Lancashire Suicide Audit Report

April 2013 – March 2015

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Lancashire County Council

Contents

List of tables

List of figures

List of maps

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North Lancashire, Preston and South West Districts Coroner's Office

East Lancashire Districts Coroner's Office

Blackburn with Darwen Coroner's Office

Blackpool and Fylde Coroner's Office

Executive summary

The audit covers the geographical area of Lancashire County Council.

Key Findings

- Lancashire's rate of deaths from suicide is significantly worse than the England rate.
- Within the county council, Preston has the highest suicide rate.
- In line with the national picture, the suicide rate in Lancashire is higher amongst males than females.
- Lancashire's rate of emergency hospital admissions for intentional self-harm is also significantly worse than the England rate.

Demographics

- In the audit cohort, deaths from suicide were highest in the 40-49 and 50-59 year age groups; and nearly 2.5 times higher in males than in females.
- The majority of suicides were of White British ethnicity but the representation of White Other ethnicity in the audit cohort was higher than its representation in the Lancashire population.

Deprivation and geography

- A significantly higher proportion of the deceased resided in the 20% most deprived areas compared to the 20% least deprived areas.
- There were more suicides amongst the youngest age groups in the most deprived areas, whilst there were more suicides amongst the oldest age groups in the least deprived areas.

Circumstances of death

- 70% of the deceased were single, divorced, separated or widowed and 43% of the deceased were living alone at the time of death.
- Hanging was the most common method of suicide, followed by self-poisoning.
- Of those who took their life by self-poisoning, 40% had used opiates.
- The top factors contributing to suicide were: mental illness, financial difficulties, relationship breakdown, substance misuse, bereavement, ongoing criminal investigation/recent police contact and abuse.
- Where there was an ongoing criminal investigation or recent police contact, the most common offence was child sex offences.

Mental health diagnoses and contact with services

- Nearly a quarter of the deceased had visited their GP for a mental health condition in the month before their death.
- Compared with females, a lower proportion of males had a mental health diagnosis and multiple GP consultations for mental health problems during the previous 12 months; suggesting that males may be less likely to seek and receive support.
- Compared to males, nearly twice as many females had one or more psychiatric inpatient admissions in the past 5 years and females were also more likely to have a recorded history of self-harm.
- 41% of the deceased had a history of self-harm and 43% of the deceased had a history of alcohol and/or drug misuse.
- Depression, anxiety disorders and substance misuse were the three most common mental health diagnoses amongst the audit cohort.

Key recommendations

- Recommendations made within this report have been structured around the six objectives of the national suicide prevention strategy (*'Preventing suicide in England: a cross-governmental outcomes strategy to save lives'*).

1. **Reduce the risk of suicide in key high-risk groups:**
   - The key high-risk groups where there should be focus in Lancashire are: young and middle-aged men, people that self-harm or have previously attempted suicide, people in contact with the criminal justice system (particularly those with a history of child sex offences) and people in contact with mental health services.

2. **Action is needed to improve the mental health of specific groups in Lancashire:**
   - Specific groups where tailored action is needed to improve mental health in Lancashire are: survivors of abuse or violence, people with long-term physical health conditions, people vulnerable because of social and economic disadvantage and people who misuse drugs and/or alcohol.
   - Steps should also be taken to improve the mental wellbeing of children and young people, as many factors contributory to suicide in Lancashire occurred during childhood or adolescence.
   - The extremely high proportion of unemployed and economically inactive people in the audit demonstrate that this is both a group at high risk of suicide and where action is needed to improve mental wellbeing.

3. **Reducing access to the means of suicide:**
   - The method of suicide identified as most amenable to reduced access in Lancashire is self-poisoning, where the majority of substances used were prescribed either for the subject or for somebody else.
   - Action is needed to support safe prescribing and dispensing in Lancashire, particularly of opiate analgesics and tricyclic antidepressants in primary care.

4. **Providing better information and support to those bereaved or affected by suicide.**
   - The majority of suicides in Lancashire are completed in the home and bereavement, particularly by suicide, is a common contributory factor.
   - Steps should be taken to develop more robust pathways and provision for those bereaved by suicide in Lancashire.

5. **Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour:**
   - Internet content had played a role in a number of suicides in Lancashire and there should be a robust approach to removing this content and seeking prosecutions where it has contributed to death.

6. **Supporting research, data collection and monitoring:**
   - In order to facilitate the availability of robust information to support suicide prevention work in Lancashire, future areas of focus should be the development of real-time suicide and self-harm surveillance in Lancashire.

Introduction

Suicide is the act of intentionally ending your life(1). The factors that lead to suicide are complicated and suicide is rarely the result of a single issue. However, there are many known risk factors for suicide including male gender, middle age, mental health conditions, previous suicide and self-harm attempts, physically disabling illnesses, substance misuse and stressful life events such as bereavement, debt or family breakdown(2).

Policy context

Suicide prevention is currently a national priority. The '*Five Year Forward View for Mental Health'* highlighted suicide prevention as a key area for improvement, with a national target for the number of people taking their own life to have reduced by 10% in 2020/21 compared to 2016/17 levels(3). The current key national strategy document within suicide prevention is *'Preventing suicide in England: a cross-governmental outcomes strategy to save lives'*(2). This sets out the government's strategy to prevent suicide in England and focused on six key areas(2):

1.Reducing the risk of suicide in key high risk groups;
2.Tailored approaches to improve mental health in specific groups;
3.Reducing access to the means of suicide;
4.Providing better information and support to those bereaved or affected by suicide;
5.Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour and
6.Supporting research, data collection and monitoring.

There have been regular reports on national progress against this strategy, with the most recent published in January 2017(4). Here, self-harm was added to the strategy as a separate key area for focus, in recognition of the fact that self-harm is the biggest indicator of suicide risk(4). Indeed, half of people who complete suicide have a history of self-harm(4).

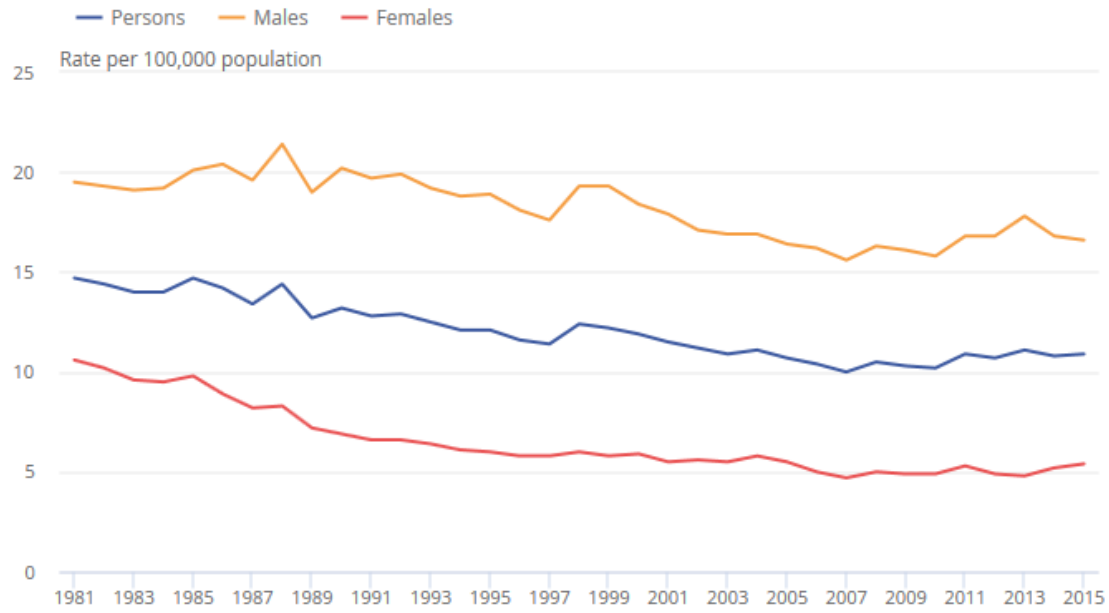
This national strategy runs alongside the government's wider mental health strategy *'No health without mental health'*(5). This recognised that, although the quality of mental health care has improved in recent years, too much emphasis has been placed on structures and processes rather than outcomes(5). The strategy set shared national objectives to improve services and to transform public attitudes towards mental health(5). A key measure within the strategy was that fewer people should suffer avoidable harm, with suicide rates placed within the Public Health Outcomes Framework(5). The on-going national focus on suicide is also evident through the *'Preventing suicide in community and custodial settings'* guideline that is currently being developed by the National Institute for Health and Care Excellence (NICE) at the request of the Department of Health(6).

Locally, suicide is also a priority. Health partners in English regions have been required to develop Sustainability and Transformation Plans (STPs) that address national priorities, including suicide(3). The suicide component of these plans is required to focus strongly on primary care, substance misuse and to incorporate evidence-based preventative interventions that target high-risk locations and high-risk groups within their population, drawing on localised real-time data(3). Analysis within the *'National Confidential Inquiry into Suicide and Homicide by People with Mental Illness'* demonstrated that of the 44 STP footprints across England, Lancashire and South Cumbria had the second highest suicide rate in 2012-2014 (12.6 per 100,000 population)(7). The Lancashire and South Cumbria STP has recognised this and has prioritised prevention and early intervention to reduce suicide(8). The data and insight generated by this suicide audit will be integral to meeting these objectives.

National trends in suicide

Since the 1980s, suicide rates in the United Kingdom (UK) have been decreasing, reaching a historical low in 2008-2010 (Figure 1)(2,9,10). Rates then increased between 2010 and 2013, a phenomenon attributed by some to the effects of the global financial crisis and the subsequent economic recession(11). Indeed, there is growing national and international evidence that a poor economic climate is associated with increased rates of suicide(12,13). This demonstrates the volatile nature of suicide rates and the need to be responsive to emerging risks(2). The most recent data from 2015 show a slight increase from the 2014 rate; this was made up of a decrease in the male suicide rate and an increase in the female rate, the highest female suicide rate since 2005. However, the UK's suicide rate remains low compared to other European countries(2,9). In 2015, there were 6,188 suicides in the UK, accounting for 1.0% of all deaths(9,14).

Figure 1: Age-standardised suicide rates by sex in the UK, deaths registered between 1981 and 2015(9)



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Gender and age

The suicide rate amongst males is consistently around three times higher than that of females across all ages in the UK, although greater reductions have been seen in male suicide, with female rates remaining more stable(9). Nevertheless, suicide remains the leading cause of death in men under the age of 50(4). Males aged 45-59 years continue to have the highest suicide rate and males aged 30-44 years the second highest, although the incidence is falling in both groups(9). In contrast, males under 30 years have the lowest male suicide rate, but this is increasing(9). Similarly, females aged 45-59 years consistently have the highest suicide rate and those aged 30-44 years the second highest(9).

Socio-economic status

As well as variation by sex, suicide rates vary considerably according to socioeconomic characteristics, with suicide rates reflecting wider inequalities. People in the lowest socioeconomic group and living in the most deprived geographical areas are ten times more likely to complete suicide than those in the highest socioeconomic group living in the most affluent areas(10).

Means of suicide

The most common method of suicide in the UK is hanging, with rates of hanging increasing in recent years, potentially as a consequence of other methods becoming less accessible; for example, the impact of catalytic converters in cars in reducing suicides by carbon monoxide poisoning(9,15). Self-poisoning is the second most common method of suicide nationally(9).

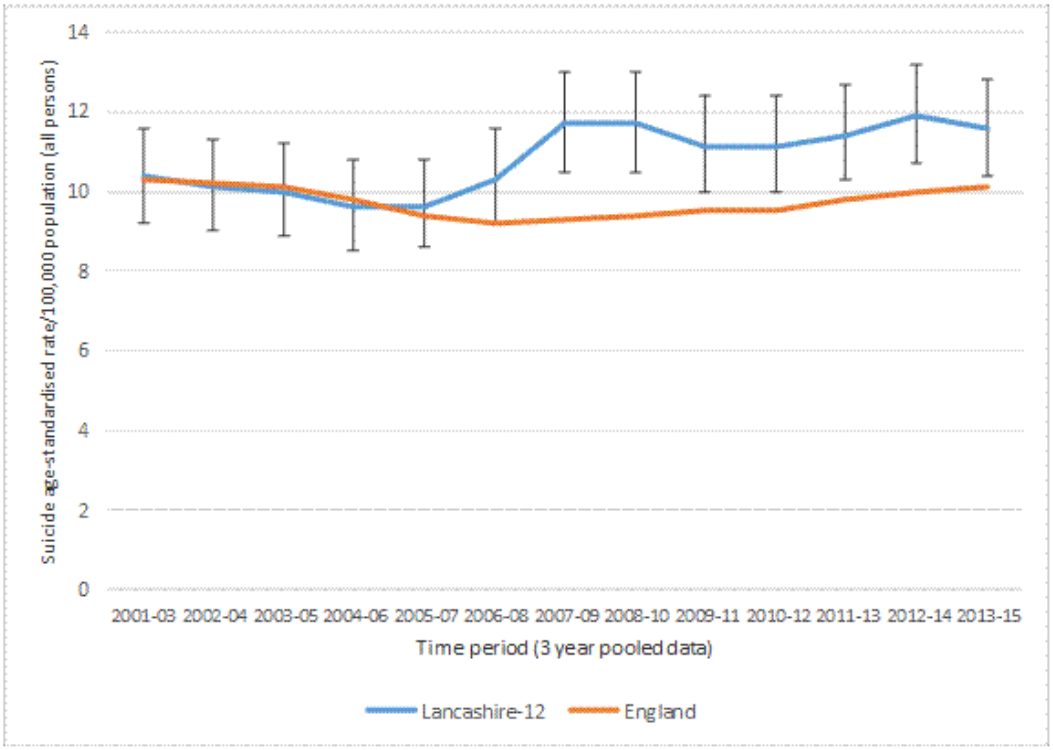
Suicide in Lancashire

Trend over time

Suicide rates in Lancashire are high. Amongst women under 30 years old and males under 40 years old, suicide is the leading cause of death in Lancashire. Overall suicide rates (all persons), female suicide rates and years of life lost due to suicide (all persons, males and females) are significantly higher than the national figures and Lancashire does not perform significantly better than the national average on any suicide indicator(16). Figures released in 2016 by the Office for National Statistics (ONS) showed that between 2012 and 2014, of 326 unitary and district authorities, Preston had the highest suicide rate of all English local authorities and Hyndburn the seventh highest rate(9). Using more recent pooled data between 2013 and 2015, Preston continues to have the fourth highest suicide rate and Hyndburn the twenty-seventh highest(16).

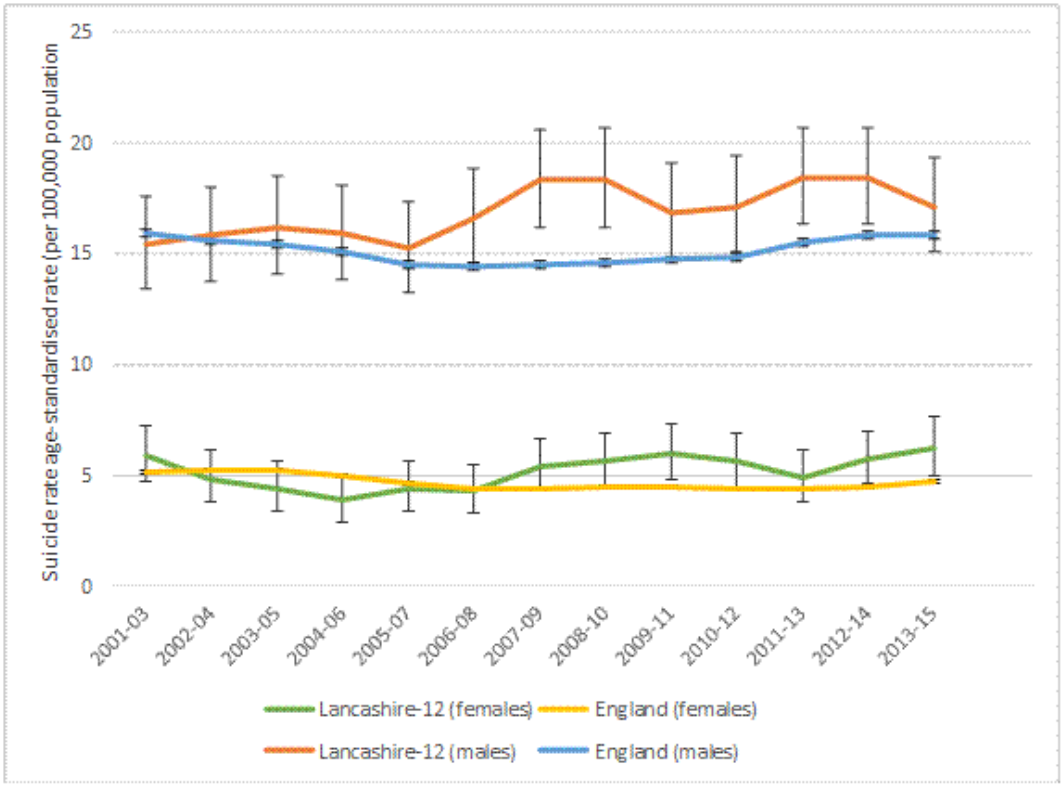
As displayed in Figure 2, suicide rates in Lancashire were in line with national figures until 2005-2007, after which rates in Lancashire increased and have remained significantly higher than the national figure since 2007-2009. This is demonstrated by the 95% confidence intervals that do not contain the national value. This divergence from the national figure has been more pronounced for males than females, as can be seen in Figure 3. Data is presented using three-year pooled averages because these provide a more resistant measure for local data, where yearly numbers are relatively low and fluctuate widely due to random error.

Figure 2: Trend in suicide rate in England and Lancashire – all persons, 2001-2003 to 2013-2015



Data source: Public Health England Suicide Prevention Profile(16)

Figure 3: Trend in male and female suicide rate in England and Lancashire, 2001-2003 to 2013-2015



Data source: Public Health England Suicide Prevention Profile(16)

These high rates are concerning for several reasons. Firstly, every suicide is a tragedy and the effects reach far into communities(10). The loss of a family member or friend by suicide can be shattering and leaves people with feelings and questions that they never come to terms with; indeed, this renders people at a higher risk of mental illness and suicide themselves(4,17). Alongside family and friends, suicide profoundly affects wider communities, including neighbours, colleagues and professionals such as healthcare staff and police whose work brings them into contact with suicide(2). There is also a serious economic impact and the cost of each death by suicide of someone of working age is estimated to be £1.67 million, with 60% of this attributed to the impact of suicide on those bereaved(4,10). Because of these costs, one European study demonstrated that if an area-wide suicide prevention intervention were to achieve only a 1% reduction rate in the number of suicides, this would still be highly cost-effective(18).

The districts of Lancashire County Council

As can be seen from Table 1 and Map 1, although the rate for Lancashire as a whole is above the national average, the only two districts where suicide rates in recent years have been above those of England are Preston and Hyndburn. Of these, it is only Preston where the rate is persistently significantly higher than the national average.

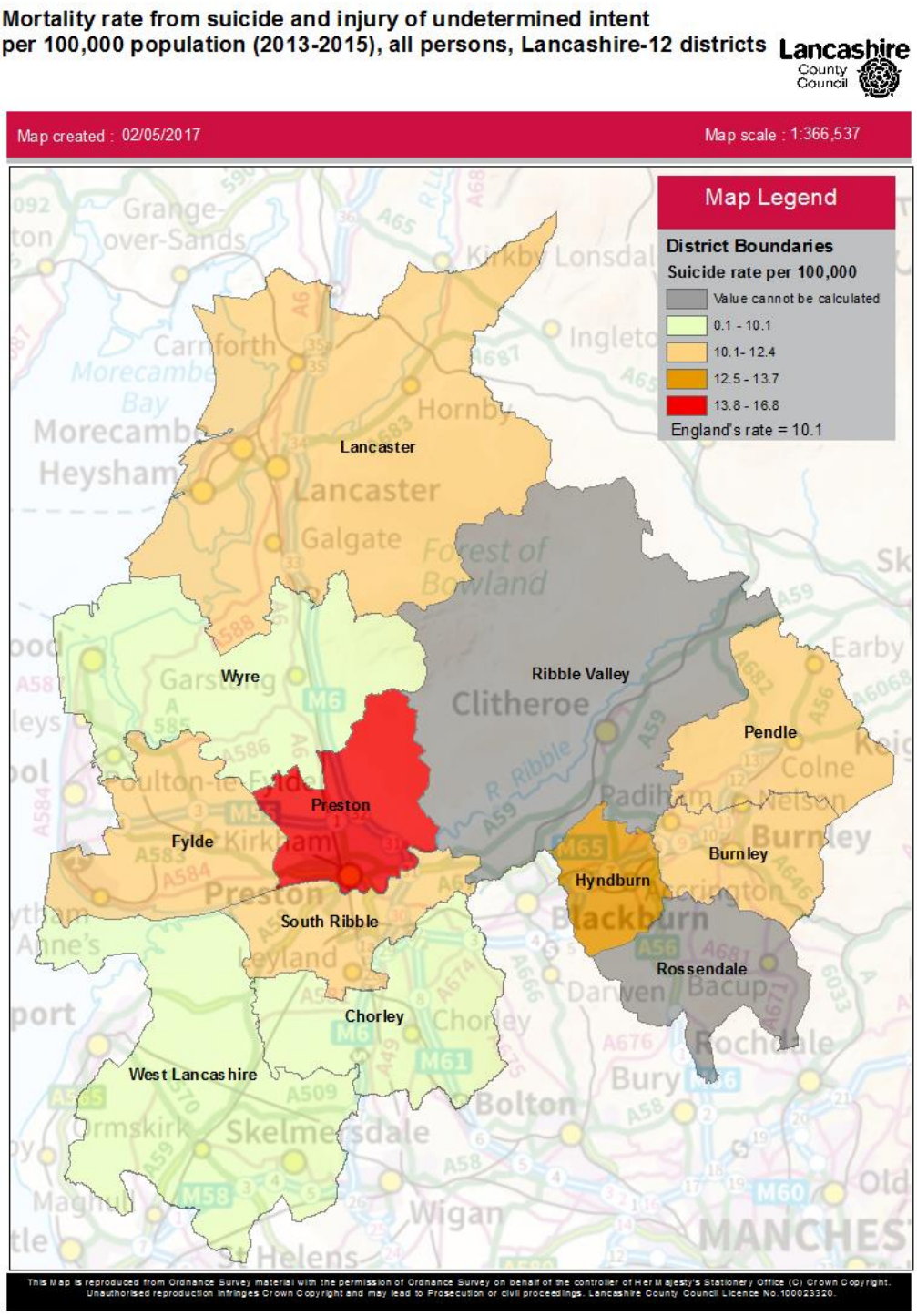
Table 1: Age-standardised mortality rate from suicide per 100,000 population, all ages, Lancashire

Area	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Burnley		11.4		10.8	12.2	10.5				11.3	11.5
Chorley				13.5	15.8	14.2	9.7	8.5			8.7
Fylde										11.8	11.7
Hyndburn					12.0		12.7	14.6	14.5	16.3	13.7
Lancaster	9.2	7.8	8.5	9.4	8.6	9.2	9.9	11.8	11.1	11.8	12.2
Pendle	12.1					12.3	11.1	10.9	12.2	13.7	12.4
Preston	11.3	11.8	13.0	12.0	15.9	13.8	14.6	14.6	16.7	18.6	16.8
Ribble Valley											
Rossendale			15.8	15.2	19.3	17.1	17.3				
South Ribble	11.7	12.9	11.1	10.1		9.4	11.2	14.6	14.6	13.5	11.3
West Lancashire	9.7				9.3	9.3	9.1	8.8	10.9	9.6	8.7
Wyre	10.3			10.0	11.7	13.7	11.7	10.1		10.4	9.2
Lancashire-12	**10.0**	**9.6**	**9.6**	**10.3**	**11.7**	**11.7**	**11.1**	**11.1**	**11.4**	**11.9**	**11.6**
England	**10.1**	**9.8**	**9.4**	**9.2**	**9.3**	**9.4**	**9.5**	**9.5**	**9.8**	**10.0**	**10.1**

Source: Public Health England, Public Health Outcomes Framework

Significantly worse than England
Similar to England
value cannot be calculated as number of cases is too small

Map 1: Map showing mortality rate (2013-2015) from suicide across Lancashire

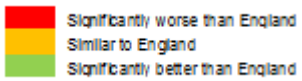


Data source: Public Health England, Public Health Outcomes Framework

Hospital admissions from intentional self-harm

Self-harm is an expression of personal distress. Following an episode of self-harm, there is a significant and persistent risk of future suicide. In Lancashire, the most recent figures (2015/16) demonstrate that the rate of hospital admissions for self-harm for the county remains significantly worse than the England rate. Looking at individual districts, presented in Table 2, the rates in Burnley, Chorley, Fylde, Hyndburn, Lancaster and Wyre are significantly worse than the England rate.

Table 2: Emergency hospital admissions for intentional self-harm, all ages, all persons, Lancashire



District	2012/13	2013/14	2014/15	2015/16
Burnley	345.9	332.9	345.1	294.6
Chorley	218.2	289.7	243.4	233.6
Fylde	266.3	203.6	242.7	257.0
Hyndburn	317.6	341.1	309.5	295.0
Lancaster	316.6	290.5	278.6	274.0
Pendle	235.0	277.5	217.9	206.2
Preston	224.9	247.1	192.5	200.3
Ribble Valley	153.8	190.9	203.8	188.0
Rossendale	235.1	286.4	240.5	222.0
South Ribble	188.6	196.6	138.0	189.4
West Lancashire	234.0	225.2	218.9	204.7
Wyre	237.2	273.8	264.4	277.5
Lancashire-12	**246.8**	**260.8**	**236.1**	**235.0**
England	**189.6**	**205.9**	**193.2**	**196.5**

Source: Public Health England, Public Health Outcomes Framework

The role of suicide audit

Suicide is often the end point of a complex set of risk factors and circumstances and it is essential that suicide prevention work addresses this complexity(2). Publically available data on suicide is limited and provides little information about the factors in somebody's life that culminated in suicide. Suicide audit provides the opportunity to examine each local suicide in depth and to form a picture of the situation and issues that led a person to end their life. This allows a rich understanding of factors that increase the risk of suicide in a local area, which may differ from the national picture. These can then be targeted through suicide prevention activities.

The most recent report on progress against the national suicide prevention strategy emphasised the need for local suicide prevention plans in all areas to be informed by local data, of which suicide audit forms a major component(4). Linked to this, Public Health England (PHE) recommends that regular suicide audit is essential to local implementation of the national suicide prevention strategy(10). This suicide audit is the first that has been undertaken since Public Health responsibilities transferred to Lancashire County Council from Primary Care Trusts in 2013.

Aims and objectives

Aim

The aim of this suicide audit was to describe suicide trends in Lancashire between 2013 and 2015 and to look in depth at individual suicides in order to learn lessons that may help to prevent future suicides.

Objectives

1. To describe patterns of suicide in Lancashire over the two year period between April 2013 and March 2015;
2. To describe contact with services amongst Lancashire residents who completed suicide;
3. To compare suicide in Lancashire with the national picture;
4. To identify factors that increase the risk of suicide in Lancashire;
5. To make recommendations based on local data and national policy and evidence to help prevent future suicides in Lancashire.

Methods

The suicide coding process

All deaths by suspected suicide are referred to the local coroner, who conducts an investigation and inquest to determine a verdict as to the circumstances of death(19). In Lancashire there are four coroner's offices (Table 3).

Table 3: Table listing the four coroner's offices in Lancashire and the districts that they serve

Coroner's office	Districts encompassed
North Lancashire, Preston and South West Districts	Preston, Chorley, South RIbble, Wyre, West Lancashire and Lancaster
Blackburn with Darwen	Blackburn*, Hyndburn and Ribble Valley
Blackpool and Fylde	Blackpool* and Fylde
East Lancashire Districts	Pendle, Burnley and Rossendale

*Unitary authorities not encompassed within the Lancashire-12 region and outside the scope of this suicide audit

Where the death is determined beyond reasonable doubt to have been intentionally self-inflicted, the coroner assigns a suicide verdict(20). Where this cannot be established beyond reasonable doubt, an open verdict is given(20). The death cannot be registered until the inquest is complete. Upon registration of death, suicide verdicts are assigned a code between X60-X84 from the International Classification of Diseases 2010 (ICD-10), denoting intentional self-harm(21,22). In contrast, open verdicts are assigned an ICD-10 code between Y10-Y34, denoting injury/poisoning of undetermined intent(22). In England, it is generally assumed that the majority of open verdicts represent suicide(23). Thus, the ONS and PHE define suicide as all suicide verdicts in individuals aged 10 years and above and all open verdicts in individuals aged 15 years and above(21). This was the definition utilised in this audit and that is referred to where the term "suicide" is used throughout this document.

Case ascertainment

Case definition

The case definition for inclusion in the audit was as follows. The case:

- Met the ONS definition of suicide(21);
- Was resident within the Lancashire-12 area;
- Died between 1 April 2013 and 31 March 2015 and
- The inquest was conducted by one of the four Lancashire coroners.

The above time period was chosen because, depending on the circumstances of death and the subsequent investigation, there can be a delay of months or even years between the date of death and the inquest completion(19). Thus, by allowing a period of 18 months between the final date of death and commencement of data collection, it was hoped that all suicides within the above time frame would be encompassed.

Case finding

Each year Lancashire County Council's public health intelligence team apply for access to the Primary Care Mortality Database (PCMD) for Lancashire residents. This centrally held database is updated monthly with details of all deaths registered in the preceding month(24). Using this dataset, cases were identified using the date of death and ICD-10 code.

Data collection

The four coroners' offices were contacted and permission gained to view their files. These contain information on demographic details of the deceased, contact with services such as primary and secondary healthcare and the criminal justice system, police records, post mortem and toxicology reports and testimony from family, friends and other relevant personnel. Using a standard proforma to guide data collection (Appendix 1), each case was reviewed in depth.

Results

Missing data

Of 243 cases that met the case definition and were identified from the PCMD, the inquest files for 216 were obtained. In addition, a further six case files were obtained from the coroners' offices that met the case definition but did not appear in the PCMD. Therefore, the total number of case files that were obtained and reviewed was 222. For the cases where files could not be obtained, this was largely due to missing fields in the PCMD that made it impossible to identify the case file or due to the case file not being present in the Records Management Department storage system. The breakdown of case numbers by coroner's office is displayed in Table 4.

Table 4: Breakdown of case numbers by coroner's office for individuals completing suicide (April 2013-March 2015)

Coroner's office	Number of cases (%)
North Lancashire, Preston and South West Districts	130 (59)
East Lancashire Districts	42 (19)
Blackburn with Darwen	29 (13)
Blackpool and Fylde	15 (7)

Section 1: Demographic details

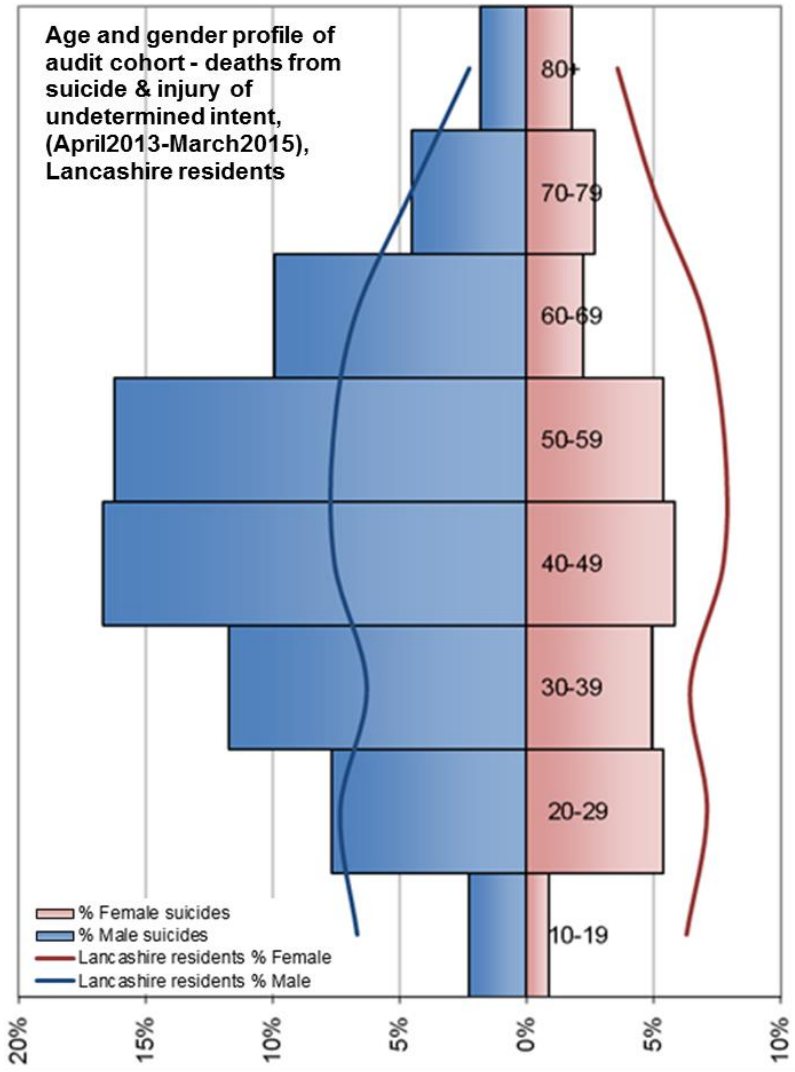
Age and gender

Deaths from suicide were highest amongst 40-59 year olds and nearly 2.5 times higher in males than females.

The age and gender distribution of the audit cohort (n=222) is presented in Figure 4. Figure 4 demonstrates that for both males and females the largest proportion of individuals taking their own life were aged 40-49 years, followed by those in the 50-59 year age group. Suicides amongst ages 40-59 formed 44% of all suicides in the cohort.

Males formed a higher proportion (71%|n=157) of the audit cohort than females (29%|n=65); this is in line with the national picture (76% males|24% females, 2013-2015). Figure 4 also demonstrates that the representation of males aged 20-69 years is greater than their representation in the wider Lancashire population.

Figure 4: Population pyramid displaying age and gender distribution of the audit cohort compared to the Lancashire population



Sexual Orientation

The majority of the audit cohort were heterosexual.

For a large proportion of the audit cohort there was no indication of their sexual orientation in the coroners' records. Hence, for many cases, this was based on the relationship history of the deceased. The vast majority of the audit cohort was identified to be heterosexual (Table 5).

Table 5: Sexuality of the audit cohort

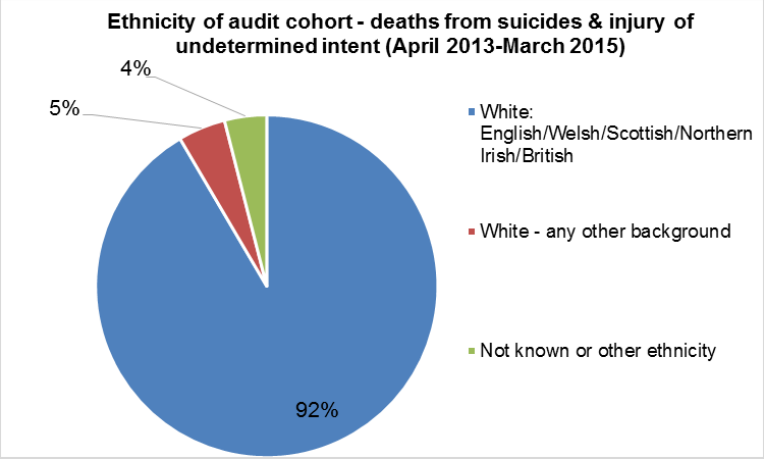
Sexuality	Number (%)
Heterosexual	178 (80)
Homosexual	6 (3)
Not known	38 (17)

Ethnicity and place of birth

The representation of those of White Other ethnicity in the audit cohort was higher than its representation in the Lancashire population and the representation of those of Asian ethnicity in the audit cohort was lower than its representation in Lancashire population. 50% of the deceased were born in Lancashire.

Figure 5 presents the ethnic breakdown of the audit cohort. 92% of the audit cohort were White British, which is similar to the representation of this ethnic group across Lancashire. However, 5% of the audit cohort was of "White Other" ethnicity, which is higher than the proportion (1.9%) resident in Lancashire. Of these individuals, the majority originated from Eastern European countries, although the exact numbers from each country cannot be shown due to small counts. Less than 2% of the audit cohort was of Asian ethnicity compared to approximately 12% resident in Lancashire.

Figure 5: Ethnicity breakdown of the audit cohort



Place of birth was identified from the PCMD and Table 6 summarises this. Half of the deceased were born in Lancashire and 6% were born overseas.

Table 6: Place of birth of the audit cohort, number and percentage

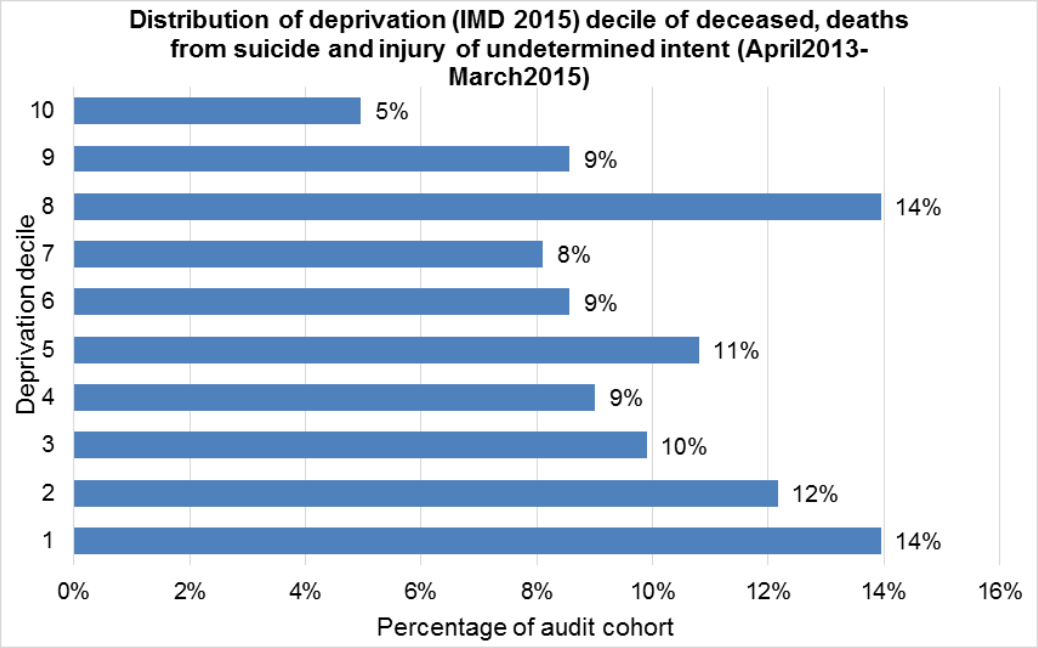
Place of birth	Number (%)
Lancashire	110 (50)
Elsewhere in UK (England, Wales, Scotland, Northern Ireland)	91 (41)
Overseas (including Republic of Ireland, the channel islands and the Isle of Man)	13 (6)
Not known	8 (4)

Geography and deprivation

Preston residents formed the highest proportion of all suicides and there were nearly twice as many suicides in the most deprived areas as in the least deprived areas of the county. Suicides in the younger age groups were higher in the deprived areas and suicides in the older age groups were higher in the least deprived areas.

The audit cohort was split into deprivation deciles (Index of Multiple Deprivation, 2015) based on postcode of residence of the deceased. Figure 6 displays the distribution of the deceased across the deprivation deciles of residence. The proportion of audit cohort residing in the 20% most deprived areas was significantly higher than the proportion residing in the 20% least deprived areas; 26% of those who took their own life resided within the 20% most deprived areas, compared with 14% in the 20% least deprived. The number of deaths from suicide in Lancashire's most deprived areas were nearly twice those in the 10% least deprived areas.

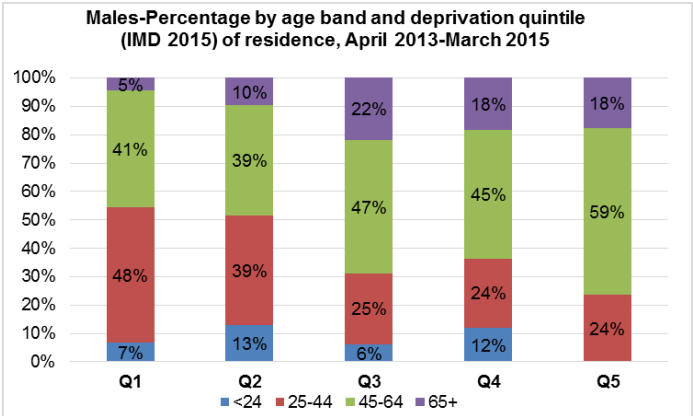
Figure 6: Deprivation decile* of residence of the audit cohort (April 2013 to March 2015)

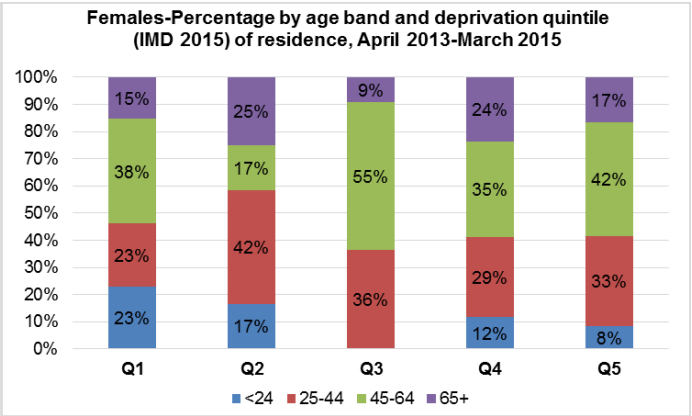


*Decile 1 = most deprived, decile 10 = least deprived

For both males and females, there were higher rates of suicide amongst the younger age groups (less than 44 years) in the most deprived quintile, compared to the least deprived quintile (Figure 7). For males, the rate of suicide deaths amongst the older age groups (45 years and older) was higher in the least deprived quintile than in the most deprived.

Figure 7: Proportion of audit cohort by gender, age band and deprivation quintile (IMD 2015) of residence





Marital and living status

70% of the audit cohort were single, divorced, separated or widowed and 43% of the audit cohort were living alone at the time of death

The most common marital status amongst the audit cohort was single. 22% of the cohort were married and 22% divorced/separated (Table 7). 43% of the deceased were living alone at the time of death (Table 8).

Table 7: Marital status of the audit cohort

Marital Status	Number (%)
Single	92 (41)
Married	49 (22)
Divorced	24 (11)
Seperated	23 (10)
Widowed	16 (7)
Co-habiting/civil partnership	10 (5)
Not known	7 (3)

Table 8: Living situation at the time of death of the audit cohort

Living situation	Number (%)
Alone	96 (43)
Spouse/partner	45 (20)
Spouse/partner and child(ren) or child(ren) under 18 only	25 (11)
Parents	25(11)
Adults (non-family)	9 (4)
Other family	7 (3)
Child(ren) over 18	5 (2)
Other	6 (3)
Not known	<5(<2)

Employment status and occupation

52% of the deceased in the audit cohort were either unemployed or economically inactive at the time of death. Of these, 74% had an ongoing mental health diagnosis.

Of the deceased, 35% were working (fulltime or part-time) at the time of death and 23% were unemployed (Table 9). This is in comparison to between 4.9-7.7% of people unemployed in the general population in Lancashire during the audit period(25). A further 28% were economically inactive, of which retirement was the most common sub-category. This compares to between 22-22.7% of the general population of England considered economically inactive during the audit period(25). Economic inactivity refers to people that are not in employment but do not meet the

criteria for unemployment because they have not been actively seeking work in the previous four weeks and/or are unable to start work in the next two weeks(25).

Table 9: Employment status at the time of death of the audit cohort

Employment status	Number (%)
Working full-time	70 (32)
Working part-time	7 (3)
Unemployed	52 (23)
Economically inactive:	63 (28)
•Retired	38 (17)
•Long-term sick or disabled	11 (5)
•Student	9 (4)
•Caring for home/family	5 (2)
Others	5 (2)
Not known	25 (11)

Where the occupation of the deceased was recorded, the National Statistics Socio-Economic classification (NS-SEC) system was assigned to the occupation of the deceased (Table 10)(26). 47% of the deceased were in occupations that placed them in less advantaged social groups (NS-SEC categories 5, 6,7 and 8)(27), whilst 43% were in NS-SEC occupation categories 1-4, which are considered to represent more advantaged social groups(27).

Table 10: NS-SEC occupation category of the audit cohort

Occupational category - National Statistics socio-economic classification	Number (%)
1 - Higher managerial, administrative and professional occupations	11 (5)
2 - Lower managerial, administrative and professional occupations	21 (9)
3 - Intermediate occupations	24 (11)
4 - Small employers and own account workers	39 (18)
5 - Lower supervisory and technical occupations	11 (5)
6 - Semi-routine occupations	25 (11)
7 - Routine occupations	29 (13)
8 - Never worked and long-term unemployed	40 (18)
Unknown	22 (10)

Section 2: Circumstances of death

Of the 222 deaths represented in the audit cohort:

- 174 (78%) were assigned suicide verdicts and 48 (21.6%) were assigned open verdicts.
- 37% (34% males|45% females) had left a suicide note (including text messages and emails).
- 58% of the deceased had consumed alcohol at the time of death (57% males|58% females).
- 15% deceased had consumed non-prescribed drugs at the time of death, of which cannabis, cocaine, heroin and benzodiazepines were the most common.

Method of death

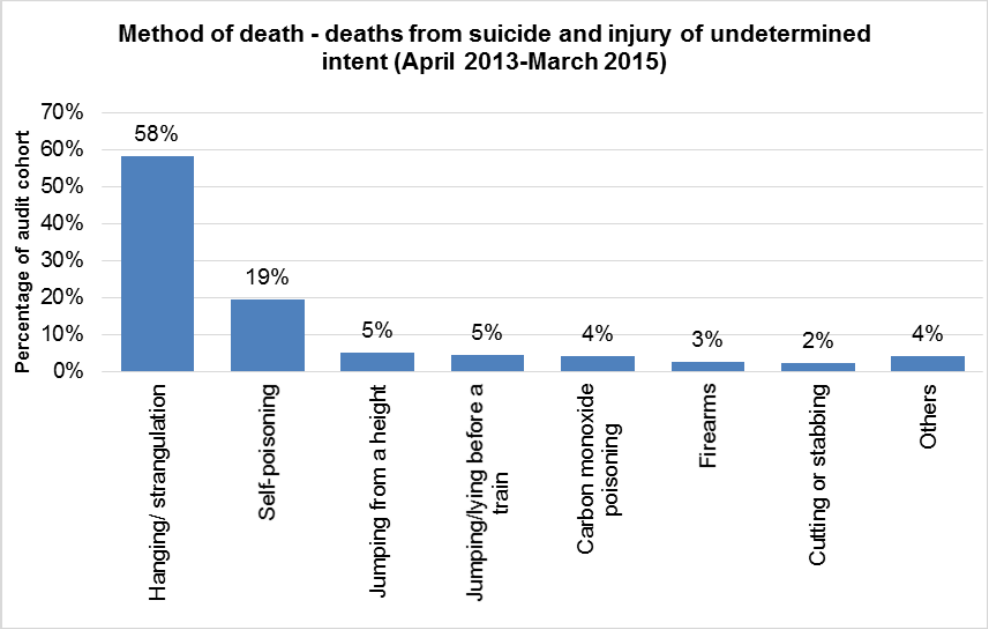
Hanging/ strangulation was the most common method of suicide in both males and females and home was the most common location of suicide.

Hanging/ strangulation was the most frequent method of suicide in both males and females (Table 11 and Figure 8). Hanging/strangulation was the method of death in 58% of cases, reflecting the national picture, with the most common ligature points being the bannister (18% of all hanging deaths) and the loft hatch (16% of all hanging deaths). Self-poisoning was the second most common method of suicide. Where the method of death was self-poisoning, the most common substances that resulted in death were opiates (40%) and tricyclic antidepressants (30%). The most common source of self-poisoning substances was prescribed for the subject (58%), followed by a combination of substances prescribed for the deceased, prescribed for somebody else or not prescribed (28%). Where opiates had been taken, the majority were prescribed analgesics such as morphine, tramadol and codeine that had been prescribed either for the deceased or somebody else, with less than five deaths relating to illicitly obtained opiates, such as heroin, or opiate replacement substances, such as methadone.

Table 11: Method of death amongst the audit cohort

Method of death	Number (%)
Hanging/strangulation	129 (58)
•Ligature point – bannister	23 (18)
•Ligature point – loft hatch	21 (16)
Self-poisoning:	43 (19)
•Opiate	17 (8)
•Tricyclic antidepressant	13 (6)
Jumping from a height	11 (5)
Jumping/lying before a train	10 (5)
Carbon monoxide poisoning	9 (4)
Firearms	6 (3)
Others (incl. cutting/stabbing, drowning)	14 (6)

Figure 8: Method of death amongst the audit cohort (April 2013-March 2015)



Location of incident

157 (71%) of the deceased took their life at their home (Table 12), whilst 32 (14%) took their life at various public locations. Three locations, across Lancashire, were identified where more than one suicide had occurred. Due to small numbers these locations can't be presented in this report, however, the Lancashire suicide prevention group have been informed of these findings.

Table 12: Place of death of the audit cohort

Location of incident	Number (%)
Home	157 (71)
Public location	32 (14)
Railway	10 (5)
Other	23 (10)

Factors contributing to suicide

Approximately 40% of the audit cohort had been experiencing relationship/family or financial problems.

The top factors contributing to suicide (Table 13) were:

- Mental illness (including history of self-harm) (32%)
- Financial difficulties (21%)
- Relationship breakdown/difficulties (20%)
- Alcohol/substance misuse (16%)
- Bereavement (14%)
- Ongoing criminal investigation or recent police contact (13%)
  - Where there was a recent police history/ongoing investigation, the highest proportion related to child sexual offences.
- Abuse (11%)

Table 13: Common factors contributing to death amongst the audit cohort

Factors contributing to suicide from coroner's perspective*	Number (%)
Mental illness (including history of self-harm)	70 (32)
Financial difficulties	47 (21)
Relationship breakdown/difficulties	45 (20)
Substance misuse	35 (16)
Bereavement	31 (14)
Ongoing criminal investigation or recent police contact	28 (13)
Abuse	25 (11)
Loneliness/social isolation	16 (7)
Family history of suicide	13 (6)
Stress at work	11 (5)
Concerns regarding children's custody	9 (4)
Internet content**	7 (3)

*More than one factor may be present in an individual.

**Here, the inquest file recorded that internet content had been relevant in the death, either in terms of websites detailing effective methods of suicide, discussion with other individuals on social networking sites about suicide or purchasing the means of suicide.

Section 3: Police Custody Related Information

36 (16%) of the deceased had a date of last custodial contact recorded. Amongst these, 30 (83%) had a date of last custodial contact within six months of death and in 31% the offence was linked to child sexual abuse/indecent child images.

History of contact with the prison or probation service

Of the deceased, 8 (4%) had a history of being in prison at any time in the 12 months before death and 15 (7%) deceased had history of being involved with the probation service at any time in the 12 months before death.

Section 4: Information relating to contact with Primary Care

Physical health

48% of the audit cohort had a physical health condition and 32% had both a mental illness and a physical health condition

As presented in Table 14, 107 (48%) of the deceased had a physical health condition recorded in the inquest file. Musculoskeletal conditions were the most common and hypertension the second most common physical conditions present in the audit cohort, followed by chronic lung disease, cancer and chronic liver disease. 70 (32%) of the deceased had a mental health diagnosis and a physical health condition.

Table 14: Physical health conditions amongst the audit cohort

Condition*	Number (%)
Musculoskeletal conditions	25 (11)
Hypertension	16 (7)
Chronic lung disease	11 (5)
Cancer	9 (4)
Liver disease	9 (4)
Diabetes	8 (4)
Thyroid disease	7 (3)
Heart disease	6 (3)
Progressive neurological conditions	6 (3)

*More than one physical condition may be present in an individual.

Mental health

24% of the deceased in the audit cohort had seen a GP for their mental health in the month before death. 63% of males and 77% of females had a mental health diagnosis.

The last primary care contact:
For 91 (41%) individuals the last primary care contact was for a mental health reason, with 13 (6%) individuals expressing suicidal thoughts, plans or intent at their last primary care contact and 73 (33%) individuals having some type of mental state assessment carried out at the last face to face contact. For 6% of individuals, there was documentation in the primary care notes of suicide risk, thoughts, plans or intent in the 6 months prior to death. 53 (24%) individuals had seen a GP for mental health reasons in the month before death (Table 15) and 36% of males and 38% of females had seen a GP for a mental health reason in the year before death.

Table 15: Period between last GP contact for mental health and death amongst the audit cohort

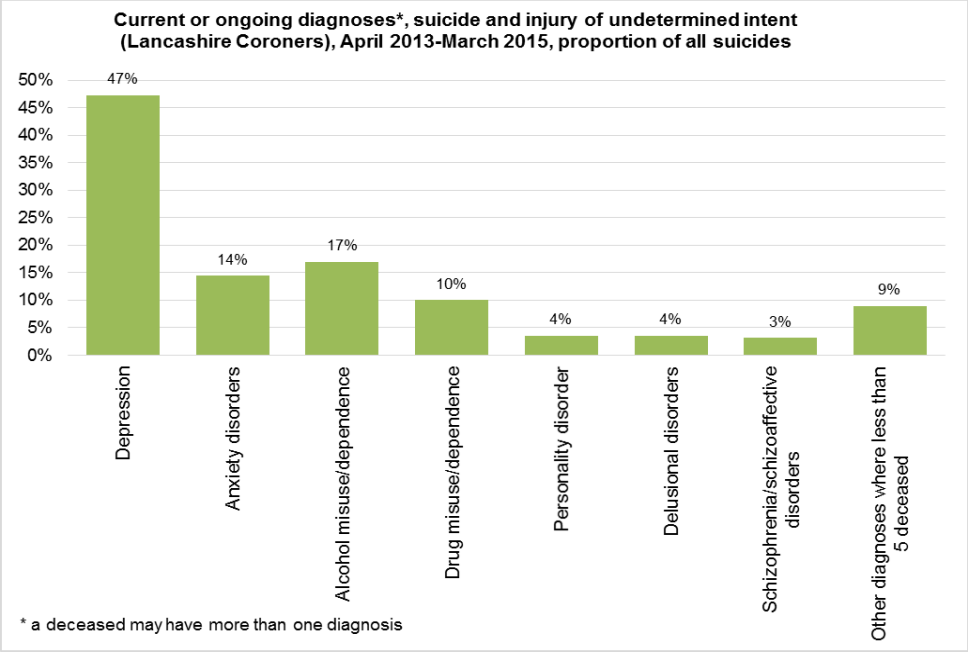
Period between last GP contact for mental health and death	Number (%)
<1 month	53 (24)
1 - 6 months	23 (10)
6 months - 1 year	5 (2)
>1 year	8 (4)

Mental health diagnoses:
52 (23%; 22% males|26%females) deceased had a diagnosis of a mental illness made in the 12 months prior to suicide and, more widely, 149 (67%; 63% males|77% females) deceased had an ongoing mental health diagnosis (Table 16). The most common mental health diagnosis for both males and females was depression (47% (45% males|54% females), followed by anxiety disorders, alcohol misuse and drug misuse (Figure 9).

Table 16: Ongoing mental health diagnoses amongst the audit cohort

Ongoing mental health diagnoses	Males	Females	All persons
	Number (%)		
Yes	99 (63)	50 (77)	149 (67)
No	33 (21)	6 (9)	39 (18)
Not known or recorded	25 (16)	9 (14)	34 (15)
Total	**157**	**65**	**222**

Figure 9: Current/ongoing mental health diagnoses amongst the audit cohort



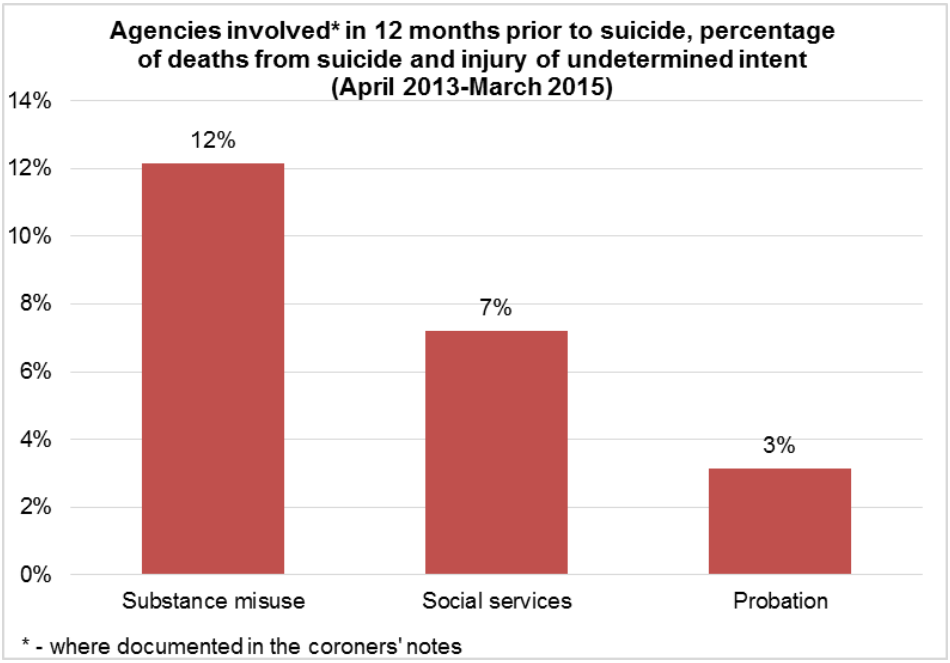
Mental health treatment:

122 (55%) individuals had received either antidepressants or talking therapies in the 12 months before death and 69 (31%; 29% males|37% females) of the deceased had 2 or more GP consultations for mental health problems during the previous 12 months. For 9 individuals (4%) it was recorded that they had been referred to specialist mental health services but took their own life before seeing a mental health specialist.

Other agencies:

Amongst 50 individuals (23%) there was documentation of other agencies being involved in the 12 months prior to suicide, the most common of which are displayed in Figure 10.

Figure 10: Other agencies involved amongst the audit cohort



Section 5: Information relating to acute hospital services (excluding specialist mental health inpatient units)

10% of the deceased had a mental health related A&E or hospital attendance in the six month period before taking their own life. A further 8 individuals (4%) had a mental health related attendance between six and 12 months before death.

Section 6: Information relating to contact with mental health services

84 individuals had a record of some type of specialist mental health contact in the 12 months prior to death.

Of the 102 (46%) deceased, where there was a record of the nature of last contact with specialist mental health services, 47 (21%) were deemed not to need specialist mental health input and were either discharged or not taken on the caseload (Table 17). 47 (21%) of the deceased were in contact with specialist mental health services less than 30 days before their death (Table 18).

Table 17: Nature of last contact with specialist mental health services amongst the audit cohort

Nature of last contact with specialist mental health services	Number (%)
Discharge from caseload	26 (12)
Contact while on caseload	55 (25)
Assessment, but not taken on caseload	21 (9)
No contact	20 (9)
Not known	100 (45)

Table 18: Period between last contact with specialist mental health services and death amongst the audit cohort

Period between last contact with specialist mental health services and death	Number (%)
Within one week	28 (13)
Between 1 week and 1 month	19 (9)
Between 1 month and 6 months	28 (13)
Between 6 months and 1 year	9 (4)
More than 1 year	26 (12)
Total	110 (50)

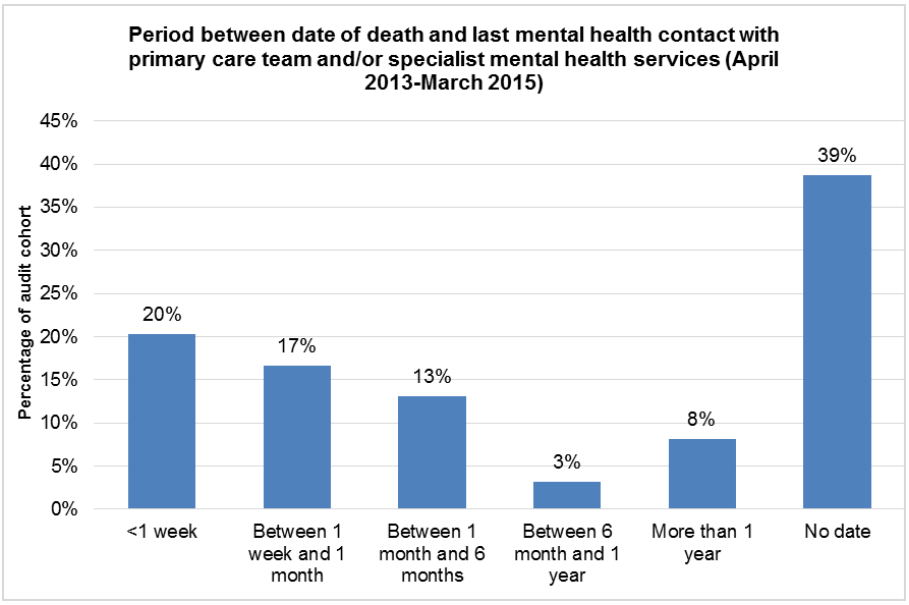
Inpatient care:
21 (9%) of individuals had been discharged from a psychiatric inpatient ward in the year before death and 41 individuals (19% (15% of males|28% of females) had at least one admission to a psychiatric inpatient ward in the 5 years before death.

Mental health related contact - primary care and specialist mental health services combined

50% of the deceased had a recorded mental health related contact with either primary care or specialist mental health services in the 6 months before death.

136 of the deceased (61%) had previously seen either their GP or specialist mental health services in relation to a mental health condition. Of these, amongst 37% the contact had taken place within the month before death and amongst 20% the contact had taken place within the week before death (Figure 11).

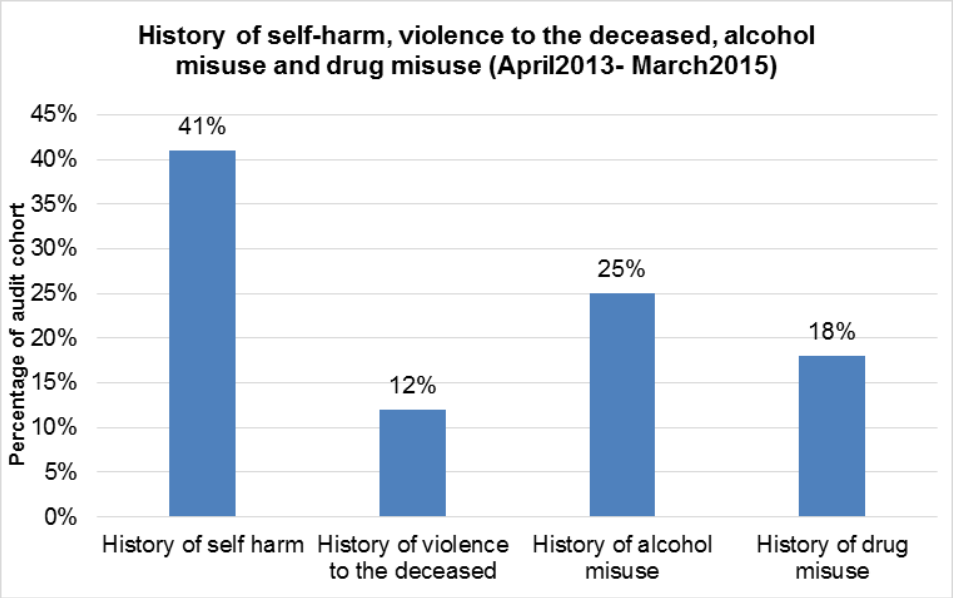
Figure 11: Period between death and last mental health related contact amongst the audit cohort



History of abuse, self-harm and substance misuse

92 (41%; 34% males|58% females) individuals had a recorded history of self-harm; of these, 47 (21%) had more than one known previous suicide attempt. Within the audit cohort, 56 (25%, 25% males|26% females) individuals had a history of alcohol misuse, 39 (18%) a history of drug misuse and 21 (9%) a history of both alcohol and drug misuse. 26 individuals (12%, 7% males|23% females) were known to have previously been victims of violence (Figure 12).

Figure 12: History of self-harm, violence towards the deceased and alcohol and drug misuse amongst the audit cohort



Serious case reviews

There were eight individuals where there was a record in the inquest file that a serious case review had been conducted by an organisation. In six of these cases, a key theme within the review was that there was a lack of communication and integration between community mental health services and either other organisations, such as the police, primary care and Emergency Departments, or other mental health teams and subspecialties.

Discussion and recommendations

The discussion and recommendations will be structured around the key objectives of the national suicide prevention strategy (*'Preventing suicide in England: a cross-governmental outcomes strategy to save lives'*) in order to identify how these can be achieved in Lancashire(2).

1. Reduce the risk of suicide in key high-risk groups:

- **Young and middle-aged men;**
- **People in the care of mental health services, including inpatients;**
- **People with a history of self-harm;**
- **People in contact with the criminal justice system and**
- **Specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers.**

Our audit data demonstrated that in Lancashire the groups at highest risk of suicide are young and middle-aged men, people with a history of self-harm (including previous suicide attempts), people in contact with the criminal justice system (most notably child sex offenders) and people in contact with mental health services. No specific occupational groups were highlighted as being at-risk, potentially because of the small numbers of each occupational group involved.

1.1 Young and middle-aged men

Although men were three times more likely to complete suicide in Lancashire than women, they were less likely to have sought help from services and to have a formal mental health diagnosis. Thus, it may be more effective to offer services for men and to train staff in locations away from formal settings such as GP surgeries(2). These may include locations such as job centres or sporting communities, as there is evidence that sport can be effective in engaging young and middle-aged men not in contact with traditional services. For example, training gym and fitness professionals to become suicide champions and providing support leaflets and information in these settings(2).

Recommendation 1: Offer services for men and train staff in community locations in Lancashire away from formal healthcare settings.

In addition to innovative methods of engagement and service provision for men, efforts should also be made locally to connect men with traditional services for mental health concerns.

Recommendation 2: Develop local campaigns to reduce the stigma of mental illness and suicide building on current national momentum, such as the "Time to Talk" campaign.

Financial difficulties was one of the biggest contributory factors to suicide in Lancashire identified in this audit and a far higher proportion of the audit cohort were unemployed than within in the general population during the same period. Males were more likely than females to be unemployed and experiencing financial difficulties. Therefore, focusing on economic factors such as debt and unemployment may help to reduce male suicide rates, particularly amongst those that are not in touch with health services. In addition, such measures contribute to meeting the second objective of the national strategy and improving mental wellbeing amongst people vulnerable because of social and economic disadvantage.

Recommendation 3: Invest in initiatives to reduce male unemployment in Lancashire.

1.2 Self-harm

Previous self-harm (including attempted suicide) is the most powerful predictor of successful future suicide. Almost half of the audit cohort in Lancashire had a recorded history of previous self-harm or attempted suicide, including historical self-harm. Professionals that come into contact with people that self-harm must be trained in how to appropriately risk assess, manage and refer on to other services(2). As people that self-harm or attempt suicide are commonly seen in Emergency Departments and subsequently admitted to hospital for treatment and monitoring of physical health sequelae, it is essential that Emergency Departments and secondary care are represented on any local suicide prevention group. Furthermore, there should be protocols in place to ensure that people receive the appropriate risk assessment and that hospital and community services communicate, with robust pathways for community follow-up after assessment in secondary care(28).

Recommendation 4: Emergency Departments and secondary care to be represented on the local multi-agency suicide prevention group.

Recommendation 5: Local pathways for the assessment, management and follow-up of people presenting to Emergency Departments with self-harm to be reviewed and, if required, integrated mental health care pathways to be developed between mental health liaison teams in secondary care and community services.

As presentation with self-harm is extremely common and is increasing, in both primary care and secondary care, it may be beneficial to train clinical staff in how to manage such individuals. This training could also be extended to cover other aspects of suicide prevention, such as safe prescribing. This could be delivered through the schedule of protected teaching sessions for doctors in training, departmental teaching in hospitals and continuing professional development programmes for GPs.

Recommendation 6: Training on suicide prevention for clinical staff in Lancashire on aspects pertinent to their work, such as self-harm risk assessment and safe prescribing, through existing programmes of professional education.

1.3 Criminal justice system

People in contact with the criminal justice system are at a high risk of suicide at all stages within the system and police should consistently apply safer custody policies and procedures to identify and care for those at risk of suicide and self-harm. This includes those at risk after they leave police custody. In Lancashire, a particularly high-risk group was people being investigated for, or already convicted of, child sex offences. Previous research from the UK has shown child sex offenders to be at increased risk of suicide, even when compared to other offenders, and this group was over-represented in this audit(29). Furthermore, the number of prosecutions and convictions for child sex offences, including historical offences, has increased in recent years and if this trend continues, there is likely to be an associated increase in suicides.

Recommendation 7: Lancashire Constabulary to review and strengthen their risk assessment, checks and safety netting procedures for when individuals leave custody, particular amongst those suspected of child sex offences.

1.4 People in contact with mental health services

In Lancashire, as is seen nationally, people in contact with mental health services are at increased risk of completing suicide. To address this, it is vital that there is sustained investment and commitment to mental health services to ensure that people are able to receive the

appropriate level of support. This is particularly relevant in the current context of public sector transformation in Lancashire.

Recommendation 8: All agencies represented on the local multi-agency suicide steering group to commit to ongoing financial commitment to mental health.

A key aspect of improving the mental wellbeing of people in contact with mental health services is to provide support to live in the community and to function as part of society, which reduces the future risk of suicide, reliance on services and promotes wellbeing. Fundamental to this is employment, with those with mental health conditions finding it more difficult to obtain employment than the general population. This was evident within the audit cohort, with 33% of people in contact with mental health services unemployed, compared to 23% of the wider audit cohort and 5.6-7.7% of the general population during the audit period. There is strong evidence that people in employment are less likely to complete suicide due to factors such as increased confidence, social networks and expectation of sufficient income and higher living standards(30). Consequently there should be targeted efforts in Lancashire to help those with mental illness to return to or enter work(2,31). This would also be beneficial for employers given that mental health problems are now the single largest cause of sickness absence in England(32).

Recommendation 9: Mental health services in Lancashire should be joined up with employment services to allow both mental health and employment needs to be addressed.

Recommendation 10: Targeted interventions and services to enable people with mental health conditions in Lancashire to return to or enter the workplace.

Although the numbers of cases that had been subject to serious untoward incident reviews were relatively small, these individuals had all been under the care of mental health services and there were some commonalities within the recommendations. In particular, it was noted that there was poor communication and collaboration between mental health services in different settings and other organisations, such as lack of integration and follow-up in the community following referrals from the police or review in Emergency Departments and lack of co-ordination between mental health subspecialties when individuals had multiple diagnoses.

Recommendation 11: Mental health services in Lancashire to review their operating procedures and explore approaches to integrated working and information sharing.

2. Tailored approaches to improve mental health in specific groups:

- **Children and young people;**
- **Survivors of abuse or violence;**
- **Veterans;**
- **People living with long-term physical health conditions;**
- **People with untreated depression;**
- **People who are especially vulnerable due to social and economic circumstances;**
- **People who misuse drugs or alcohol;**
- **Lesbian, gay, bisexual and transgender (LGBT) people and**
- **Black, Asian and minority ethnic groups and asylum seekers.**

Several specific groups were highlighted within the national suicide prevention strategy as requiring tailored approaches to improve mental health. Of these specific groups, those that emerged as at particularly high risk of suicide in Lancashire were survivors of abuse or violence,

people living with long-term physical health problems, people vulnerable due to social and economic circumstances and people who misuse drugs or alcohol. In addition, although there were very small numbers of children and young people represented in the audit, it was noted that many of the contributory factors to suicide, such as sexual abuse or bereavement by suicide, had occurred during childhood and adolescence. Consequently, this group is a key focus for suicide prevention. With regards to the other groups highlighted within the national strategy, such as LGBT groups and veterans, although these are likely to represent key areas for suicide prevention nationally, there were very few individuals within these groups in the audit cohort.

2.1 Survivors of abuse or violence

In Lancashire, 12% of the audit cohort and 23% of females had a recorded history of previous physical or sexual abuse. Work to address abuse in Lancashire is therefore essential and should encompass both upstream efforts to prevent abuse and work to identify and tackle abuse once it has occurred. It is essential that there is integration between mental health and domestic abuse services. When people present to clinical settings with suicidal thoughts, they may be accompanied by perpetrators of abuse and can be too ashamed or afraid to raise the issue of abuse or may not see the connection where the abuse is historical(33). Therefore, seeing an individual on their own for at least part of the encounter and directly asking about a history of abuse should form part of the mental health risk assessment(33). Similarly, when abuse is first highlighted the emphasis of care may be upon the safety of an individual, with the helplessness and hopelessness associated with abuse considered later(33). Consequently, assessing and addressing the mental state and suicide risk of abuse victims should form part of the front-line care of abuse victims(33).

Recommendation 12: Ensure that there is integration between the multi-agency suicide prevention group in Lancashire and the Pan-Lancashire Strategic Domestic Abuse Board.

2.2 People with long-term physical health problems

As demonstrated by the fact that 48% of the audit cohort had a recorded physical health condition and 32% had dual physical and mental health diagnoses, people living with physical health problems in Lancashire are at increased risk of suicide. In light of this, there should be increasing acknowledgement of the mental health implications of physical illness by professionals treating these conditions and facility to treat both in conjunction(4). Closely linked to physical illness, whilst also being a contributory factor to suicide in itself, is the issue of social isolation, with people becoming increasingly isolated and low in mood as a result of disabling physical illness.

Recommendation 13: Training for primary and secondary care clinicians to recognise and manage the mental health implications of physical illness.

Recommendation 14: Integrated management pathways for physical and mental health, including routine mental state assessment, self-care advice and referral to services and organisations that address social isolation as part of the regular review for chronic conditions such as osteoarthritis and respiratory disease.

2.3 People vulnerable due to social and economic disadvantage

As demonstrated by the large proportion of people unemployed and in the most deprived quintile, those vulnerable because of social and economic disadvantage are at increased risk of suicide in Lancashire. Tailored approaches to improve the mental wellbeing of this group should primarily focus on reducing social and economic disadvantage through the wider determinants of health and extends far beyond individual mental health problems and access to services such as primary care and mental health, although these remain important.

Initiatives to reduce unemployment, as discussed above, are vital to improving wellbeing amongst people vulnerable to social and economic disadvantage. In addition, there are many organisations in Lancashire that are in contact with deprived populations such as housing associations, particularly those providing specialist housing such as recovery housing, Lancashire County Council Welfare Rights service and 'Well North'(34). These organisations form an important conduit because, although individuals may not be seeking support for emotional concerns, they may be seeking support for other aspects of their life such as housing or finances. Forming partnerships with these local organisations, building upon their skills and enabling their staff to address suicide risk in their work can enable in-reach into deprived communities, local approaches to improve wellbeing and greater uptake of suicide reduction services(35).

Recommendation 15: Form partnerships with local organisations that work with deprived communities.

Closely linked to this, the presence of financial problems, particularly debt, was a major contributory factor to suicide in Lancashire. Evidence suggests that people who complete suicide as a result of financial difficulties are less likely to have previously self-harmed or to have been in touch with psychiatric services(36). This was supported by the audit data, which demonstrated that financial difficulties were more likely to be present amongst those people with no mental health diagnosis than those with a diagnosis. This shows the importance of engaging non-clinical agencies to prevent financial-related suicide, as well as ensuring that health professionals are aware of the wide range of services and interventions relevant to suicide prevention.

Recommendation 16: Provide public information to signpost people to information and support if they are in debt or at risk of getting into debt, advice on maintaining wellbeing during difficult times and guidance on where to go for further help.

Recommendation 17: Ensure that healthcare professionals in primary care, secondary care and mental health settings are aware of services relating to financial support and debt prevention/management to enable them to signpost patients presenting with low mood, anxiety or suicidal thoughts as a result of financial difficulties.

Recommendation 18: Training for staff in services such as housing and Welfare Rights that regularly encounter people at high-risk of suicide to manage self-harm and suicide declarations and develop frameworks to support these.

2.4 People who misuse drugs or alcohol

The proportion of people that were known to misuse drugs and alcohol in Lancashire was high and the proportion that had consumed drugs or alcohol at the time of death was even higher. People that have both a mental illness and who misuse substances are at particularly high risk of suicide although it is not entirely clear whether substance misuse leads to suicide or whether suicidal feelings result in substance misuse(37). Nevertheless, it is accepted that measures to address alcohol and drug dependence are key to reducing suicide. However, although this is commonly recognised within suicide prevention plans, the link with suicide prevention is often not explicitly acknowledged in local drug and alcohol strategies(38).

Recommendation 19: Specific consideration and mention of suicide prevention in drug and alcohol strategies in Lancashire to ensure that work on substance misuse is fully aligned with suicide prevention.

As both substance misuse and suicide are likely to result from a complex set of factors, a multi-faceted approach is required. Substance misuse services that address the wider determinants of

health, such as housing, adult education and employment are most likely to have a sustained impact. Alongside this, substance misuse services should be equipped to identify and address mental illness(2). A large proportion of people who misuse alcohol are seen in primary care and Emergency Departments and suicide risk should be assessed as part of brief interventions for harmful drinkers(38).

Recommendation 20: There should be a joint responsibility between substance misuse and mental health services in Lancashire to treat both substance misuse and other mental health conditions.

Recommendation 21: Training on suicide prevention and intervention for staff working in addiction services in Lancashire.

Recommendation 22: Work with CCGs and hospital trusts in Lancashire to incorporate suicide risk into brief interventions for harmful drinkers.

Due to the complexity of both suicide prevention and substance misuse, it is vital that individuals with lived experience are involved in the design and delivery of services.

Recommendation 23: Engage people with experience of substance misuse and self-harm or suicide attempts in service design and delivery; for example, through the Lancashire User Forum or the Recovery Infrastructure Organisation.

2.5 Children and young people

Although the number of children and young people dying by suicide in Lancashire is very low, many factors that were identified as being contributory to suicide occurred in childhood, such as abuse and bereavement by suicide. Thus it is essential that universal services in Lancashire work to provide all Lancashire children with the best start in life.

Recommendation 24: Sustained investment and commitment to universal children's services in Lancashire.

In addition to universal services to promote wellbeing, action is also needed to improve wellbeing and reduce the risk of suicide amongst more vulnerable young people, such as those that have experienced or witnessed abuse, young people that have suffered a bereavement and looked-after children.

Recommendation 25: Sustained investment and commitment to specialist children's services in Lancashire and those that work with vulnerable children, such as children's social care, CAMHS and the Lancashire County Council Wellbeing Prevention and Early Help service.

3. Reducing access to the means of suicide

Those methods of suicide most amenable to reduced access are hanging and strangulation in inpatient/criminal justice settings, self-poisoning, deaths that occur at high-risk locations and on the rail network. There were less than five deaths by hanging or strangulation in inpatient/criminal justice settings in Lancashire during the audit period, however self-poisoning was the second most common method of suicide and is a highly relevant area for action. The most common source of self-poisoning substances was prescribed for the subject and the two most common substances responsible for death were prescribed opiates and tricyclic antidepressants. This mirrors the national picture, whereby deaths involving opiates doubled in the three years up to 2015(39). At the same time there has been a marked rise in the prescription of opioids for non-

cancer pain in the UK in recent years, with opioids now prescribed more often, for longer periods and in higher doses than would be predicted by their known efficacy(40). Therefore, safe and appropriate prescribing is vital to reduce suicide by self-poisoning.

Recommendation 26: Training of GPs in Lancashire regarding safe prescribing of analgesia and antidepressants, particularly at times of high risk.

Recommendation 27: Work with GPs and pharmacists in Lancashire to ensure that there are effective medicines management strategies to highlight non-compliance and diversion of medications.

Recommendation 28: Engagement of the Lancashire Medicines Management Group to support safe prescribing of analgesia and antidepressants in Lancashire.

Recommendation 29: Where individuals disclose suicidal thoughts, risk assessment should include assessment of the means of suicide and attempts to remove and relinquish the means; for example, medication review.

In total, there were 12 deaths that took place on the rail network in Lancashire, combining those deaths from being struck by a train and jumping from a railway bridge. These were spread across the county of Lancashire with no hotspots on the rail network.

During the audit period, there were three public locations in Lancashire where more than one suicide had been completed. Although these locations cannot be named here, due to the small numbers involved, the details have been provided to the Lancashire Multi-agency Suicide Prevention Group in order to review the steps taken at these locations to prevent future suicides.

Recommendation 30: Lancashire multi-agency suicide group to review interventions in place at suicide hotspots in Lancashire.

4. Providing better information and support to those bereaved or affected by suicide

Bereavement is known to be a risk factor for suicide and this risk is increased where people have been bereaved by suicide(17). Of the audit cohort, 6% had a recorded history in their inquest file of suicide in a close family member, demonstrating that people affected by suicide are likely to go on to complete suicide themselves. Suicide can have a long-term impact on the psychological development of all family members, particularly children, and there can be decreased cohesion and family breakdown afterwards(41). Suicide has traditionally been stigmatised and family members experience more guilt and self-blaming than in deaths by other methods and are often judged more negatively than survivors of other types of loss(41). Therefore, it is important to reduce the stigma of suicide, raise public awareness and proactively offer support to people bereaved by suicide as discussed earlier and addressed through recommendation 2.

It was also noted in the audit cohort that the vast majority (71%) of suicides had been completed in the home of the deceased, which is likely to have had a significant impact on other family members that shared the home and increase their need for support.

Recommendation 31: To work with existing support organisations, for example Survivors of Bereavement by Suicide, to offer support to Lancashire residents affected by suicide via existing groups and developing new support networks.

Recommendation 32: To develop routine pathways and information packs for all families bereaved by suicide that could be disseminated via GPs or the relevant coroner's office.

Aside from those individuals bereaved by suicide, bereavement in general was a contributory factor to death amongst 14% of the wider audit cohort. It is therefore vital that there is appropriate support for those that experience bereavement and that this extends beyond the immediate period following the death. It may be beneficial to link in with bereavement support services and organisations, such as Cruse Bereavement in Lancashire, as well as those seeking to address social isolation.

5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

The media has an important role to play in influencing suicidal behaviour. Where there is a high profile death, media reporting can result in imitative behaviour, particularly at suicide hotspots and clusters of suicides. In addition, internet content promoting suicide, detailing effective methods of suicide or making available the means of suicide can influence peoples' decision to attempt suicide and the effectiveness of their attempts. This is a recognised offence and individuals can be prosecuted(2). Internet content had played a role amongst seven people within the audit cohort and is especially relevant to suicides amongst young people.

Recommendation 33: Where internet content is identified as being a factor in the suicide, either by the police or during the Coroner's investigation, Lancashire Constabulary should support the internet industry to remove the content.

Recommendation 34: Where websites, including people in online chat rooms and social networks, are found to be persistently promoting suicide or suicide methods, Lancashire Constabulary should seek prosecutions.

It is essential that local people in Lancashire have access to accurate and appropriate information about suicide, including links to support and evidence-based resources and information following any high-profile suicide.

Recommendation 35: To improve and develop the suicide component of Lancashire County Council's website as a reliable source of support and resources, linking to third party websites where appropriate.

Recommendation 36: The multi-agency suicide prevention group should proactively engage the local media to develop a standard for reporting suicides responsibly.

6. Supporting research, data collection and monitoring

Robust and reliable research, data collection and monitoring are crucial when developing any meaningful suicide prevention strategy. This suicide audit has identified that the four coroners' offices in Lancashire take different approaches to suicide inquest investigations, particularly in terms of the information collected to inform the inquest and the subsequent interpretation of what constitutes an open and suicide verdict by individual coroners. This affects the data collection process in local suicide audits such as this, with, for example, many risk factors likely to be missed if health records are not gathered as part of the inquest investigation process. In addition, there is an impact on national data when differing interpretations of verdicts are employed. Planned reform to the coroner system in Lancashire combining the three offices of the East Lancashire Districts, Blackburn with Darwen and the North Lancashire, Preston and South West

Districts will go some to way to addressing this variation locally. There is also the potential for this to speed up the inquest process and potentially improve services to the bereaved.

Although suicide audit is a valuable activity and integral to suicide prevention work, there was a delay of months and in some cases years between the death occurring, the inquest being completed and the process of suicide audit. Real-time suicide surveillance enables the multi-agency group to rapidly implement interventions after a death has occurred; for example, to respond to clusters in suicide hotspots, to become aware of new methods of suicide and ensure that support is provided to the bereaved.

Recommendation 37: Local multi-agency suicide prevention group to explore with the Lancashire coroners the possibility and practicality of establishing real-time suicide surveillance in Lancashire.

As completed suicides represent a very small cohort of people and exclude the much larger population of people that attempt suicide or seriously self-harm who are at high-risk of future suicide, real-time surveillance of self-harm may also be beneficial.

Recommendation 38: Local multi-agency group to explore the possibility and practicalities of real-time self-harm surveillance in Lancashire.

Regardless of whether real-time surveillance is established, it is likely that suicide audit will continue to play a role in future data collection and monitoring in order to gather the depth of information that is collated during the inquest process and to ensure that any deaths not immediately suspected to be suicides are captured. Throughout the course of this project, it became clear that the audit proforma required further development for future work due to areas of repetition and other pertinent areas not being fully encompassed, for example whether an individual was transgender, perinatal mental health etc. Thus, an adapted proforma has been developed based upon the learning from this audit (Appendix 2).

Recommendation 39: If future suicide audits are carried out in Lancashire, an adapted suicide audit proforma should be adopted that has been standardised with other local authorities within the Lancashire and South Cumbria STP footprint in order to improve collection and comparability of data.

Limitations

This project had various limitations, some of which have already been mentioned. In many instances relevant information was missing from the inquest file, for example ethnicity and sexual orientation, complicating analysis of such risk factors. In addition, there was inconsistency between coroners' offices in the records gathered within the inquest file, with health records and police records where there had been a recent custody often missing. This limits understanding of the care and services provided by these organisations. Furthermore, even where records were present the depths of certain aspects of care were not fully captured; for example, many individuals had failed to attend appointments with services such as mental health and substance misuse and been lost to follow up. However, it wasn't clear why this was the case and qualitative work engaging people and staff affected by suicide may be beneficial to better understand these nuances. Exploration of factors contributory to suicide may also benefit from a qualitative approach. Many factors are likely to be under-represented within the audit, such as social isolation, which was rarely directly reported in case notes but likely to have played a significant role in many suicides, as suggested by the large numbers of people that had experienced bereavement, lived alone, were single or divorced and were unemployed.

Recommendation 40: Engage people affected by suicide and staff working in mental health services to inform deeper aspects of suicide prevention.

Much of the information within inquest files was based upon statements from family and friends and gathered at a very traumatic time. It is therefore likely to be susceptible to recall bias, whereby recollection and representation are influenced by the recent suicide. A final limitation is that it was not possible to make comparisons with previous suicide audits and trends in Lancashire prior to 2013 when public health had been situated in primary care trusts and not on a pan-Lancashire basis within Lancashire County Council.

Conclusion

This was a large suicide audit that was conducted using data from a two-year period across the large and diverse footprint of Lancashire County Council. The audit data has been used to describe patterns of suicide across the county, to highlight groups at increased risk of suicide and areas for future focus. Recommendations have been made in light of the audit data and the current national policy and evidence base in England. It should be noted that, whilst different groups and topic areas have been discussed separately, there is massive overlap between these areas, for example substance misuse and deprivation, and integration and partnership working are essential to any suicide prevention work. Finally, whilst the purpose of this audit is to prevent suicide in Lancashire, this is not a standalone objective and measures to prevent suicide, including the recommendations discussed, have wide and far-reaching societal benefits aside from reducing suicide rates.

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Appendix 1 – Suicide audit proforma

Lancashire Suicide Audit Proforma

Section 1: Demographic details

1.1 Date of birth	DD	MM	YYYY
1.2 Date of death	DD	MM	YYYY
1.3 Age			

1.4 Sex	Male	01	Female	02

1.5 Sexual orientation

Heterosexual	01	Homosexual	02
Bi-sexual	03	Not known	04

1.6 Resident's postcode

1.7 Ethnicity

White British	01	White Irish	02	any other White background	03
Mixed White and Black Caribbean	04	Mixed White and Black African	05	Mixed White and Asian	06
Any other mixed background	07	Indian	08	Pakistani	09
Bangladeshi	10	Any other Asian background	11	Caribbean	12
African	13	Any other Black background	14	Chinese	15
Any other ethnic group	88	Not known	99		

1.8 Marital status

Single	01	Married	02	Divorced	03
Widowed	04	Separated	05	Co-habiting	06
Civil partnership	07	Other (specify)	88	Not known	99

1.9 Living situation at time of death

Alone	01	Spouse/partner	02	Spouse/partner and child(ren) < 18	03
Child(ren) under 18 only	04	Child(ren) over 18	05	Parents	06
Other family	07	Adults (non-family)	08	Other shared	09
Other (specify)	88			Not known	99

1.10 Occupation at time of death

Free text field

1.11 Employment status at time of death

Working full-time	01	Working part-time	02	Sheltered work	03
Unemployed	04	Long-term sick or disabled	05	Caring for home/family	06
Student (full-time)	07	Student (part-time)	08	Retired	09
Housewife/househusband	10	Other (specify)	88	Not known	99

1.12 History of being in prison or Young Offenders Institution at any time in the 12 months before death (including being a remand prisoner)

Yes	01	No	02	Not Known	03

1.13 History of being involved with the probation service at any time in the 12 months before death

Yes	01	No	02	Not Known	03

Section 2: Circumstances (Coroner related information)

2.1 Was there a suicide note?

Yes	01	No	02	Not Known	03

2.2 Location and description of event

Freetext

2.3 Location postcode (where possible)

2.4 Method of death (if more than one, please give direct cause)

Self-poisoning	01	Carbon monoxide poisoning	02	Hanging/ strangulation	03
Drowning	04	Firearms	05	Cutting or stabbing	06
Jumping from a height	07	Jumping/lying before a train	08	Jumping/lying before a road vehicle	09
Suffocation	10	Burning	11	Electrocution	12
Other (please specify)	88	Not known	99		

2.5 If self-poisoning, specify substance (If more than one substance, list all drugs or substances)

Method not self-poisoning	00	Anti-psychotic drug	01	Tricyclic anti-depressant	02
SSRI/SNRI anti-depressant	03	Lithium / other mood stabiliser	04	Benzodiazepine/ other hypnotic	05
Paracetamol	06	Paracetamol/opiate compound	07	Salicylate	08
Opiate (heroin, methadone etc.)	09	Other poisons (e.g. weedkiller)	10	Not known	99

Other drug (please specify)	88	

2.6 Where did the self-poisoning substance referred to above come from?

Method of suicide was not self-poisoning	01	Prescribed for the subject	02	Prescribed for someone else	03
A combination of substances prescribed for more than one person	04	Not prescribed	05	Not known	99

2.7 Was alcohol taken at time of death?

Yes	01	No	02		Not Known	03

2.8 Were other non-prescribed drugs taken at the time of death?

Yes	01	No	02	Not Known	03

2.9 Factors contributing to suicide from coroner's perspective

For example: job loss/ social isolation/ relationship breakdown/ bereavement/ financial difficulties/ bullying

2.10 Suicide or open verdict?

Suicide verdict	01	Open verdict	02

2.11 In the opinion of the coroner are there lessons to be learned from this case that might help prevent suicides in the future?

Free text

Section 3: Police Custody Related Information (if applicable)

3.1 Date of last custodial contact DD MM YYYY

3.2 Custody location

3.3 Offence type

3.4 Number of previous times in custody

3.5 Pre-custody risk assessment information

E.g. disclosure of self-harm history, MH diagnosis, risk level, observations etc.

3.6 Pre-release risk assessment information

E.g. Risk identified before release, further assessment carried out by PPU or nurse, sectioned and admitted to hospital, actions taken before release.

3.7 Custodial outcome

Bailed to police station	01	Charged and bailed to court	02	Arrested but released without charge	03
Detained for court on warrant	04	Charged and detained for court	05	Sectioned	06
Other (specify)	07				

Section 4: Information relating to contact with Primary Care

4.1 Other physically and/or sensory disabling condition (non-psychiatric) at the time of death (please state if the condition is chronic or temporary)

Free text field

4.2 Date of last contact General Practitioner or primary health care team

DD	MM	YYYY

4.3 Reason for contact

Mental health	01	Physical health	02	Both	03

4.4 Suicidal thoughts, plans or intent expressed at last primary care contact

Yes	01	No	02	Not Known	03

4.5 Number of consultation with the GP for mental health problems during the previous 12 months

4.6Date of first consultation for mental health problems

DD	MM	YYYY

4.7 Diagnosis of any mental illness made in 12 months prior to suicide

Yes	01	No	02	Not Known	03

4.8 Current and / or ongoing diagnoses (tick all that apply)

Schizophrenia/schizoaffective disorders	01	Delusional disorders	02	Bipolar affective disorder	03
Depression	04	Post-natal depression	05	Anxiety/phobia/panic disorder/OCD	06
Alcohol misuse	07	Alcohol dependence	08	Drug misuse	08
Drug dependence	10	Personality disorder	11	Adjustment disorder/reaction	12
Learning disability	13	Eating Disorder	14	Dementia	15
Other psychotic illnesses (e.g. psychotic depression, unspecified nonorganic psychosis, drug and alcohol related psychosis)	16	Asperger's/Autistic spectrum	17	ADHD	18
No mental disorder	19	Not known	20		

4.9 Any relevant information with regards to current and/or on-going mental health and learning disability diagnoses

E.g. units of alcohol, drug misuse type/quantity/method of administration (smoking, injecting), personality disorder

4.10 Type of mental state assessment carried out at last face to face contact **(tick all that apply)**

No mental state assessment documented	01	Some level of mental health assessment documented	02	Assessment tool used (e.g. HAD, Beck's depression inventory)	03
Some level of mental health assessment documented & assessment tool used	04	Other form of mental state assessment	05	Not known	99

4.11 Date of last mental state assessment in primary care

DD	MM	YYYY

4.12 Documentation of suicide risk (related to the last mental state assessment either at last face to face contact or in last 12 months)

No thoughts, plans or intent of suicide documented	01	Thoughts and ideas about suicide documented but no intent or plans	02	Clear suicide intent or suicide plans documented	03

4.13 Risk management interventions (distinguish between planned and implemented)

Planned	Implemented

4.14 Treatments taken up in last 12 months (tick all that apply)

Social Prescribing/Interventions	01	Talking therapies	02	Prescribed medication	03
Other	04	No treatment offered	05	Treatment declined	06
Not known	99				

Additional comments (e.g. list all medications prescribed at time of death irrespective of purpose, safe prescribing, and dates) Use psychotropic group types outlined in appendix 2 for analysis.

4.15 Did the patient adhere to their medication/treatment plan?

Yes	01	No	02	Partially	03
Not Known	99				

4.16 History of self-harm

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

4.17 Number of known previous suicide / self-harm attempts and when

4.18 Suicidal thoughts, plans or intent expressed at last primary care contact

Yes	01	No	02	Not Known	03

4.19 Suicide risk, thoughts, plans or intent documented in the 6 months prior to suicide in primary care notes

Yes	01	No	02	Not Known	03

4.20 Other agencies involved in 12 months prior to suicide

Substance misuse services	01	Alcohol services	02	Probation service / youth justice	03
Social services	04	Voluntary sector services	05	Accommodation services	06
Occupational health	07	Faith community	08	Employment service	09
Other	10	Not known	99		

Section 5 Information relating to acute hospital services – other than psychiatric hospital (this information can often be obtained from primary care file)

5.1 Number of times patient seen in A&E/hospital in 12 months prior to suicide

None	01	1 - 5 times	02	6 - 10 times	03
More than 10 times	04	Multiple occasions but exact number not known	05	Not known	06

5.2 Reasons for attendance at A&E or hospitalisation (if hospitalised) in 12 months prior to suicide

Date	Reason for attendance

5.3 Date of last discharge from A&E Department or hospital (if recently hospitalised)

DD	MM	YYYY

5.4 Was a psychosocial assessment carried out prior to discharge?

Yes	01	No	02	Not Known	03

Section 6: Information relating to psychiatric history (likely to be found in mental health trust records or Post Incident Review Reports in Coroner's files)

6.1 Past psychiatric status (includes contact before the 12 months prior to death)

No known previous contact with mental health service	01	One or more previous contacts with mental health services (community only services) within a psychiatric specialty but not subject to CPA	02	One or more previous contacts with mental health services (community only services) within a psychiatric specialty and subject to CPA	03
One or more previous contacts involving hospital in-patient service within a psychiatric specialty	04	Not known	99		

6.2 Date of last contact with specialist mental health services (excluding any based within primary care e.g. practice based counsellors or graduate workers – but including link workers and CMHT staff)

DD	MM	YYYY

6.3 Nature of last contact

No contact	01	Assessment, but not taken on caseload	02
Discharge from inpatient care	03	Discharge from caseload	04
Contact while on caseload	05	Not known	99

6.4 If applicable, dates of last admission and discharge from psychiatric in-patient ward.

	DD	MM	YYYY
Admission			
Discharge			

6.5 If applicable, had there been face to face contact with the patient by mental health provider within 7 days of discharge from in-patient care?

Yes	01	No	02	Not Known	03

6.6 Please state the number of days between discharge and first contact

6.7 Number of admissions to psychiatric in-patient ward in the past 5 years (including any admission at time of death)

None	01	1 – 5 admissions	02	More than 5 admissions	03
Not known	99				

Additional comments associated with diagnosis

Free text

6.8 History of violence to the deceased (i.e. serious threat or assault causing significant physical harm, including sexual assault)

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.9 History of alcohol misuse

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.10 History of drug misuse

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.11 Was a serious untoward incident (SUI) report carried out? This report may be separate to the individual patient file and therefore may need to be requested separately.

Yes	01	No	02	Not Known	03

If yes, note the theme of recommendations

Appendix 2 – Adapted audit proforma

Lancashire Suicide Audit Proforma

Section 1: Demographic details

1.1 Date of birth

DD	MM	YYYY

1.2 Date of death

DD	MM	YYYY

1.3 Age

1.4 NHS number

1.5 Coroner's office

1.6 District of residence

1.7 Sex

Male	01	Female	02	Non-binary	03

1.8 Sexual orientation

Heterosexual	01	Homosexual	02
Bi-sexual	03	Not known	99

1.9 Resident's postcode

1.10 Ethnicity

White British	01	White Irish	02	Any other White background (please specify ……)	03
Mixed White and Black Caribbean	04	Mixed White and Black African	05	Mixed White and Asian	06
Any other mixed background	07	Indian	08	Pakistani	09
Bangladeshi	10	Any other Asian background	11	Caribbean	12
African	13	Any other Black background	14	Chinese	15
Any other ethnic group	88	Not known	99		

1.11 Marital status

Single	01	Married	02	Divorced	03
Widowed	04	Separated	05	Co-habiting	06
Civil partnership	07	Other (specify……)	88	Not known	99

1.12 Living situation at time of death

Alone	01	Spouse/partner	02	Spouse/partner and child(ren) < 18	03
Child(ren) under 18 only	04	Child(ren) over 18	05	Parents	06
Other family	07	Adults (non-family)	08	Other shared	09
Prison	10	Fostercare/ children's home	11	Other (specify……..)	88
Not known	99				

1.13 Did the deceased have any dependants at time of death?

Yes (please specify …….....)	01	No	02	Not Known	99

1.14 Occupation at time of death

Free text field

1.15 Employment status at time of death

Working full-time	01	Working part-time	02	Sheltered work	03
Unemployed	04	Long-term sick or disabled	05	Caring for home/family	06
Student (full-time)	07	Student (part-time)	08	Retired	09
Housewife/househusband	10	Volunteer	11	Other	88
Not known	99				

1.16 Had the deceased ever served in the armed forces?

Yes (please give details …….....)	01	No	02	Not Known	99

Section 2: Circumstances of death

2.1 Was there a suicide note (to include emails, text, social media posts etc)?

Yes (please give details……)	01	No	02	Not Known	99

2.2 Location and description of event

Freetext (e.g. home/elsewhere, who found them)

2.3 Location postcode/address (where possible)

2.4 Method of death (if more than one, please give direct cause)

Self-poisoning	01	Carbon monoxide poisoning	02	Hanging/ strangulation	03
Drowning	04	Firearms	05	Cutting or stabbing	06
Jumping from a height	07	Jumping/lying before a train	08	Jumping/lying before a road vehicle	09
Suffocation	10	Deliberate fire	11	Electrocution	12
		Other (please specify…….)	88	Not known	99

2.5 If self-poisoning, specify the substance group and individual substance that <u>directly</u> caused death (Obtained from post mortem/toxicology report. If more than one substance directly responsible, list all drugs or substances)

Method not self-poisoning	00	Anti-psychotic drug……	01	Tricyclic anti-depressant……..	02
SSRI/SNRI antidepressant	03	Lithium / other mood stabiliser	04	Benzodiazepine/ other hypnotic	05
Paracetamol	06	Paracetamol/ opiate compound ……..	07	Salicylate …….	08
Opiate …….....	09	Other poisons (e.g. weedkiller) ……..	10	Other illicit drug ……	11
Other drug ……...	88	Not known	99		

2.6 Where did the self-poisoning substance referred to above come from?

Method of suicide was not self-poisoning	01	Prescribed for the subject	02	Prescribed for someone else	03
A combination of substances prescribed for more than one person	04	Not prescribed (please specify method of obtainment if known……)	05	Not known	99

2.7 Aside from the direct cause of death, had any other substances been taken at the time of death? Specify the substance groups and individual substances (To include deaths by any cause where a non-fatal overdose had also been taken) Use directory for reference

No (other) substances taken	00	Anti-psychotic drug ……	01	Tricyclic anti-depressant ……..	02
SSRI/SNRI anti-depressant ……	03	Lithium / other mood stabiliser ……	04	Benzodiazepine/ other hypnotic ……	05
Paracetamol	06	Paracetamol/opiate compound ……...	07	Salicylate ……	08
Opiate ……	09	Other poisons (e.g. weedkiller) ……..	10	Other illicit drug ……	11
Other Drug ……	88	Not known	99		

2.8 Was alcohol taken at time of death?

Yes	01	No	02		Not Known	99

2.9 What was the blood alcohol % (can be found in post mortem/toxicology report)?

2.10 Factors contributing to suicide

For example: job loss/ social isolation/ relationship breakdown/ bereavement/ financial difficulties/ bullying

Suicide verdict	01	Open verdict	02

2.12 In the opinion of the coroner or other agencies are there lessons to be learned from this case that might help prevent suicides in the future?

Free text

2.13 Was a serious untoward incident (SUI) report, root cause analysis or serious case review carried out by any agency involved in the case?

Yes	01	No	02	Not Known	99

If yes, note the theme of recommendations

Section 3: Contact with criminal justice system

3.1 History of any known previous contact with the criminal justice system

Yes	01	No	02	Not Known	99

3.2 If yes, did this contact occur in the 12 months before death?

Yes	01	No	02	Not Known	99

If no to question 3.2 please give details, including the date/time-frame of contact (if known)

If yes go to question 3.3

3.3 History of being in prison or Young Offenders Institution at any time in the 12 months before death (including being a remand prisoner)

Yes	01	No	02	Not Known	99

3.4 History of being involved with the probation service at any time in the 12 months before death

Yes	01	No	02	Not Known	99

3.5 Had there been any custodial contact in the 12 months before death?

Yes	01	No	02	Not Known	99

If the answer to question 3.5 was yes

3.6 Date of last custodial contact

DD	MM	YYYY

3.7 Custody location

3.8 Offence type

3.9 Custodial risk assessment information (either pre-custody or pre-release)

E.g. disclosure of self-harm history, MH diagnosis, risk level, observations, actions taken etc

Section 4: Information relating to contact with health services

4.1 Other physically and/or sensory disabling condition (non-psychiatric) at the time of death

Free text field

4.2 Medications prescribed for the deceased at time of death

4.3 Were primary care records present in inquest file?

Yes	01	No	02

4.4 Date of last contact with General Practitioner or primary health care team

Within 1 week	01	Within 1 month	02	Within 3 months	03	Within 6 months	04
Within 1 year	05	More than 1 year	06	Not known	99		

4.5 Reason for last contact

Mental health	01	Physical health	02	Both	03

4.6. If contact was for physical health had the patient ever been seen by their GP for mental health problems?

Yes	01	No	02	Not Known	99

4.7 If yes to question 4.6, had they been seen by their GP within the 12 months before death?

Yes	01	No	02	Not Known	99

4.8 If known, when did the patient first develop mental health problems/consult their GP for mental health problems? (Please give the date or year/age of patient if exact date not known)

DD	MM	YYYY

4.9 Did the deceased have a diagnosed mental health condition? (Only include diagnoses corroborated by GP/mental health/other health or service records and not based solely upon the testimony of family or friends)

Yes	01	No	02	Not Known	99

4.10 Current and / or ongoing diagnoses (tick all that apply)

Schizophrenia/schizoaffective disorders	01	Delusional disorders	02	Bipolar affective disorder	03
Depression	04	Post-natal depression	05	Anxiety/phobia/panic disorder/OCD	06
Alcohol misuse	07	Drug misuse	08	Personality disorder	09
Adjustment disorder/reaction	11	Learning disability	12	Eating disorder	13
Dementia	12	Eating Disorder	13	ADHD	14
Other psychotic illnesses (e.g. psychotic depression, unspecified nonorganic psychosis, drug and alcohol related psychosis)	15	Asperger's/Autistic spectrum	16	No mental disorder	17
Other (please specify……)	88	Not known	99		

4.11 Did the deceased have a history of perinatal mental health problems?

Yes (please specify ……)	01	No	02	Not applicable	03	Not known	99

4.12 Any relevant information with regards to current and/or on-going mental health and learning disability diagnoses

E.g. units of alcohol, drug misuse type/quantity/method of administration (smoking, injecting), personality disorder

4.13 Had the patient ever been in touch with specialist mental health services?

No known previous contact with mental health service	01	One or more previous contacts with mental health services (community only services) within a psychiatric specialty but not subject to CPA*	02	One or more previous contacts with mental health services (community only services) within a psychiatric specialty and subject to CPA	03
One or more previous contacts involving hospital in-patient service within a psychiatric specialty	04	Not known	99		

*CPA=Care programme approach (formal care plan for someone with a mental health condition)

4.14 Details of contact with specialist mental health services e.g. timescale of contact, team(s) involved

4.15 Date of last contact with specialist mental health services (either face to face or by phone)

Within 1 week	01	Within 1 month	02	Within 3 months	03	Within 6 months	04
Within 1 year	05	More than 1 year	06	Not known	99		

4.16 Nature of last contact

No contact	01	Assessment, but not taken on caseload	02
Discharge from inpatient care	03	Discharge from caseload	04
Contact while on caseload	05	Assessment and taken on caseload	06
Referred/transferred to another mental health service	07	Not known	99

4.17 Date of last mental state assessment (if known)?

DD	MM	YYYY

4.18 Who carried out this mental state assessment? (E.g. GP, psychiatrist, mental health practitioner, counsellor, recovery worker)

4.19 Nature of mental state assessment

Face to face	01	Telephone	02	Other (specify……)	88

4.20 Type of mental state assessment carried out (tick all that apply)

No mental state assessment documented	01	Some level of mental health assessment documented	02	Assessment tool used (e.g. HAD, PHQ9)	03
Some level of mental health assessment documented & assessment tool used	04	Other form of mental state assessment	88	Not known	99

4.21 Documentation of suicide risk in the previous 12 months

No thoughts, plans or intent of suicide documented	01	Thoughts and ideas about suicide documented but no intent or plans	02	Clear suicide intent or suicide plans documented	03

4.22 Risk management interventions (distinguish between planned and implemented)

Planned	Implemented

E.g. Increase visits: frequency/duration, CBT Strategies: increase activities, Arrange prescription or change of medication, referrals to other services (state the service)

4.23 Treatments taken up in last 12 months for mental health problems (select all that apply)

Social Prescribing/ Interventions	01	Talking therapies	02	Prescribed medication	03
No treatment offered	04	Treatment declined	05	Other (please specify…..)	88
Not known	99				

4.24 Number of admissions to psychiatric inpatient ward in the past 5 years (including any admission at time of death)

None	01	1 – 5 admissions	02	More than 5 admissions	03
Not known	99				

4.25 If applicable, dates of last admission and discharge from psychiatric in-patient ward.

	DD	MM	YYYY
Admission			
Discharge	DD	MM	YYYY

4.26 If most recent admission was in the 12 months before death, had there been face to face contact with the patient by mental health provider within 7 days of discharge from in-patient care?

Yes	01	No	02	Not Known	99

4.27 Number of times patient seen in A&E/hospital in 12 months prior to suicide

None	01	1 – 5 times	02	6 – 10 times	03
More than 10 times	04	Multiple occasions but exact number not known	05	Not known	99

4.28 Reasons for attendance at A&E, hospitalisation (if hospitalised) or attendance at outpatient clinic in 12 months prior to suicide

Mental health	01	Physical health	02	Both	03

Date	Reason for attendance

4.29 Date of last discharge from A&E Department, hospital (if recently hospitalised) or attendance at outpatient clinic

DD	MM	YYYY

4.30 Was a psychosocial assessment carried out prior to discharge?

Yes (please give Details……)	01	No	02	Not Known	99

4.31 Any further details relating to contact with healthcare services

Section 5: Information relating to contact with other services

5.1 Other agencies involved in 12 months prior to suicide

Substance misuse services	01	Residential care (including looked after children)	02	Probation service / youth justice	03
Social services	04	Voluntary sector services	05	Accommodation services	06
Occupational health	07	Faith community	08	Employment service	09
Benefits services	10	None	11	Other (please specify ……)	88
Not known	99				

5.2 Please give details of their involvement (if known)

5.3 Date of last contact with other services

DD	MM	YYYY

5.4 Details of last contact (if known)

Free text

Section 6: Personal details

6.1 History of previous suicide attempts

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.2 History of self-harm

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.3 History of violence to the deceased (i.e. serious threat or assault causing significant physical harm. This includes sexual assault)

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.4 If there is a history of violence, please give details relating to the nature of violence

6.5 History of alcohol misuse

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.6 History of drug misuse

No history	01	Only within 12 months prior to death	02	Only prior to 12 months before death	03
Lifetime history	04	Unknown	99		

6.7 If there is a history of drug misuse please give details e.g. substances used, nature of administration, timescale of use
