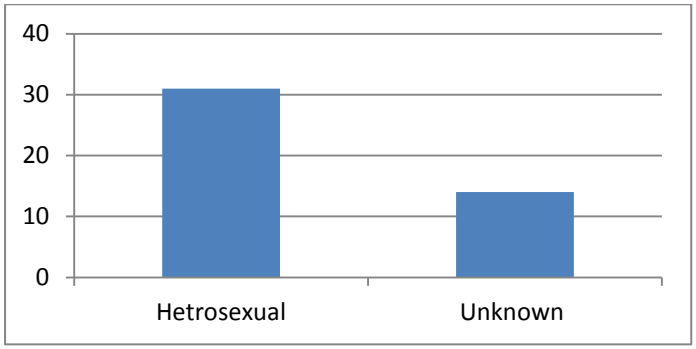


Grand total	45

Sexual Orientation

It would seem that if the sexual orientation of a person did not play a role in the suicide then it was not recorded clearly in the inquest files as it was only recorded in the narrative statements in one case where it was felt to be important evidence in the case. Indeed, for the majority of cases sexual orientation had to be presumed (based on the person having had a relationship with a person of the opposite sex).

Fig 5 bar chart by sexual orientation

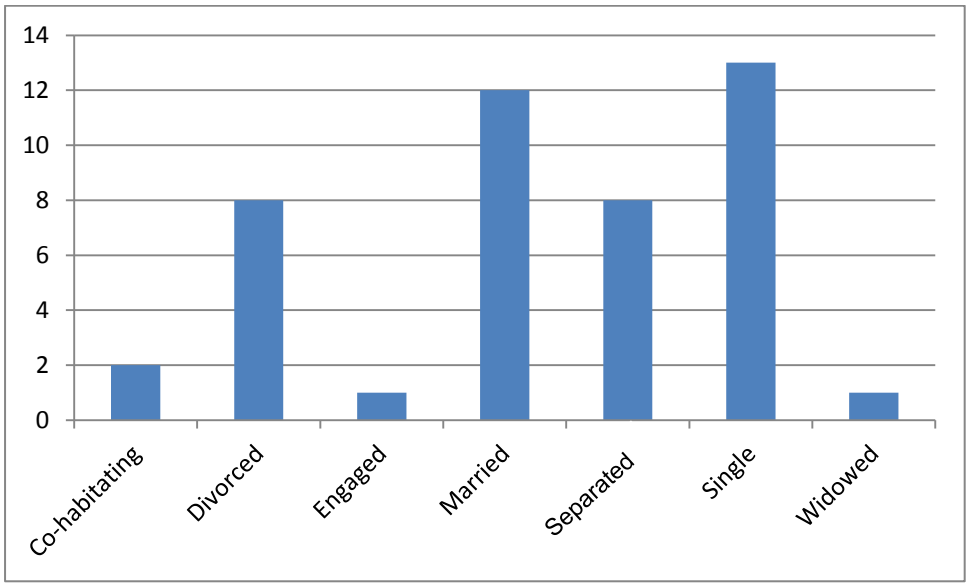


Heterosexual	31
Unknown	14
Grand Total	**45**

Relationships

Numerous sources were used to identify the marital status of the deceased and it was not always clear from the notes. For example it should be noted that in some cases although the person was legally married, witness statements indicated the individual may have been separated. For consistency, the marital status identified on the summary of death page beginning the inquest was used where possible.

Fig 6 - bar chart of relationships

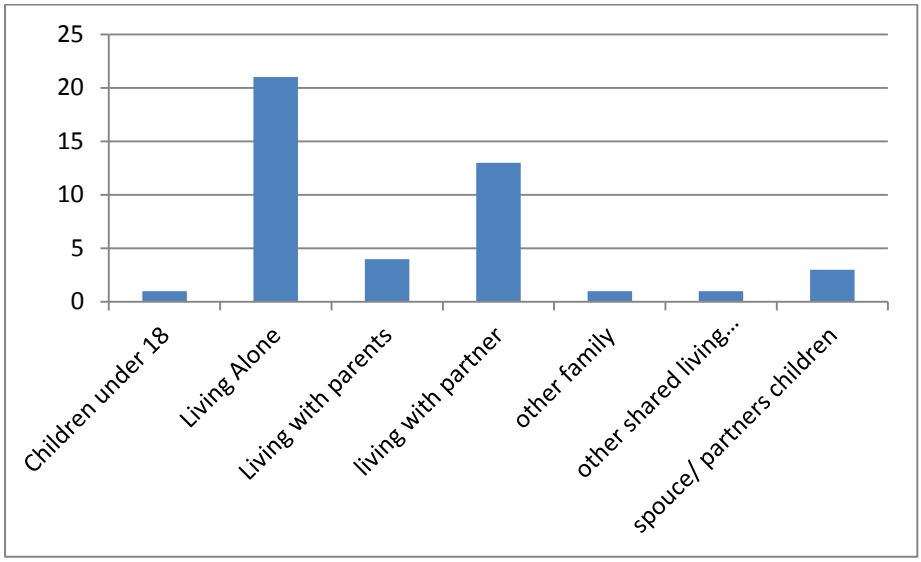


Co-habitating	2
Divorced	8
Engaged	1
Married	12
Separated	8
Single	13
Widowed	1
Grand Total	**45**

Home Situation

Again the recording of home situation was not always formally identified in the inquest files and some judgment on the part of the audit team had to be exercised. The results however mirror that provided by national evidence.

Fig 7 - bar chart by home situation

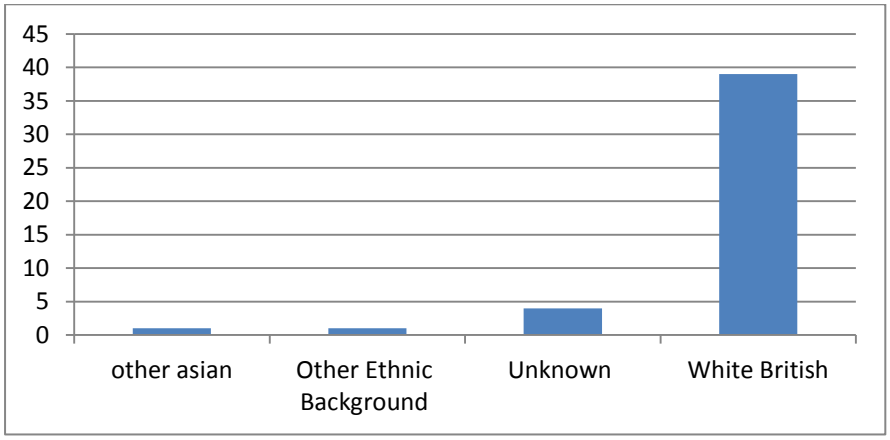


Children under 18	1
Living Alone	21
Living with parents	4
living with partner	13
other family	1
other shared living arrangements	1
spouse/partners children	3

Ethnicity

Ethnicity was not always formally recorded. In the post-mortem an indication of ethnicity was usually included but the detail was not always sufficient to identify detailed ethnic classification (eg. Caucasian). This was used along with other information to make an informed identification of ethnicity, acknowledging that this does not allow for self-identification. If unsure, ethnicity was recorded as unknown. These classifications were used as they followed the categories that were used when ethnicity was recorded.

Fig 8 - bar chart by ethnicity

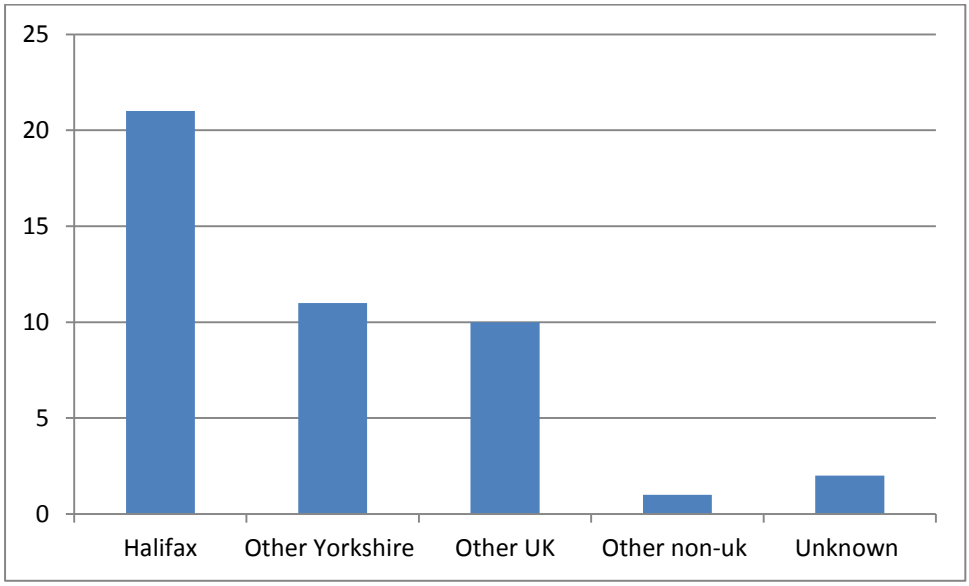


Other Asian	1
Other Ethnic Background	1
Unknown	4
White British	39
Grand Total	**45**

Place of Birth

Unsurprisingly the largest category was Halifax with other areas of Yorkshire the second largest. These primarily included Huddersfield and Leeds. Although only one person had their place of birth recorded as outside of the UK, several had spent a significant time abroad and had returned within a year of their deaths.

Fig 9 - bar chart by place of birth

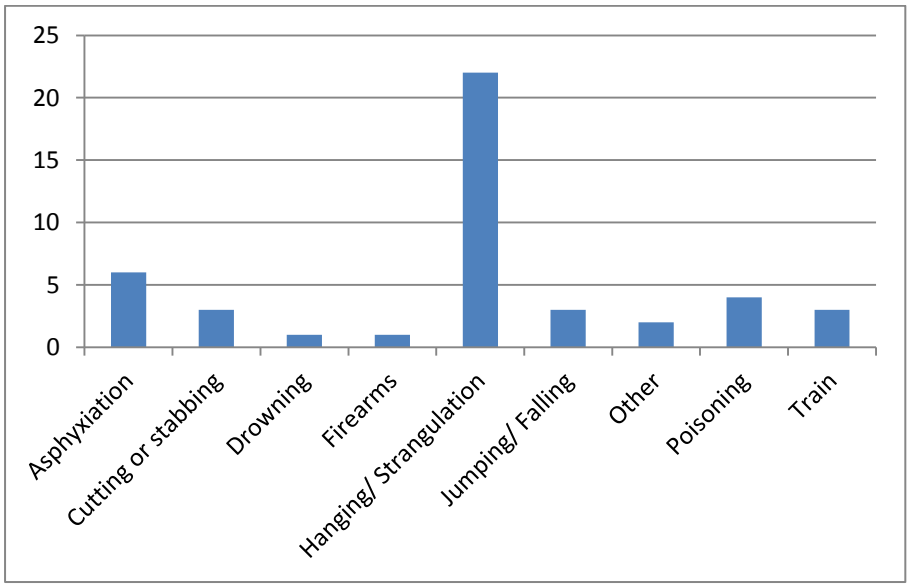


Halifax	21
Other Yorkshire	11
Other UK	10
Other non-UK	1
Unknown	2
Grand Total	**45**

Manner of Death

Manner of death was recorded for all records – although for a small number of deaths the cause of death was not clear. The data largely follows what would be expected as per the national data. One cause (asphyxiation) was notably higher than expected; this is discussed in further detail in the subsequent section.

Fig 10 - bar chart of manner of death

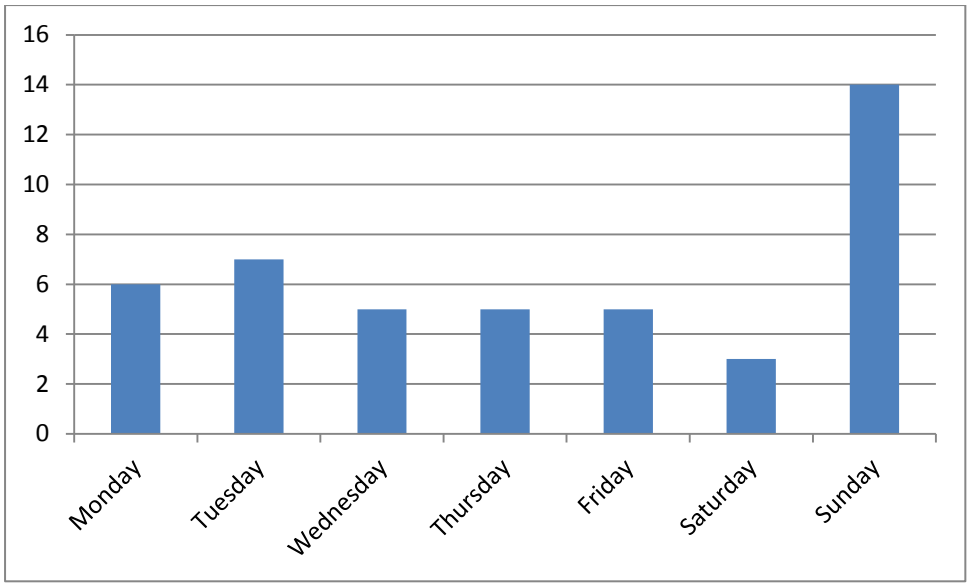


Asphyxiation	6
Cutting or stabbing	3
Drowning	1
Firearms	1
Hanging/ Strangulation	22
Jumping/ Falling	3
Other	2
Poisoning	4
Train	3
Grand Total	**45**

Day of Week

Although we are dealing with small numbers and results could be spurious there does seem to be a higher number of suicides occurring on a Sunday. As such the potential reasons for this are explored in the following section.

Fig 11 - bar chart by day of the week

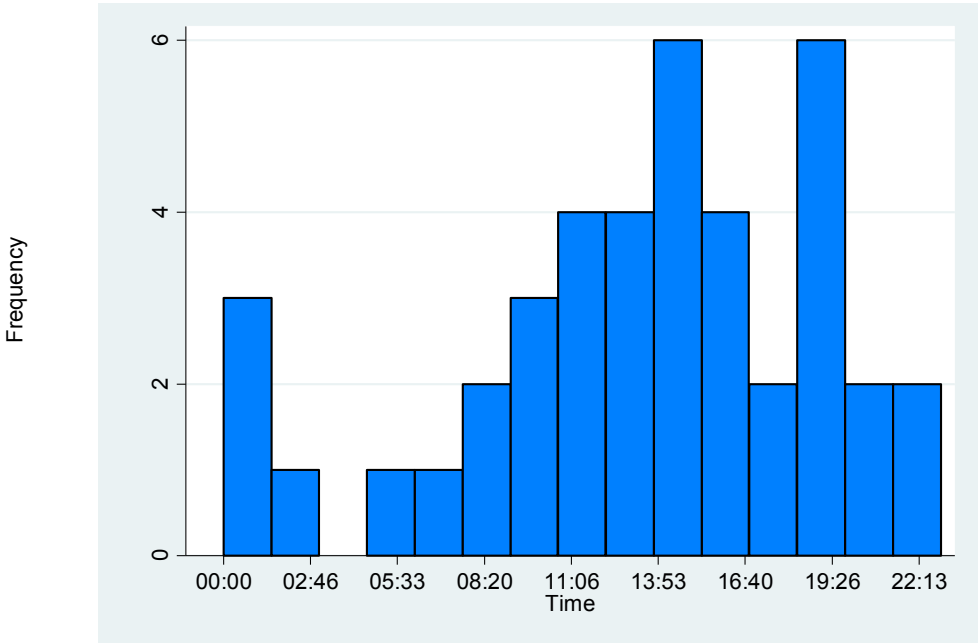


Monday	6
Tuesday	7
Wednesday	5
Thursday	5
Friday	5
Saturday	3
Sunday	14
Grand Total	**45**

Time of Day

There was a spread of times of death throughout the day and although there were two peaks in times of day (at about 2pm and 7pm) the numbers are so small it is difficult to comment upon.

Fig 11- histogram by time of day

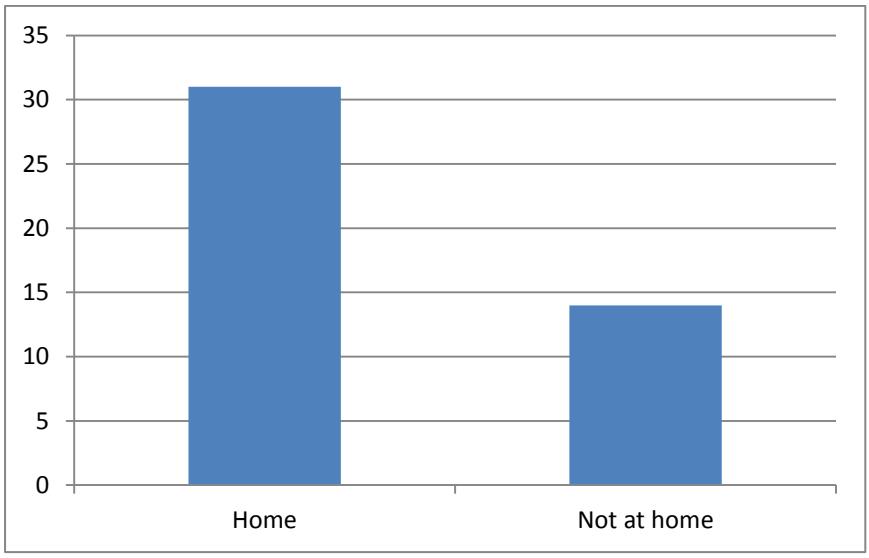


Place of Death/ Suicide Attempt

When classifying place of death it became difficult to not comment on numbers that were incredibly small therefore they were divided into those that occurred within the home and those that occurred outside of the home. Although the majority occurred

within the home it is important to note those that happened outside of the home as these provide a clear intervention opportunity.

Fig 12- bar chart by place of death



Home	31 (69%)
Not at home	14 (31%)

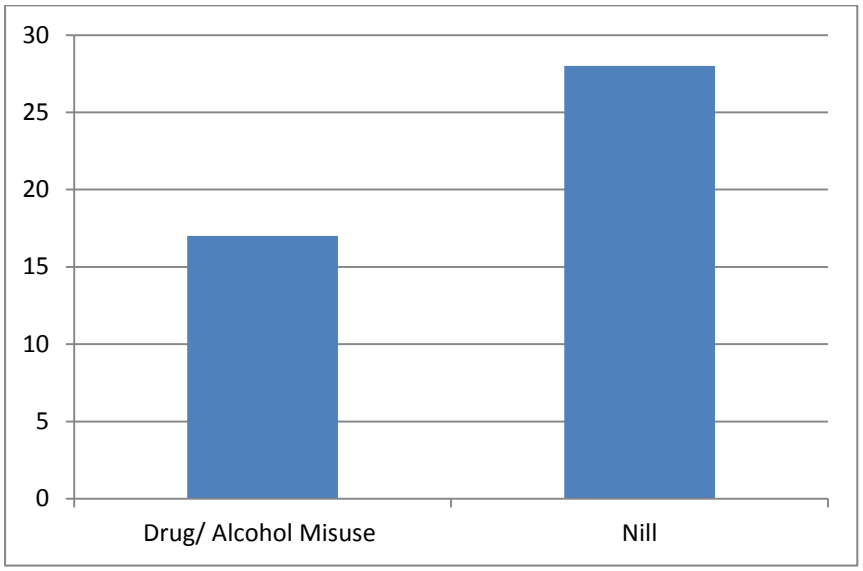
Of those occurring outside of the home, the leading causes of deaths were from a bridge (21%) in a rural area (21%) and on train tracks (21%).

Indication of Drug or Alcohol Misuse

The following information was taken from a number of sources including the toxicity reports of the post mortems, GP records and witness statements. Some of the recorded substances were present at time of death and others were recorded because the deceased had had a substance misuse problem in the past. It may be of potential note that all three of the deceased under the age of 30 were cannabis users. If there was no mention of substance misuse this was recorded as nil. It should also be noted that the numbers may add up to more than the number of suicides as individuals may have had more than one substance recorded.

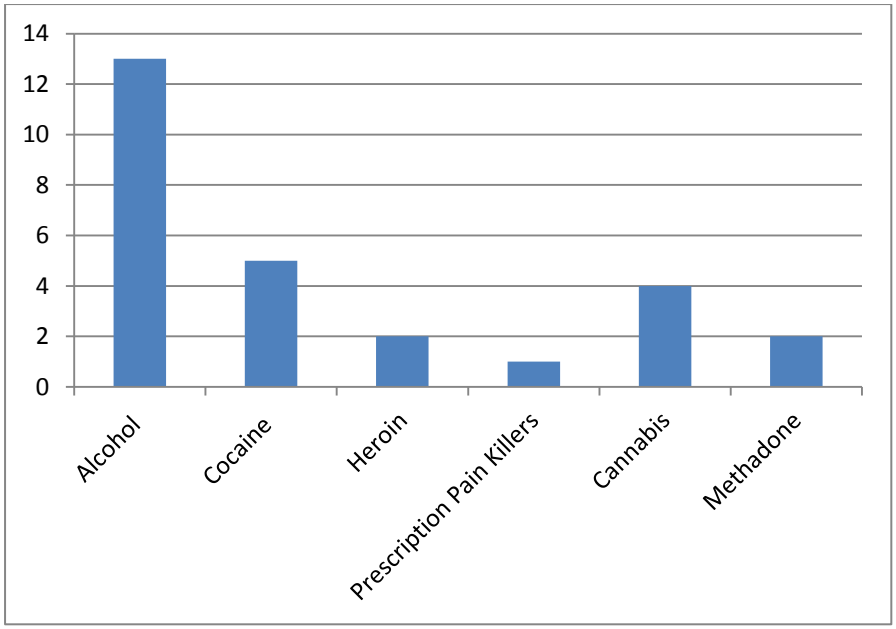
A further audit specific to substance misuse is currently being conducted in Bradford and it may be possible to get further information on this.

Fig 13 - bar chart comparing numbers of those with a history of substance misuse versus those without



Drug/ Alcohol Misuse	17
Nil	28

Fig 14 - of those with substance misuse recorded, bar chart displaying substance



Alcohol	13
Cocaine	5
Heroin	2
Prescription Pain Killers	1
Cannabis	4
Methadone	2

Previous Suicide Attempt

This is discussed in the narrative section due to issues with coding.

Contact with services

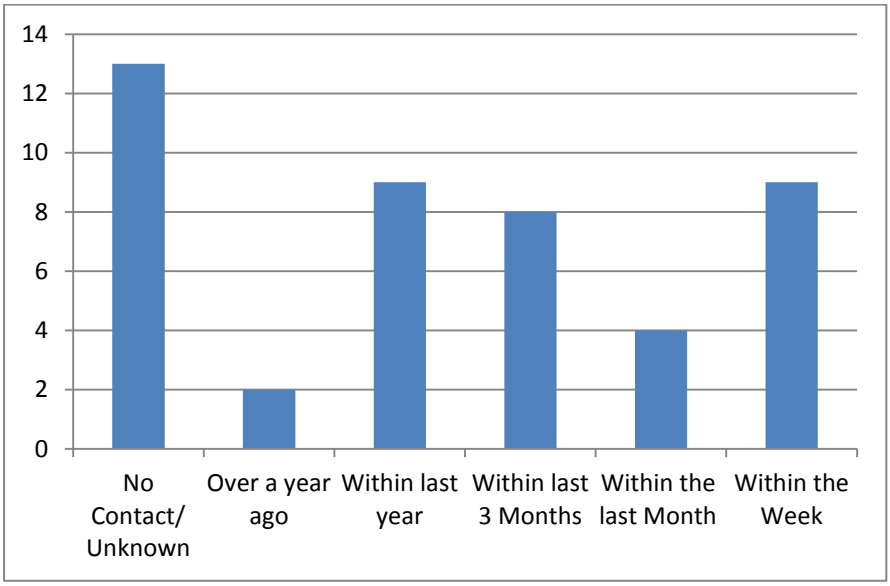
As with the majority of the data – caveats apply. For example, if a person was under the care of a specialist hospital/ in prison it may be unlikely they would see their GP during that period. Therefore a recoded 'no contact' may not represent a lack of

contact with health care professionals. Additionally although we attempted to identify contact with A&E and specialist services the information recorded in the audit was not always sufficient. It would seem that most individuals did not have contact with A&E or specialist services.

Contact with GP

The information on contact with GP was usually obtained from the statements sent via the GP to the coroner and was placed in the records. This was not done in every case. 67% of people had contact with their GP up to a year prior to their death.

Fig 15 - bar chart displaying last known contact with GP

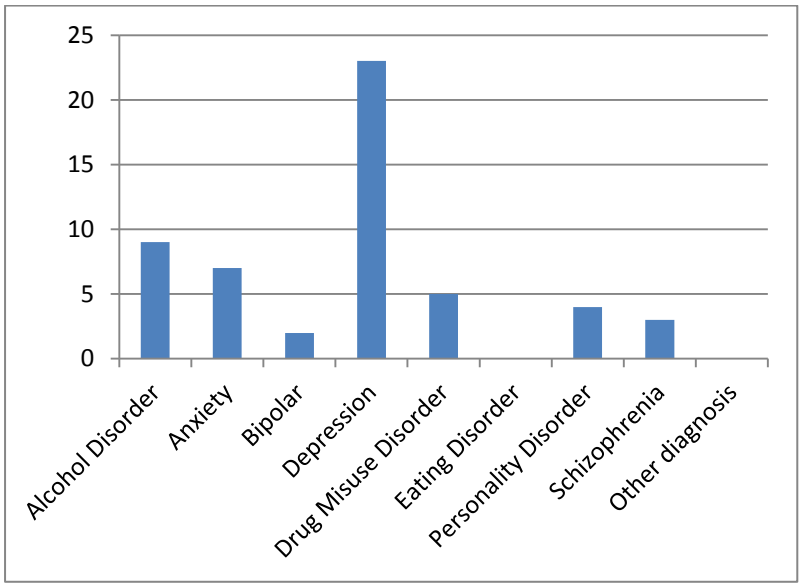


No Contact/ Unknown	13
Over a year ago	2
Within last year	9
Within last 3 Months	8
Within the last Month	4
Within the Week	9
Grand Total	45

Mental Health Diagnosis

GP records were available for most individuals and allowed for coded diagnosis of mental ill-health to be identified. However, this was not available for all records and not all were followed up. In some cases witness statements and other forms of evidence were used to identify mental ill-health if reference was made to certain conditions such as depression and personality disorder.

Fig 16 - bar chart displaying mental health diagnosis if one was recorded

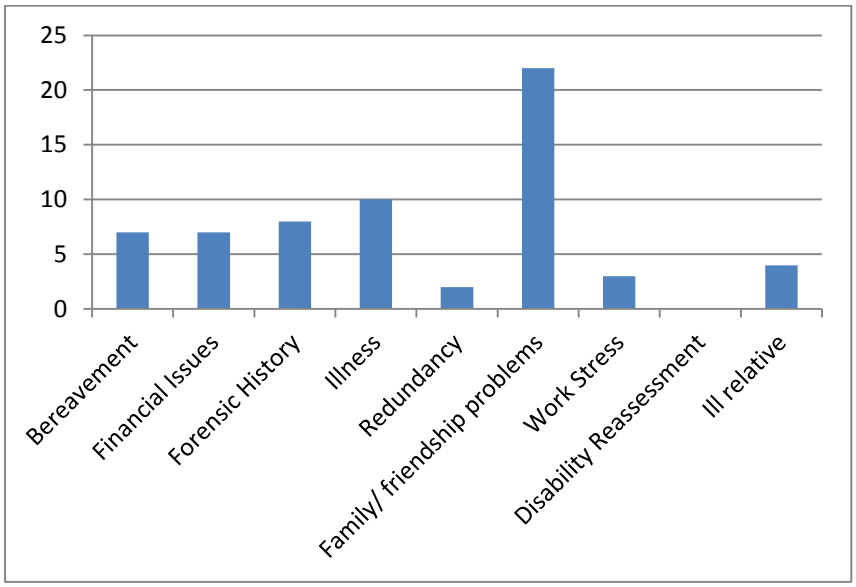


Alcohol Disorder	9
Anxiety	7
Bipolar	2
Depression	23
Drug Misuse Disorder	5
Eating Disorder	0
Personality Disorder	4
Schizophrenia	3
Other diagnosis	0

Identified Risk Factors

Note: numbers below may not add up to the number of suicides as individuals may have several apparent risk factors.

Fig 17- bar chart displaying risk factors if present



Bereavement	7
Financial Issues	7
Forensic History	8
Illness	10
Redundancy	2
Family/ friendship problems	22
Work Stress	3
Disability Reassessment	0
Ill relative	4

Narrative / Themes

As part of the audit proforma, space was left to enable free text of particular note to be written by the audit team. The aim of this was to allow for certain themes to be pulled out that may not otherwise be captured. These have been categorised below according to specific area to allow for recommendations to be made.

Manner of death

In terms of poisoning by overdose, prescription medication was used the most but these numbers were still small. In certain circumstances this poses particular challenges where the medication used is essential and also life threatening at toxic levels. In these cases, good practice guidance has recommendations surrounding the need for appropriate review prior to issuing repeat prescriptions and sharing of medical records prior to prescribing drugs[11]. In many circumstances, this audit found that weekly or daily prescriptions were issued for a period of time. Unfortunately, in one circumstance a different method was then used. Zopiclone, a hypnotic drug or sleeping tablet is a commonly prescribed drug in small quantities and often not on repeat; however in one circumstance it was prescribed by a new GP unaware of a patient's past history and the past refusal of other GPs to prescribe the drug because of overdose risk.

Asphyxiation as a cause of death was noted to be higher than expected, in particular, using helium as a gas of choice. Nitrogen and carbon monoxide were also used but helium was used the most frequently and also mentioned several times in records where the cause or method was determined to be different. In terms of ease of access and reducing means, this is a particular important point to note.

Demographic information

Overall, the audit highlighted that there are certain categories that are poorly recorded and therefore it makes it particularly difficult to target interventions and services at different demographics. Both sexual orientation and ethnicity were poorly recorded throughout the records that the audit team reviewed. Data was frequently recorded as 'presumed' or 'unknown.' This in itself allows for future discussion on data recording to implement change. Although there is limited information on targeting suicide prevention interventions at specific ethnic groups it is important to understand what is happening within certain groups. There is more information related to sexual orientation and suicide risk and so it is important to ascertain how Calderdale compares in these areas.

As discussed earlier, there are several issues with the recording of a death of a child as a suicide. Although a coroner is able to give a verdict of suicide for those as young as 10 years old there is known subjectivity between coroners with regards to classifying children's deaths as suicides. The rates, as highlighted in this audit, may be lower than actually the case but this should not prevent child suicides being considered as an issue.

Although there were small numbers, by far the most common day that suicides occurred were on Sundays. There is very little specific evidence related to this but it should be considered if this is related to access to services on this day. There are currently plans and funding to set up a crisis café or safe haven, which may act as a place for support for people who may be developing a mental health crisis. It is aimed that this will be open on certain evenings and weekends.

[11] http://www.gmc-uk.org/Prescribing_guidance.pdf_59055247.pdf

Risk Factors

The common risk factors quoted in research were added to the proforma to capture a snapshot of the risk factors in the lives of the people who were included within the audit. This does not mean that these were the only risk factors and in several instances no risk factors at all were noted. Interestingly all those who took their own life who were under the age of 30 also had a history of cannabis use but as the numbers are small it is difficult to draw conclusions. Although not specifically included as a risk factor in the data collection, several of the people who were included within the audit had made reference to knowing people who had taken their own lives themselves and this should be noted in terms of recommendations for bereavement support.

Marital and relationship breakdown was identified as the biggest risk factor within this audit. This highlight the need to consider how those suffering from inter-personal relationship difficulties may be better supported.

The other two main risk factors identified both within this audit and nationally are those living alone and those struggling financially. The importance of social relationships and particularly social isolation should be considered and also the impact of the current financial climate. It is expected that in this time of austerity, financial uncertainty may worsen and this could be considered when deciding where best to target services.

Although there is no prison within Calderdale, it is a known risk factor that those with a forensic history have a higher risk of suicide. Several of the people included within this audit fell into this category.

The audit attempted to identify physical ill-health which may have contributed to the suicides. Although a range of physical ill-health was mentioned in regards to recent GP visits it was not obvious that these conditions (e.g. persistent cough, hypertension) contributed to the suicide. However, from the witness statements and, in some circumstances, suicide notes a number of themes related to physical ill-health may be identified. Firstly, there were numerous individuals who took their lives shortly after being refused a kidney transplant due to physical ill-health. Secondly although the causes were heterogeneous there were a number of suicides for which living with chronic pain was cited as a contributory factor. This was most apparent in older individuals.

Contact with Services

The majority of people included within the audit had no known contact with specialist services reflecting the current known national evidence. This makes targeting interventions harder and makes it particularly difficult for services to spot red flags. It is therefore important to consider more upstream prevention and the need for population resilience programs related to risk factors outlined above.

Previous Self Harm and Suicide

Although there was a clear aim to investigate episodes of previous self-harm and suicide this was particularly difficult given coding issues that we came across during the audit. There was a difference in documentation as to whether a previous suicide attempt constituted a history of self-harm and this made it particularly difficult to draw any inferences between the two. There was also some confusion where family members in witness statements alluded to previous suicide attempts or self-harm but no mention of this was found in medical records or it contradicted other information.

Recommendations

To ensure consistency with national and regional activities aimed at reducing suicides the recommendations that follow are informed by the local audit but structured under the areas for action advocated by the government strategy and are in line with national evidence to 'make it happen locally'.

Reduce the risk of suicide in key high-risk groups

There are a number of high risk groups - as identified in the government's preventing suicide in England strategy. Based on the information identified in the local audit a number of tentative recommendations may be made in regards to a number of these groups:

Young and middle-aged men

1. Those who work with men in different settings, especially primary care, need to be particularly alert to the signs of suicidal behaviour. This mirrors the findings of this local audit in which 55% of the males who took their own lives were under the age of 50.

2. Multi-agency partnership working between statutory and voluntary sector organisations need to be strengthened. Evidence suggests that multi-agency partnership working is key to promoting positive mental health in young men and that community outreach programmes are seen by men as more approachable than formal healthcare services for example, Men's Sheds in Halifax.

People in contact with the criminal justice system

3. Individuals arrested for or under investigation for child sex crimes are offered adequate support and risk of suicide is assessed. This may require training or awareness training to be delivered by specialist organisations. In a number of cases locally, the deceased had recently been in contact with the criminal justice system in relation to child pornography allegations. Although evidence of the police offering support to the individuals was apparent in the inquests - further assurance should be sought that timely support is available and provided.

Tailor approaches to improve mental health in specific groups

4. Routine assessment for depression as part of personalised care planning for people with long-term conditions can help reduce inequalities and help people to have a better quality of life. A high proportion of those in the local audit had depression – whether a formal diagnosis or anecdotally documented. Although some cases had no known risk factors many had a combination of those outlined above. Given the links between mental ill-health and social factors like

unemployment, debt, social isolation, family breakdown and bereavement, the ability of front-line agencies to identify and support (or signpost to support) people who may be at risk of developing mental health problems is important for suicide prevention.

Reduce access to the means of suicide

Although it is evident that the majority of suicides in Calderdale take place in the individuals' own homes and by hanging (offering little opportunity for means of reduction) there are a number of potential opportunities that may be gleamed from a small subset of the cases in the audit.

5. Further work is undertaken to assess and, if possible reduce, pedestrian access to North Bridge and Burdock Way Flyover, including the erection of signs of places of support. This recommendation is made as the audit identified two completed suicides, one past attempt and numerous suicidal ideations, which mention jumping from this location as a means of death.

6. Potential opportunities for reductions in access to gasses should be explored. In particular party/balloon shops could be targeted to increase awareness of suicide with their staff and consider reducing the access to helium. The audit identified a higher number of deaths from asphyxiation in Calderdale (not due to hanging) than would be expected from national statistics. In regards to these deaths nitrogen, helium and carbon monoxide were used alongside plastic bags as means of death.

Provide better information and support to those bereaved or affected by suicide

Every suicide that occurs affects many different people be it friends, families, colleagues and the local community. It is important to provide effective and timely support for families bereaved or affected by suicide have in place effective local responses to the aftermath of a suicide; and provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

7. Community-level interventions should be strengthened to support families and friends following suicide and to help prevent 'copycat' or clusters of suicides. Evidence from the national strategy suggests that this approach is effective. This approach may be adapted for use in schools, workplaces, and health and care settings. They are particularly focussed at providing bereavement support. The audit identified several cases where bereavement was a specific risk factor and several people where they have known someone who had recently died by suicide. It is important to further investigate what resources are available for bereavement support particularly in this circumstance in Calderdale.

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The portrayal of suicide and suicidal behaviour in the media is one which needs to be dealt with in a responsible and sensitive fashion. Evidence suggests that this too can lead to copycat behaviour.

8. It is recommended that local media outlets are contacted and engaged. It may be helpful to distribute the national media guidelines, developed by Leeds public health team, to the relevant places.

Support research, data collection and monitoring

9. That regular audits are conducted, including audits on accidental, narrative and open verdicts. This audit highlighted a particular need for better data collection. Ongoing audit is essential to collecting in-depth data from historical records. There was a particular problem with gaining access to other verdicts that may relate to suicide and HM Coroner will be able to assist with this information.

10. Access to real-time data on suicides and attempted suicides. In recent weeks it has been reported (but not confirmed) that there have been several suicides in a particular area in Calderdale. Public health currently only has access to historical data and real time data is only gained by sharing this information between organisations. Without this it is hard to pick up on potential clusters or a real time increase in incidence.

Following discussion, it has been decided that the police and ambulance services will be contacted to ascertain if they can provide organisations with more real time notifications of when suicides occur in Calderdale. This information can then be distributed between the suicide prevention group, crisis team and regional network. Each individual organisation can then respond as they see fit given their roles and resources and the suicide prevention group can discuss potential links and demographics if this information is available and it is felt that there is a cluster.

Appendix 1

Details collected from the audit

Case Number

Gender
- Male
- Female

Age

Postcode

Ward

Sexual Orientation
- Heterosexual
- Homosexual
- Bisexual
- Transgender
- Other
- Unknown

Marital Status
- Married
- Divorced
- Cohabiting
- Civil Partnership
- Separated
- Single
- Widowed
- Engaged
- Unknown
- Other

Home Situation
- Children under 18
- Children over 18
- Living Alone
- Living with Parents
- Living with Partner
- Other Family
- Shared Living Arrangements
- Spouse/ partner children
- Unknown
- Other

Ethnicity
- White British
- Black Caribbean
- Indian
- Mixed white/ black
- African
- Other Asian
  - Other ethnic background
- Other white background

- Pakistani
- Black African
- White Irish
- Unknown

Employment Status
- Carer
- Employed
- Housewife/husband
- Long Term Sick/ disabled
- Retired
- Student
- Unemployed
- Prison
- Other
- Unknown
- Job Role

Manner of Death
- Burning
- Cutting or stabbing
- Drowning
- Electrocution
- Firearms
- Hanging/ strangulation
- Jumping/ falling
- Poisoning
- Asphyxiation
- Train
- Other
- Unknown

Day of Week

Place of Death

Poison Substance

Drug or Alcohol Mentioned
- Timeframe
- Details

History of Self Harm

Previous Suicide Attempt

Risk factors

Bereavements
- Financial Issues
- Forensic History
- Illness/ Disability
- Redundancy
- Friendship Family Issues
- Work Stress
- Benefit Re-assessment
- Ill-relative
- Other

Contact with GP
Contact with GP time-frame
Contact with GP reason/ details

Contact with A&E
Contact with A&E time-frame
Contact with A&E reason/ details

Contact with specialist service
Contact with specialist service time-frame
Contact with specialist service reason/ details

Details on contact with other service
- Alcohol
- Anxiety
- Bipolar
- Depression
- Drug Misuse
- Eating Disorder
- Personality Disorder
- Personality Disorder
- Schizophrenia
- Other

Mental Ill-Health
- Alcohol dependence
- Anxiety
- Bipolar
- Depression
- Drug disorder
- Eating disorder
- Personality disorder
- Schizophrenia
- Other

Verdict

Other Details and Narrative / Case Summary

Appendix 2

Suicide Prevention: Dr Katie Comer, Specialist Registrar Calderdale Council

Introduction

It is estimated that about 800 000 people take their own life each year worldwide with many more who attempt suicide. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. It was the second leading cause of death among 15–29-year-olds globally in 2012[1].

The Public Health Outcomes Framework 2012-2014 indicates that the suicide rate in Calderdale is 10.5 per 100 000, higher than the national average at 8.9 per 100 000[2]. In 2010, a five-year retrospective suicide audit was undertaken for Calderdale and concluded that although Calderdale was on target to achieve reduction in the rates of suicide there was scope for some prioritisation in services. Since the data from this audit was collected national rates have increased significantly. A new audit looking at suicides from 2009-2014 has been proposed but there have been delays in gaining access to the appropriate records and data from the coroner's office. With such an important cause of premature mortality on the increase, it was decided that the scale of the problem needed to be investigated as a matter of urgency, therefore primary care mortality data (PCMD) was used to evaluate the issue further before a more in depth analysis of coroner's records could be conducted.

Methods

A review of available data was undertaken and although not providing all the information required to undertake a complete suicide audit, the primary care mortality data could provide key information in the interim and contribute to the full audit. It was decided that 2012-2014 held the most information in terms of coding and demographics of suicide so these were the year parameters used. All deaths were extracted from these years and specific searches on these deaths to narrow them down to suicide and unexplained deaths were performed. The definition of suicide and specific codes used were based on the ONS classification which includes codes giving underlying cause of 'intentional self-harm' or 'injury and poisoning of undetermined intent.' On further analysis we included any death with the ONS definition on any cause line not just the underlying cause as it became clear that without doing this some apparent suicides would be excluded. Each record was then assessed to confirm it was likely to be a suicide (e.g. adverse effects from chemotherapy was removed)

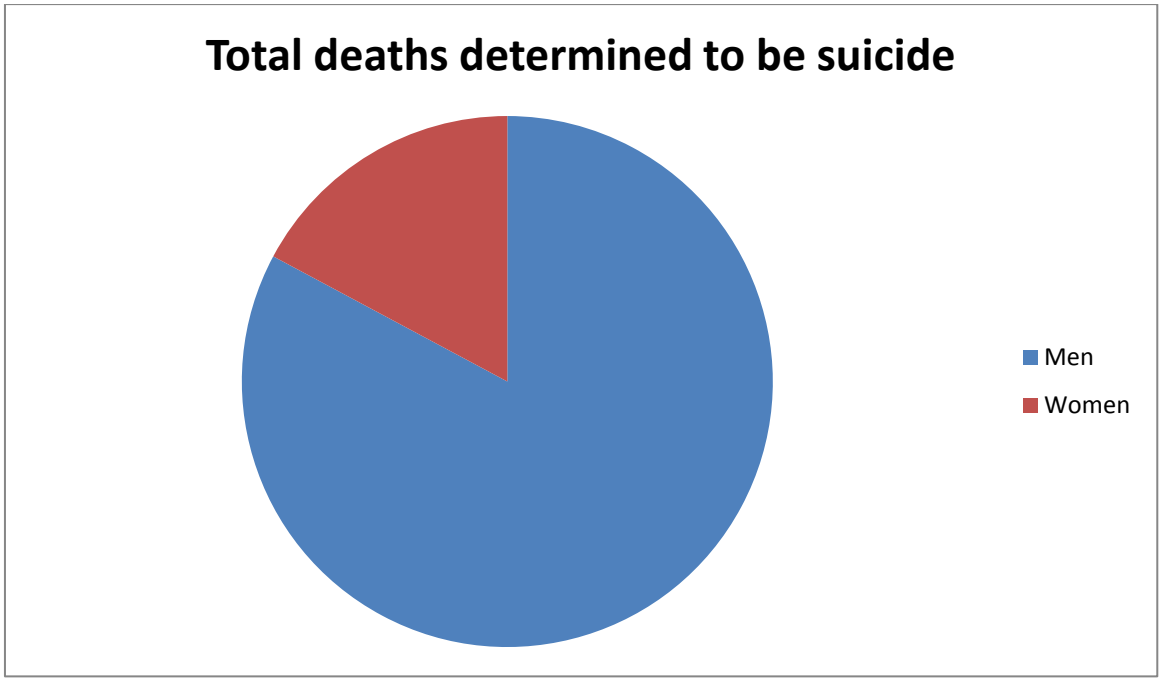
It is hoped this information can inform the full suicide audit that will be conducted using the coroner's records.

A standard for this type of audit is not easy to find. Using the Detroit model as evidence, they used a standard of zero suicides and managed to successfully reduce suicides exponentially and achieve the goal of zero suicides in the final two years of the ten year project. This extraordinary outcome came about as a result of sustained collaborations in local areas, working with those with lived experience alongside subject experts to build on good practice and identify areas for improvement.

Leading on from this the Zero Suicide Collaborative in the South West has adopted the same approach with data expected to be released soon to measure their outcomes. Although the aim is ambitious it has proven not to be unrealistic and therefore this audit would take the same approach and set the standard for zero suicides.

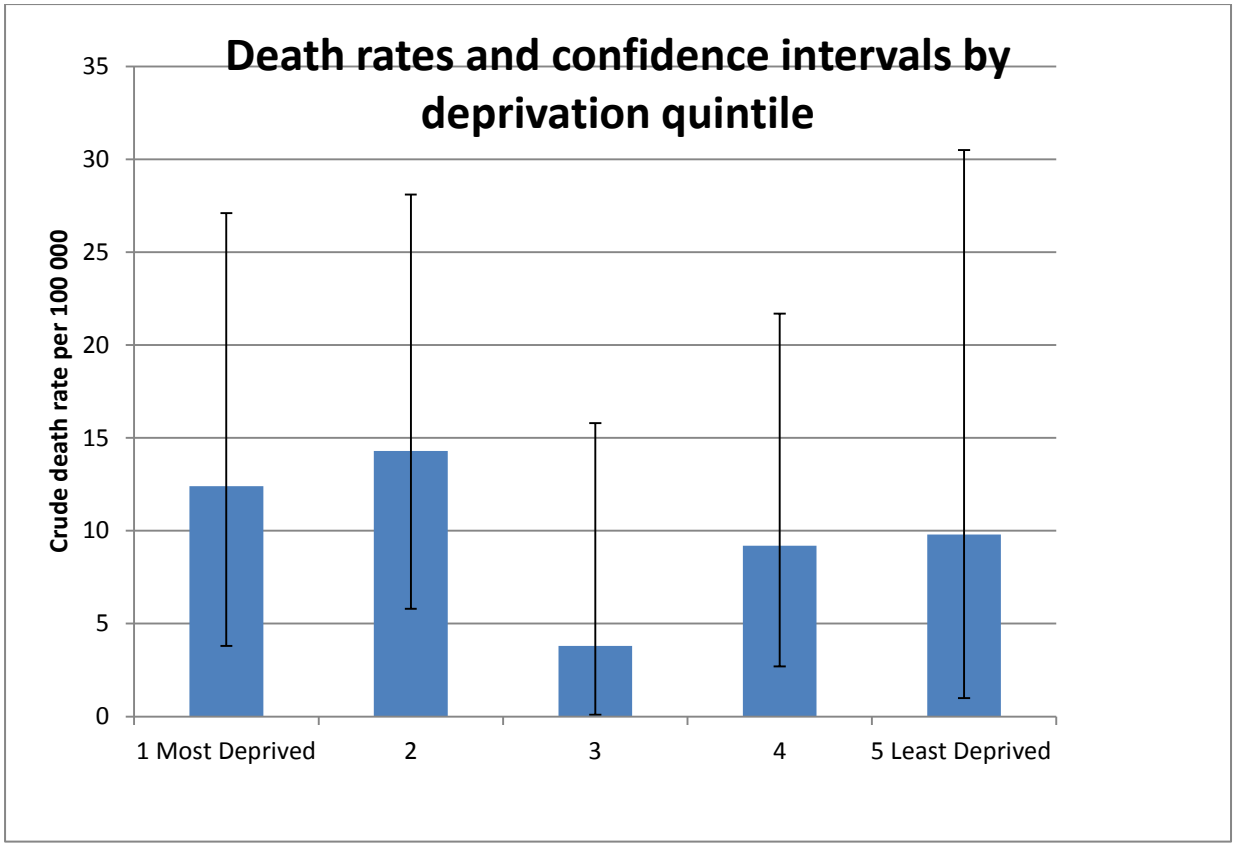
Results

This data review identified a total of 64 deaths over the period of 2012-2014, broadly matching the statistics from the public health outcomes framework. The majority of which (83%) were men with only 17% being women.



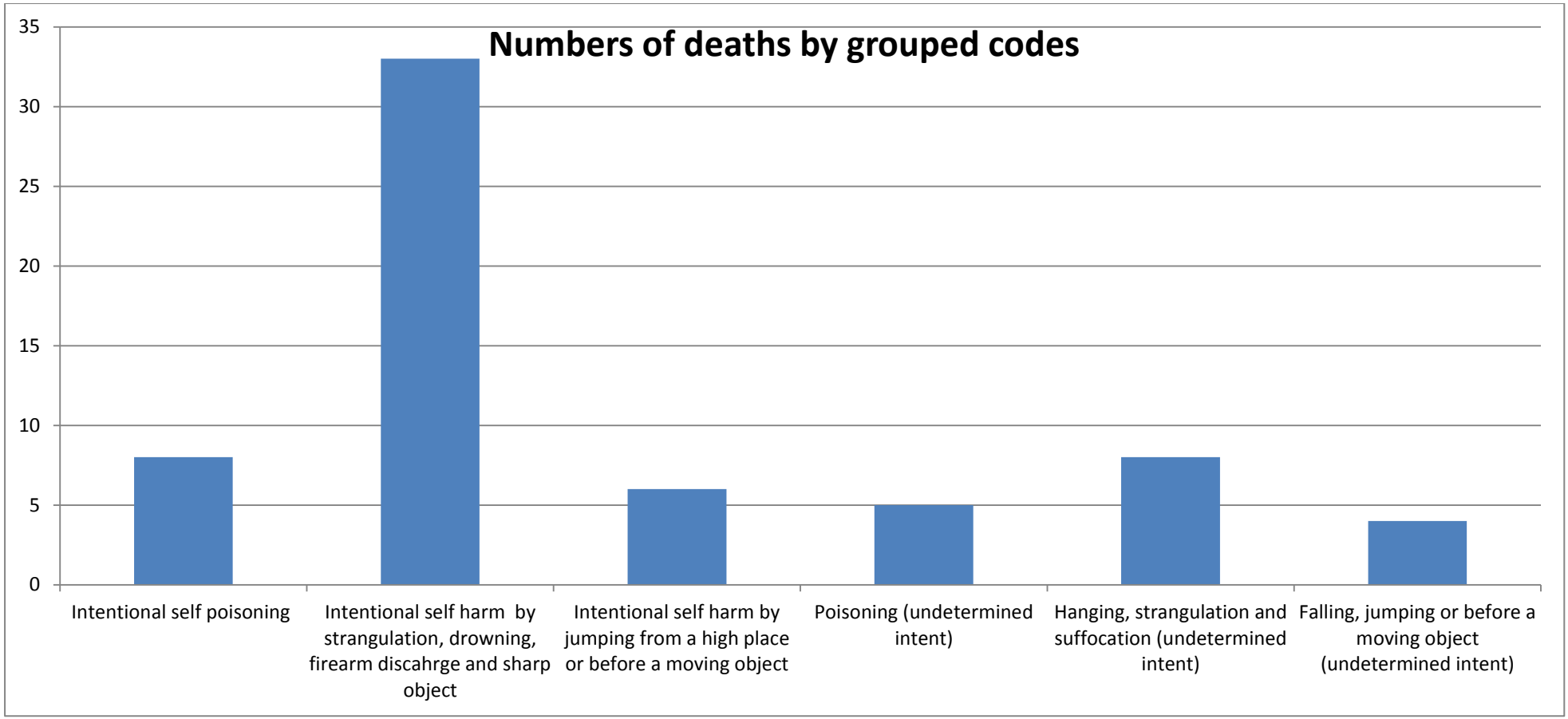
The average age of the deceased looking at all persons was 45 with a range of 13-87. The mean male age was 53 (range 13-87) and mean female age was 42 (range 22-57).

Death rates by deprivation quintile were calculated with 1 being the most deprived and 5 the least deprived. The graph below shows some clear trends but the confidence intervals are wide making it difficult to infer any statistical significance.



More analysis was conducted looking at deaths per geographical ward. The actual numbers were converted into rates to reflect the relative populations of each ward. Confidence intervals were calculated and as the numbers are so low and may not be statistical significant they have not be shown graphically. Broadly speaking however, it showed Brighouse, Elland and Calder to have the highest rates of suicide.

The chart below shows the main causes as recorded in the primary care mortality data by cause of death. The ICD 10 codes that were identified by the ONS classification have been grouped together as the numbers relating to each code were too low to display in a graphical format. They were grouped by similar codes and whether intent was known or not. The largest group was the group 'intentional self- harm by hanging, drowning, firearm discharge and self- harm with a sharp object.' Of this group the majority (85%) were coded as 'intentional self- harm by hanging strangulation and suffocation.' Further analysis showed 86% of this group were men in keeping with what we are aware of nationally about suicide methods[3].


Numbers of deaths by grouped codes
35
30
25
20
15
10
5
0
Intentional self poisoning
Intentional self harm by strangulation, drowning, firearm discahrge and sharp object
Intentional self harm by jumping from a high place or before a moving object
Poisoning (undetermined intent)
Hanging, strangulation and suffocation (undetermined intent)
Falling, jumping or before a moving object (undetermined intent)

The data collected above gives a broad picture of the scale of the problem in Calderdale. We know that suicides have been increasing across Calderdale since 2010 and are projected to increase further due to environmental factors and the current economic climate[iv]. Although the primary care mortality data provides us with base demographics and an idea of high risk groups, there are clear gaps that need to be filled by conducting a full audit using the coroner's records. This will hopefully give a clearer idea of any previous contact with services for example and other information to give a clearer picture. It is hoped that this data will be collected within the next month. It can then be used in conjunction with current strategy and policies to inform the suicide prevention group and action plan.

Strategies and policies

The foresight project produced a report entitled the 'Five Ways to Wellbeing'[v]. It explores the evidence behind five approaches to everyday life to improve overall health and wellbeing. The document looks at connecting with the people around you, being active, taking notice of the world around you, continuing to learn and giving. Each of these approaches has associated evidence to suggest they improve mental health and can improve overall wellbeing.

There are several documents published to improve mental health. The national guidance for preventing suicide outlines 6 key action areas[vi]:

1. Reduce the risk of suicide in high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support the bereaved
5. Support the media in delivering sensitive approaches to suicide
6. Support Research, data collection and monitoring

The follow up report from the national strategy called on local authorities to produce a suicide prevention action plan. It suggests a collaborative approach with the police, CCG, NHS, Coroners and Voluntary Sectors to help to prevent suicide in the community[vii].

It is hoped that using these 6 key points and the audit data we can inform a new action plan to reduce suicides in Calderdale.

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