

April 2019



Hertfordshire Suicide Audit 2017

Background

- ◆ Hertfordshire's Suicide Prevention Strategy was developed in 2017, in line with national guidance. This guidance recommends that local authorities carry out an annual suicide audit. Suicide audits identify the context in which suicides occur, the local groups potentially most at risk, and how the picture changes over time.
- ◆ This audit provides an overview of suicides in Hertfordshire given a Coroner's conclusion at inquests held in 2017. The audit uses information from files held by the coroner service and has been carried out to a new, more robust and repeatable methodology. The 74 deaths included were given a Coroner's conclusion between 1 Jan and 31 Dec 2017, with the majority of deaths occurring in 2016.
- ◆ The report includes recommendations for improving the process but does not include recommendations for action since the information is drawn from relatively small numbers and there is a danger in drawing conclusions on the basis of this data alone. Although each of the 74 deaths included represents a personal tragedy with potentially devastating consequences for others, statistically speaking these are small numbers. Other data sources such as ONS death registrations, police, NHS and other service data are also taken into account by multi-agency working to reduce and prevent suicide. This audit is just one source of information and data.
- ◆ The number of suicides in this audit is an increase from the 56 included in the 2015/16 audit. As the numbers of suicides at local authority level are relatively small, changes between years are best reviewed by using three year age standardised rates.
- ◆ The suicide rate in Hertfordshire is significantly lower than the rate for England and has remained lower over time. There has been no significant change in the rate for Hertfordshire over time.

Key findings from 2017 audit

- ◆ In line with national findings, men aged 40-59 years old made up the highest proportions of people dying by suicide in the 2017 Hertfordshire Suicide Audit.
- ◆ Mental health issues were the most common risk factor mentioned in coroner's files.
- ◆ Over a third of people included in the audit were known to a mental health service at the time of death, whilst almost a quarter discussed mental health issues with a member of their GP practice in the four weeks leading up to their death.
- ◆ A third of people who died by suicide were known to have made a previous suicide attempt.
- ◆ More than one in ten suicides took place on the railway, higher than nationally.

Recommendations

- ◆ While no longer a statutory requirement, suicide audits should continue to be carried out every year for Hertfordshire.
- ◆ Hertfordshire's suicide prevention strategy should be refreshed drawing on data from this audit, and the forthcoming 2018 audit.
- ◆ Trends should be reviewed once the 2019 audit has been completed.
- ◆ The next audit (for 2018) should:
 - report the number of deceased people known to the local mental health trust separately from those known to trusts out of area
 - collect postcode data for the location of each suicide, to identify potential hotspots
 - review the list of risk factors, to ensure categories are meaningful and significant.
- ◆ The findings of this and future audits should be communicated in order to inform and support the work of partners.
- ◆ An update on recommendations from the last Audit is included as Appendix 3.

Conclusion

- ◆ Review of the coroner's records for each individual showed, with hindsight, that there remain opportunities to identify and support people at risk of suicide. The continued challenge is to spot and act on these signs, for individuals, for communities, and for services across Hertfordshire.

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Contents

Introduction.....	5
Methodology	6
Suicide definition	6
Data collection	6
Summary of audit findings	8
Demographics	9
Age and sex.....	9
Marital status.....	9
Employment status.....	9
Place of birth.....	10
Place of residence.....	10
Equality data.....	12
Circumstances of death	13
Method of suicide.....	13
Location of suicide.....	14
Suicide message.....	14
Alcohol and drug use at time of death	14
Contact with health care services.....	14
Primary care.....	14
Mental health services	15
Alcohol and drug services.....	16
Accident and Emergency attendances	17
Other risk factors	17
Recommendations.....	19
Conclusion.....	19
Appendix 1: Data collection template	20
Appendix 2: Forensic toxicology groupings.....	23
Appendix 3: Update to 2015/16 recommendations.....	24

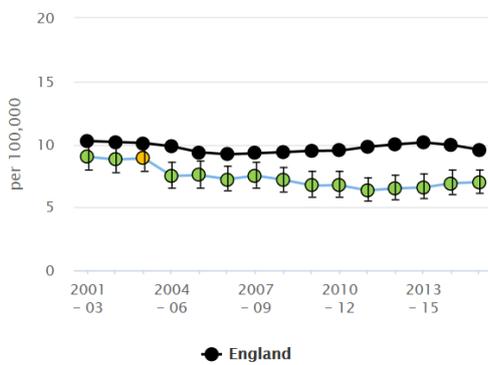
Introduction

There has been a downward trend in suicide rates within England (and East of England), albeit with several statistically significant peaks.¹ However, there is no room for complacency: in 2017 there were 5,821 suicides registered in England, an age-standardised rate of 10.1 deaths per 100,000 population.

Over the latest three year period (2015-17) 214 suicides were registered in Hertfordshire (74 in 2015, 64 in 2016 and 76 in 2017²), an age-standardised rate of 7.0 per 100,000 (Figure 1). The suicide rate in Hertfordshire has been statistically significantly lower than the rate for England from 2004-06 onwards and has remained statistically similar over time (Figure 1). As local authority level rates are based on relatively small numbers, changes can often be a result of random fluctuation. The annual number of suicides registered in Hertfordshire has fluctuated between 52 and 95 over a 16 year period (2002 to 2017)².

Compared with benchmark: Better Similar Worse

Suicide: age-standardised rate per 100,000 population (3 year average) (Persons) Hertfordshire Directly standardised rate - per 100,000



Period	Count	Value	Lower CI	Upper CI	East of England region	England
2001 - 03	240	9.0	7.9	10.2	9.6	10.3
2002 - 04	235	8.8	7.7	10.0	9.6	10.2
2003 - 05	240	8.9	7.8	10.1	9.3	10.1
2004 - 06	202	7.5	6.5	8.6	9.1	9.8
2005 - 07	206	7.5	6.5	8.7	8.8	9.4
2006 - 08	200	7.2	6.3	8.3	9.0	9.2
2007 - 09	213	7.5	6.5	8.6	8.9	9.3
2008 - 10	206	7.2	6.2	8.2	8.9	9.4
2009 - 11	196	6.7	5.8	7.8	8.8	9.5
2010 - 12	197	6.7	5.8	7.8	8.9	9.5
2011 - 13	187	6.3	5.5	7.3	8.9	9.8
2012 - 14	194	6.5	5.6	7.5	9.0	10.0
2013 - 15	197	6.6	5.7	7.6	9.3	10.1
2014 - 16	209	6.9	6.0	7.9	9.7	9.9
2015 - 17	214	7.0	6.1	8.0	9.3	9.6

Source: Public Health England (based on ONS source data)

Figure 1: Suicide rates, Hertfordshire and England, 2001-03 to 2015-17, Public Health England, Suicide Prevention Profile³

The death of someone by suicide can have a devastating effect on families, friends, colleagues, first responders, staff, the wider community and beyond. It has been estimated that around 135 people may be affected by each person dying by suicide.⁴ There is also a considerable economic cost- estimated at around £1.7 million per death.⁵

Hertfordshire has lower rates of suicide than the national and regional levels, but nonetheless, in 2017, inquests were concluded by the Coroner on 75 deaths attributable to suicide.⁶

¹ Office for National Statistics (2018). *Suicides in the UK: 2017 registrations*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

² Office for National Statistics (2018). *Suicides in England and Wales by local authority*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

³ Public Health England (2019). *Suicide Prevention Profile*. <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide>

⁴ Cerel, J. et al. (2018). *How Many People are Exposed to Suicide? Not Six*. *Suicide and Life-Threatening Behaviour* <https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12450>

⁵ Forward for life (2016). *Suicide and Suicide Prevention*. https://hgs.uhb.nhs.uk/wp-content/uploads/Suicide-and-Suicide-Prevention_SandB_Handout.pdf

⁶ recorded as suicide or open verdict (see 'Suicide definition', page 6)

National guidance⁷ recommends that every local authority carries out an annual suicide audit, though they are no longer a statutory requirement, develops a suicide prevention action plan, and establishes a multi-agency group to co-ordinate effective action within the local area. In 2016 Hertfordshire responded to this guidance by developing a multi-agency approach to suicide prevention and a strategy and plan. Part of this plan was to review and improve the suicide audit process. There is no nationally agreed standard for an audit.

Work was carried out by a multi-agency group consisting of representatives from Hertfordshire County Council (Public Health, Coroner Service, Integrated Health and Care Commissioning), Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire Police Constabulary and British Transport Police. The group agreed what information to capture from the coroner's files on each individual, and a more robust, consistent and objective process was developed. The aim was to ensure the integrity of the audit results irrespective of who carried it out, and also ensure the comparability of results from audits in subsequent years. This audit, covering the calendar year 2017, is the first to be carried out following the revised process.

Apart from providing a more detailed insight into suicide within Hertfordshire, the key value of suicide audits is to identify trends and any areas where additional focus or emphasis is required locally versus the national picture. This intelligence is used to inform the local strategy. Data for the 2018 suicide audit was collected in February 2019, and will allow two years' worth of directly comparable, consistent data to be used to inform a 2019/20 revision of the Hertfordshire Suicide Prevention Strategy. An update on recommendations from the last audit is at Appendix 3

Accordingly, this report will comprise analysis of the 2017 data. As it is an audit it will not attempt to draw direct conclusions about what additional work needs to be done within Hertfordshire to reduce suicides. National guidance is currently being updated and a national sector led improvement exercise is being led by the Association of Directors of Public Health which will report shortly.

Methodology

Suicide definition

This audit uses the National Statistics definition of suicide, also used by Public Health England; this includes all deaths from intentional self-harm for persons aged 10 years and over (where a coroner has given a suicide conclusion), and deaths from injury or poisoning where the intent was undetermined for those aged 15 years and over (mainly deaths where a coroner has given an open conclusion).⁸ This is a commonly used method.

Data collection

75 deaths by suicide with a Hertfordshire Coroner Service inquest concluding in 2017 were identified for the audit. 70 deaths were recorded as suicide (intentional self-harm) and five were identified as injury or poisoning of undetermined intent. One suicide (intentional self-harm) was excluded as the coroners file was unavailable at the time of the audit, reducing the total to 74.

⁷ Department of Health and Social Care (2012). *Suicide prevention strategy for England*. www.gov.uk/government/publications/suicide-prevention-strategy-for-england

⁸ Office for National Statistics (2018). *Suicides in the UK: 2017 registrations*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

The 74 inquests concluding in 2017 included deaths occurring between June 2015 and June 2017. The median length of days between the date of death and inquest conclusion was 226 (approximately 32 weeks). For comparison, ONS recorded a median registration delay of 152 days (approximately 22 weeks) in England in 2017.⁹ Registration of a death typically occurs within a few days or weeks of the inquest conclusion.

Hertfordshire Coroner Service is responsible, in the main, for investigating deaths that occur in Hertfordshire. This means this audit, and future audits:

- may include people whose usual place of residence was not Hertfordshire
- may not include all Hertfordshire residents as some will have died outside of Hertfordshire and been investigated by another coroner's office
- use a different cohort to the annually published ONS and Public Health England figures, as these are based on local authority of residence and calendar year of registration.

As coroners can pass cases to each other, this may include deaths of Hertfordshire residents where the death took place outside the county, and vice versa.

Collection of the data involved staff visiting the coroner's office to review records in detail. Significant time was required to sift through the paper files to pull out the items of interest. On average, around six deaths per staff member were reviewed in a day. A standardised electronic questionnaire was developed in Microsoft Excel to collect the data from each record using a combination of free text and dropdowns wherever possible (see Appendix 1). This included:

- coroner's conclusion
- post-mortem and toxicology
- General Practitioner (GP) records
- reports from hospital doctors or other specialists including Mental Health Services
- police reports (including witness statements)

The questionnaire ensured that reporting was targeted to pertinent areas of the coroners' records and that data were collected consistently by staff. The records were reviewed by local authority public health staff on-site at the coroner's office, with input from the Mortality Governance Team at Hertfordshire Partnership University NHS Foundation Trust during the initial two data collection days. In total, ten staff members collected the data from the records between September and November 2018. These data were then collated into one dataset.

Statistical analysis

Because of the small numbers and the incompleteness of data available for many variables, statistical analysis for this report is mainly limited to counts and percentages. Due to rounding, numbers presented throughout this report may not add up precisely to the totals indicated and percentages may not precisely reflect the absolute figures for the same reason. All findings are indicative, and no significance testing of differences was carried out. Due to the smaller number of women who died by suicide (15 suicides) breakdowns by sex are not always provided.

Lower and upper confidence limits are shown on the age specific and local authority district charts (Figures 2 and 4) to highlight the range of uncertainty (caused by sample size and random variation) around the rate values. They appear as whiskers extending above and below the value. If the confidence interval around a figure overlaps

⁹ Office for National Statistics (2018). *Suicides in England and Wales by local authority*.

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures. Calculations based on small numbers of events are often subject to random fluctuations.

Summary of audit findings

The summary below is based on the 74 suicides with a Hertfordshire Coroner Service inquest concluding in 2017 (details of data and collection process are provided in the Methodology section on page 6).

Demographics

- More than three-quarters (80%) of the 74 suicides included in the audit were by men.
- Almost half (45%) of people who died by suicide were aged 40 to 59.
- The highest suicide rate was among men aged 45 to 59-years old.
- There were five suicides by young people aged under 25, and seven by people over 80 years old.
- 14% of the people included in the audit lived outside of Hertfordshire.
- 81% were born in the UK (22% in Hertfordshire).
- Over a third (36%) of people dying by suicide were married.
- 41% were employed, whilst 22% were unemployed and 22% were retired.

Circumstances of death

- Over half (55%) of suicides were by hanging, strangulation or suffocation. The second most common method of suicide was self-poisoning (20%), followed by deaths on the railway (12%).
- Most suicides took place at the individual's home (54%). The next most common location was woodland or park (15%), followed by railway (12%).
- Almost half (46%) left a suicide message.

Contact with primary care

- 62% of people who died by suicide had a mental health issue or condition recorded by their GP practice.
- Almost a quarter (23%) of people who died by suicide discussed mental health issues with a member of their GP practice in the four weeks leading up to their death.
- Around one in six (16%) were known to have contacted their GP practice in relation to their physical or mental health in the week prior to their death.

Contact with mental health services

- 41% of people who died by suicide were known to a mental health service at the time of death.
- A third (33%) of those in contact with a mental health service were in touch during the week leading up to their death, almost two-thirds (63%) were in touch in the four weeks prior to death.

Contact with alcohol and drug services

- 14% of people who died by suicide were known to drug or alcohol services.

Accident and Emergency attendance

- 16% of people who died by suicide had attended A&E due to self-harm, suicidal thoughts or suicide attempts in the 12 months prior to death.

Other risk factors

- Mental ill health issues were the most commonly reported risk factor.
- A third (32%) of people who died by suicide were known to have made a previous suicide attempt and one in five (20%) had a history of self-harm.
- A quarter (24%) of people who died by suicide were known to have been involved with the criminal justice system, 12% were in contact at the time of their death.

Demographics

Age and sex

Of the 74 suicides included in the audit, 80% (59) were men and 20% (15) were women. This is in line with national findings where males make up three-quarters of suicides, a proportion which has been mostly consistent since the mid-1990s.¹⁰

Almost half (45%) of the 74 suicides were by people aged 40 to 59 (Figure 2). Over a third of all suicides (37%) were men aged between 40 and 59 years old (Figure 2). In line with national findings the highest rate per 100,000 population for men was in the 45 to 59-year age group (Figure 3). It is harder to determine a pattern by age for the 15 women dying by suicide due to the smaller number. Nationally rates are highest for women in the 45 to 59-year age group, as they are for men.

In Hertfordshire the average age of people who died by suicide was 50. There were five suicides by young people aged under 25, including one aged under 18. There were seven suicides by people aged over 80.

Marital status

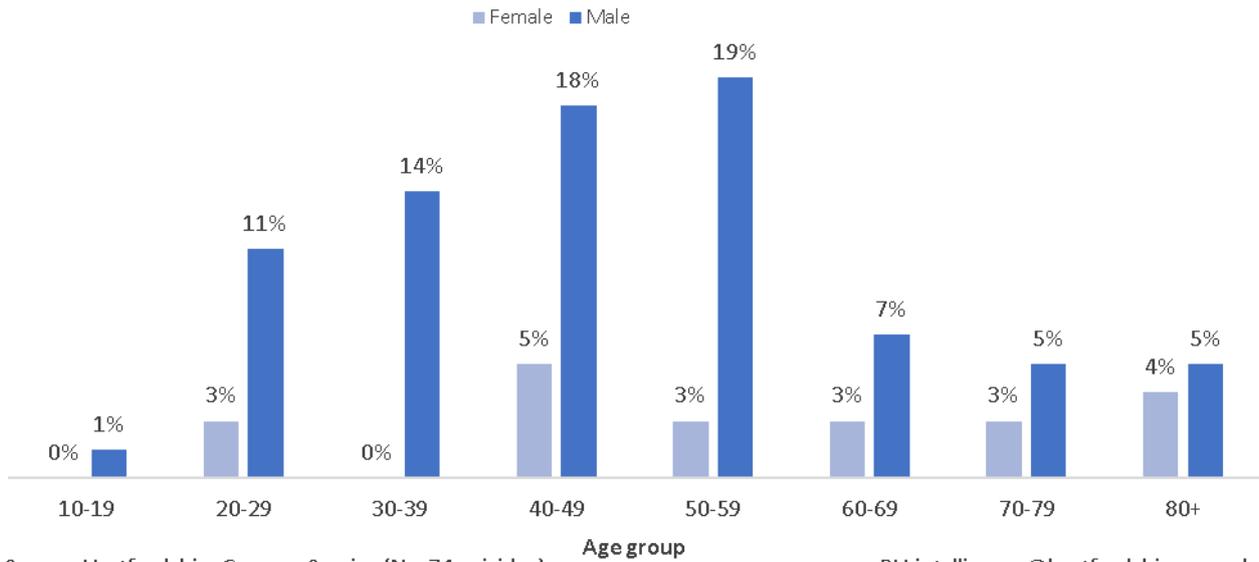
39% of individuals were recorded as single, with 36% married, 14% divorced and 11% widowed (although 'single' includes people who are in a relationship, but not married).

Employment status

41% of individuals were identified as in employment, with 22% unemployed, 22% retired and 7% unable to work due to illness or disability. The remainder were either full-time students or homemakers (5%) or missing employment status (4%).

¹⁰ Office for National Statistics (2018). *Suicides in the UK: 2017 registrations*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

Age and sex breakdown of suicides, percentage of all suicides, Hertfordshire Suicide Audit, 2017

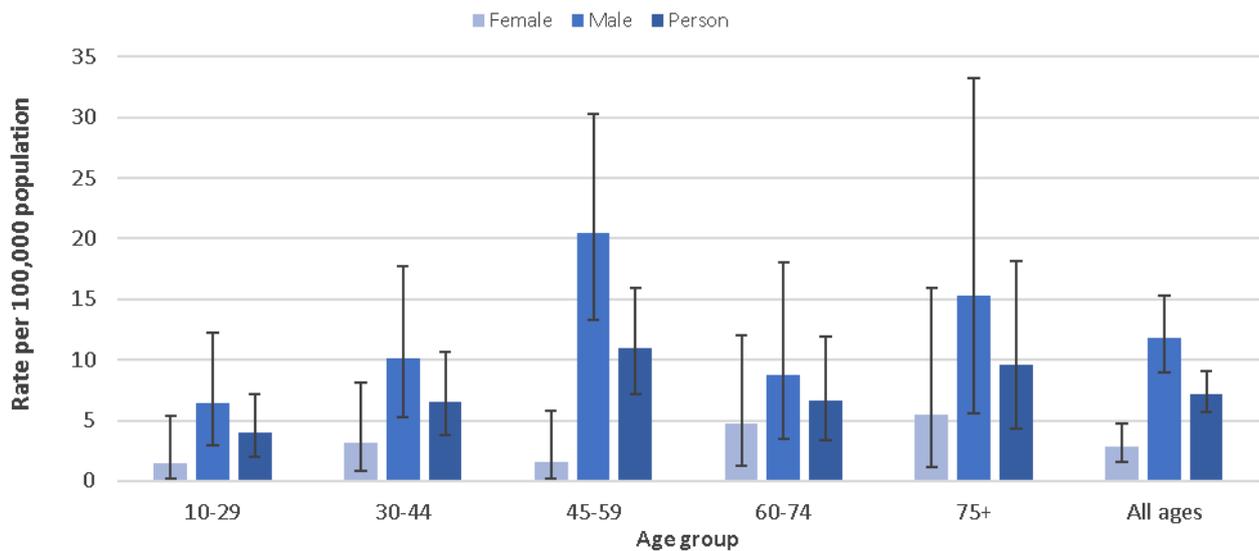


Source: Hertfordshire Coroner Service (N = 74 suicides)

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Figure 2: Age and sex breakdown of suicides

Age-specific suicide rates by broad age groups, by sex, Hertfordshire Suicide Audit, 2017



Source: Hertfordshire Coroner Service (N = 74 suicides), ONS MYE 2017

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Figure 3: Age-specific suicide rates by sex

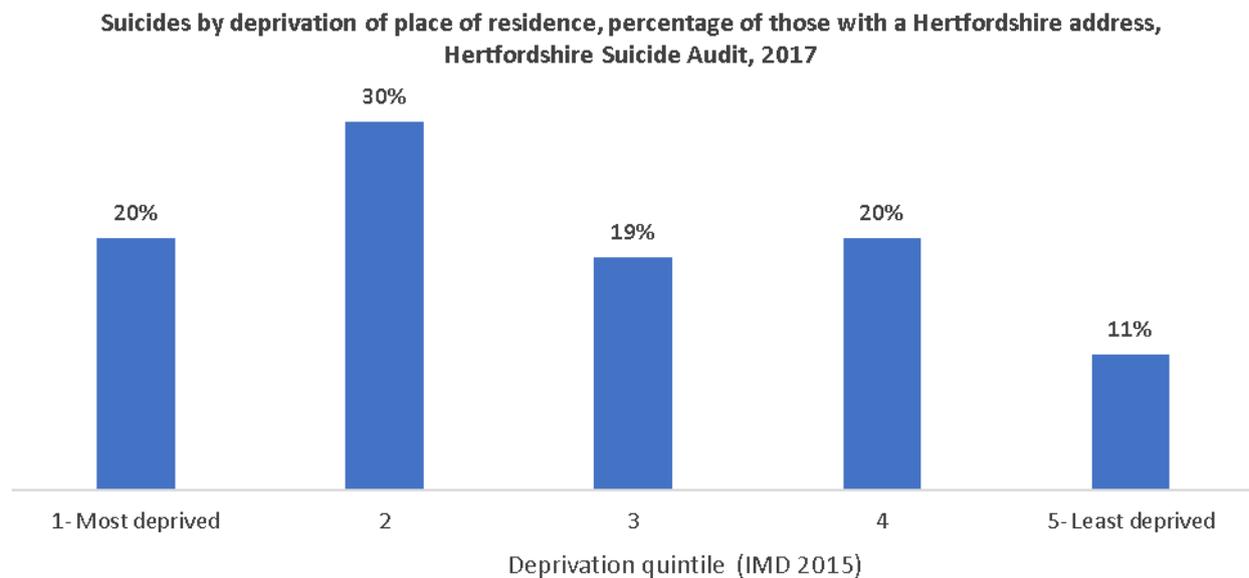
Place of birth

81% of people who died by suicide were born in the UK (22% Hertfordshire, 34% London, 26% rest of UK) and 18% were born outside of the UK. One record was missing place of birth.

Place of residence

Hertfordshire addresses were recorded as the usual place of residence for 64 (86%) of the 74 suicides. 11% of addresses were linked to a postcode outside of Hertfordshire and two suicides (3%) were recorded as no fixed abode.

Fewer suicides occurred amongst people living in the least deprived areas of Hertfordshire (11%), based on local quintiles (fifths) of deprivation. The highest proportion (30%) was amongst people living in the second most deprived quintile (Figure 4).



Source: Hertfordshire Coroner Service (N = 64 suicides)

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Figure 4: Suicides by local deprivation quintiles

Rates of suicide, based on the usual place of residence, were calculated for Hertfordshire districts and Clinical Commissioning Groups (CCG) (Figure 5). Although rates vary across the districts, due to the small numbers at this level (an average of less than 7 per district), the confidence intervals are wide, and we cannot say that these differences are statistically significant.

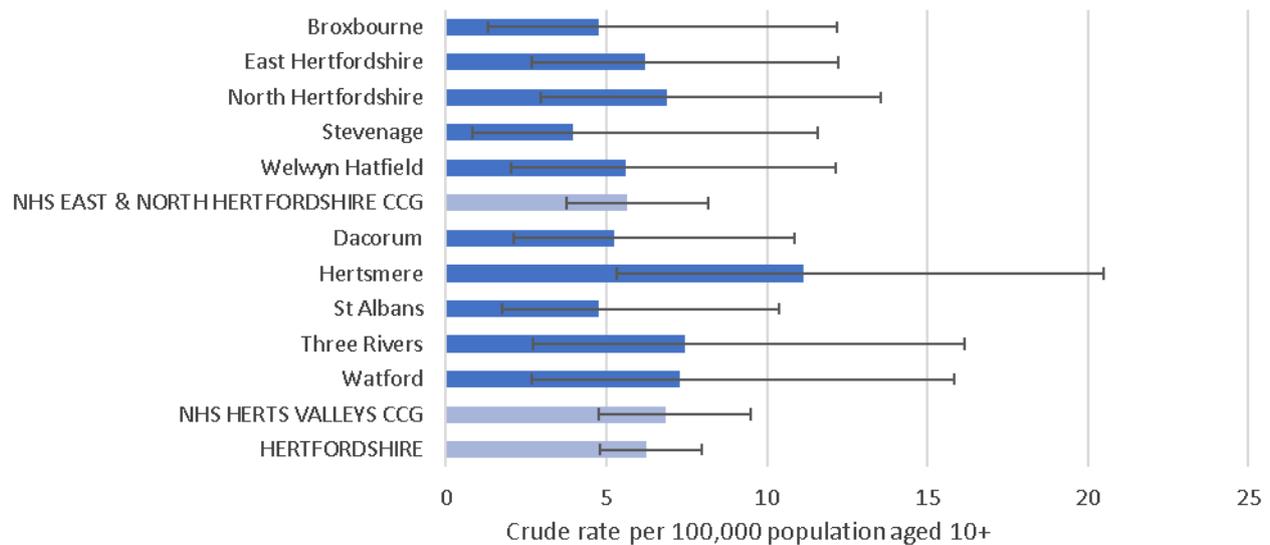
There were 28 suicides in the audit with an address in NHS East and North Hertfordshire CCG (ENHCCG), a crude rate of 5.7 per 100,000 population, and 35 in NHS Herts Valleys CCG (HVCCG), a crude rate of 6.8 per 100,000. The CCG rates are not statistically significantly different to each other or the rate for Hertfordshire (Figure 5). Nationally, rates for local authorities and CCGs are presented by aggregating three years of data and standardising for age (where numbers allow) for more meaningful comparisons.^{11 12}

¹¹ Office for National Statistics (2018). *Suicides in England and Wales by local authority*.

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

¹² Public Health England (2019). *Suicide Prevention Profile*. <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide>

Suicides by CCG and district of residence, crude rate per 100,000 population, Hertfordshire Suicide Audit, 2017



Source: Hertfordshire Coroner Service (N = 64 suicides), ONS MYE 2017 PH.intelligence@hertfordshire.gov.uk

Figure 5: Suicide rates by Clinical Commissioning Group (CCG) and district

Equality data

All files were checked for details of ethnicity, religion, sexual orientation, gender identity, disability and caring responsibilities. Sexual orientation was only recorded if explicitly stated in the coroners file (it was not assumed from marital or relationship status). Disability was only recorded if there was evidence of a registered disability. The Carers Trust definition was used to identify carers: “A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem, or an addiction cannot cope without their support.”¹³

These equality characteristics were not routinely recorded and were missing from most files. Table 1 lists the percentage of suicides where this data was available. Less than 20% of suicides had sexual orientation or religion recorded. Although ethnicity was recorded in 58% of suicides, not all could be matched to 2011 Census categories¹⁴ (e.g. ‘Caucasian’ or ‘White’ could not be mapped to Census categories), resulting in availability in only 42% of files. As these equality characteristics are unavailable for most suicides, breakdowns are not provided.

Equality characteristic	Data availability as percentage of all suicides
Ethnicity (2011 census categories)	42%
Religion	14%
Sexual orientation	15%
Gender identity (reassignment or intent)	0%
Disability	44%
Carer	43%

Table 1: Data completeness, percentage, of equality characteristics, Hertfordshire Suicide Audit, 2017
Source: Hertfordshire Coroner Service (N = 74 suicides)

¹³ Carers Trust (2019). *About carers*. <https://carers.org/what-carer>

¹⁴ Cabinet Office (2019). *Ethnicity categories and the 2011 census*. www.ethnicity-facts-figures.service.gov.uk/ethnicity-in-the-uk/ethnic-groups-and-data-collected

Circumstances of death

Method of suicide

Hanging, strangulation and suffocation: The most common method of suicide, for both men and women, was hanging, strangulation or suffocation as shown in Table 2. This accounted for 55% of all suicides in the audit (41 suicides), a similar proportion to nationally¹⁵. Among men the proportion was 59% (35 suicides) and among women it was 40% (6 suicides).

Method of suicide	Female	Male	Total
Hanging, strangulation, suffocation	40%	59%	55%
Self-poisoning	27%	19%	20%
On the railway	33%	7%	12%
Jumping from a height	0%	8%	7%
Other	0%	7%	5%

Table 2: Method of suicide, by sex, Hertfordshire Suicide Audit, 2017
Source: Hertfordshire Coroner Service (N = 74 suicides)

Poisoning: The second most common method overall was self-poisoning (20%, 15 suicides), although there were differences between men and women. Among men, self-poisoning accounted for 19% (11) of suicides (similar to nationally), and was the second most common method, whilst for women it accounted for 27% (4 suicides) and was the third most common method. Nationally the second most common method for women is self-poisoning (38%).

Of the 15 suicides by poisoning, the following substances were identified as contributing to the death (a suicide may have more than one contributing substance):

- prescription drugs (8 suicides, 4 involved drugs prescribed for the person who died by suicide)
- carbon monoxide (4 suicides)
- alcohol and/ or recreational drugs (4 suicides)
- analgesics / painkillers (3 suicides)

Railway: Overall, suicides on the railway was the third most common method accounting for 12% of suicides (9 suicides). These took place at, or near, seven different railway stations (six located in Hertfordshire) and involved eight people from Hertfordshire. For men it was the fourth most common method (7%, 4 suicides), with jumping from a height the third (9%, 5 suicides). For women, suicides on the railway was the second most common method (33%, 5 suicides). It should be noted that the smaller number of suicides by women in the audit means these proportions are more prone to fluctuations. Nationally, it is reported around 4.5% of suicides in the UK take place on the railway.¹⁶

¹⁵ Office for National Statistics (2018). *Suicides in the UK: 2017 registrations*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

¹⁶ Network Rail (2019). *Fatalities*. www.networkrail.co.uk/running-the-railway/looking-after-the-railway/delays-explained/fatalities

Location of suicide

Over half (54%) of people who died by suicide took their own life at home (53% of men and 60% of women). The next most common location was woodland or park (15%) followed by railway (12%).

Suicide message

There was evidence of a suicide message left by the deceased (using a variety of media such as a note or text) in just under half (46%) of suicides (47% of women and 46% of men).

Alcohol and drug use at time of death

A post mortem is always conducted in a case of suspected suicide. This includes a toxicology report to identify any substances present in the body that may have caused the death. For a small number of suicides there was no toxicology report as toxicology was either not possible or appropriate.

Alcohol, of varying levels of concentration, was recorded in approximately a quarter (27%) of suicides. Some toxicology reports suggested low levels of alcohol may be as a result of post-mortem changes.

Drugs listed in the toxicology results were grouped according to the Sheffield Teaching Hospitals NHS Foundation Trust Forensic Toxicology Test screening groups (Appendix 2).

- Opiates were recorded in the toxicology reports of 12% of suicides (9 suicides). Opiates include pain killers such as codeine and morphine, as well as heroin and methadone.
- Stimulants were recorded in 9% of suicides (7 suicides). Stimulants include amphetamine, cocaine, MDMA (ecstasy), etc.
- Cannabis was recorded in 4% of suicides (3 suicides).

Contact with health care services

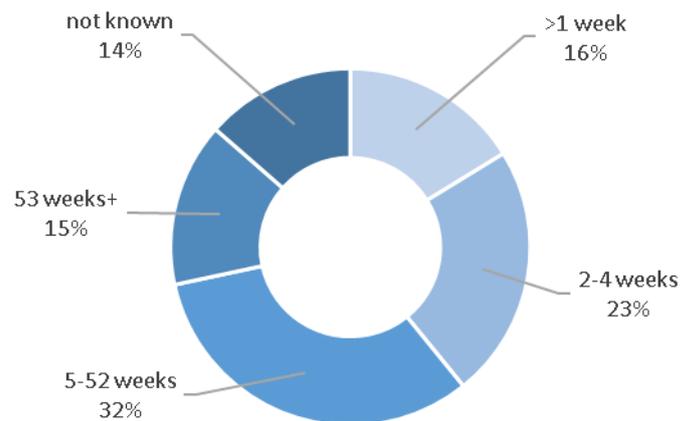
Primary care

93% of people who died by suicide were registered with a GP practice (76% with a GP practice in Hertfordshire). Three people who died by suicide (4%) were not registered with a practice, whilst it was unknown for two (3%).

Date of last contact with GP practice was missing for 10 (14%) of the 74 suicides (Figure 6). As shown in Figure 6, of the 74 suicides, it was known that around:

- three-quarters contacted their practice in the 12 months prior to their death (72%, 53 suicides)
- a third contacted their practice in the four weeks prior to their death (39%, 29 suicides)
- one in six contacted their practice in the week prior to their death (16%, 12 suicides)

Number of weeks between last contact with GP practice and death, Hertfordshire Suicide Audit, 2017



Source: Hertfordshire Coroner Service (N = 74 suicides) PH.intelligence@hertfordshire.gov.uk

Figure 6: Number of weeks between last contact with GP practice and suicide

Details of the reason for last contact with the primary care team was missing for 8 suicides (11%).

Last contact with the primary care team was known to be in relation to a mental health issue for over a third (39%, 29 suicides) of all people who died by suicide; 40% (24 suicides) for men and 33% (5 suicides) for women.

GP recorded mental health issues and conditions

There was evidence of GP recorded mental health issues or conditions for 62% (46) of people who died by suicide, 67% (10 suicides) for women and 61% (36 suicides) for men. Of these, 70% (32) had a treatment plan in place through primary care (60% for women and 72% for men). The most commonly recorded mental health issues and conditions were anxiety, stress, depression and psychotic disorders.

Almost a quarter (23%, 17 suicides) of people who died by suicide were known to have discussed mental health issues with a member of the primary care team in the four weeks leading up to their death (27% of women and 22% of men). Six people (8%) had discussed mental health issues with their primary care team in the week leading up to their death.

Mental health services

Mental health services include the local NHS trust (Hertfordshire Partnership University NHS Foundation Trust), out of area NHS trusts and private mental health services. All information in this section was provided by the relevant mental health services in response to a request from the coroner.

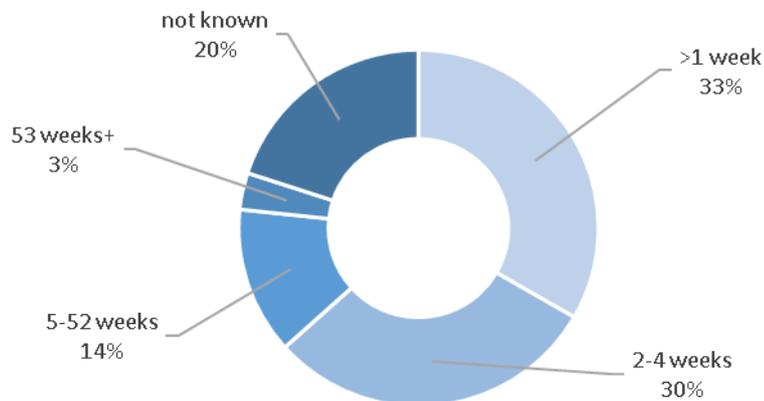
Overall, 41% (30 suicides) of people who died by suicide were known to a mental health service at the time of death (53%, 8 suicides, for women; 37%, 22 suicides, for men).

As shown in Figure 7, of the 30 people known to a mental health service at the time of death:

- the majority had been in contact within the 12 months prior to their death (77%, 23 suicides)
- 63% had been in contact in the 4 weeks prior to their death (19 suicides)

- a third were in contact in the week leading up to their death (33%, 10 suicides)
- the date of last contact with a mental health service was not recorded in coroner files for 20% (6 suicides)

Number of weeks between last contact with mental health services and death, Hertfordshire Suicide Audit, 2017



Source: Hertfordshire Coroner Service (N = 30 suicides) PH.intelligence@hertfordshire.gov.uk

Figure 7: Number of weeks between last contact with mental health service and suicide, known to a mental health service at the time of death

45% (33 suicides) of people who died by suicide had a history of contact with mental health services, with similar proportions for both women and men. 55% (41 suicides) were identified as having been known to a mental health service at some point in their life (either before or at time of death).

The most common mental health diagnoses or working diagnoses recorded by a mental health professional, either before or at time of death were:

- depression (71%, 29 suicides)
- anxiety (39%, 16 suicides)
- dual diagnoses of alcohol or drug misuse (27%, 11 suicides)
- schizophrenia and/ or personality disorder (15%, 6 suicides).

Please note: More than one diagnosis may have been recorded for each person.

Twelve people who died by suicide and had been in contact with a mental health service had no diagnoses recorded in the coroner files.

Alcohol and drug services

There was evidence that 14% (10 suicides) were known to a local, or out of area, drug or alcohol service. In line with the higher proportion of male suicides, the vast majority of these were men.

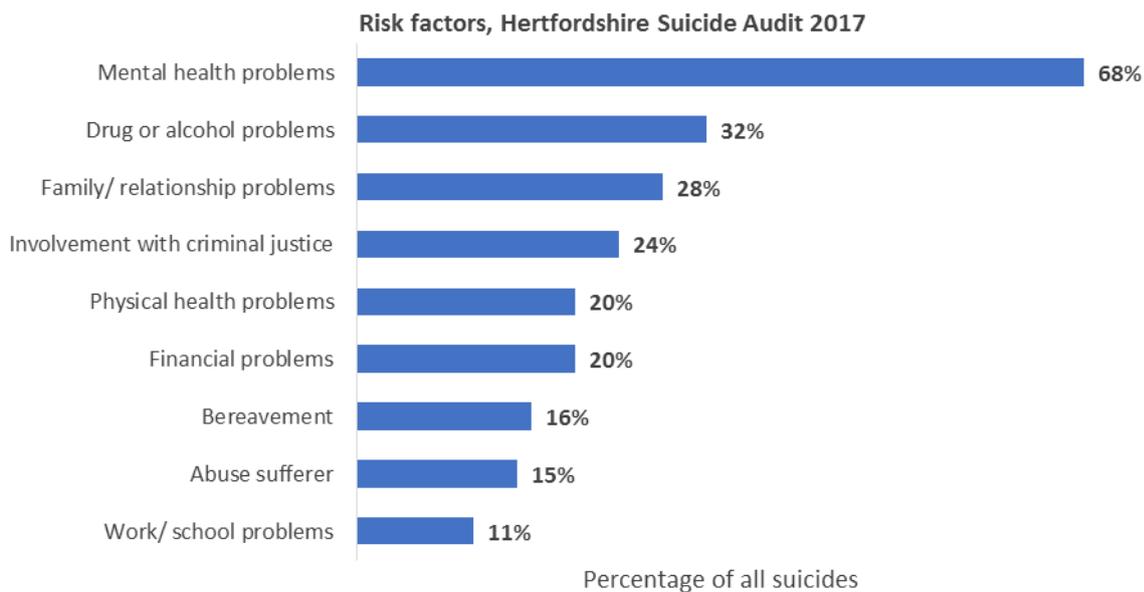
Accident and Emergency attendances

Twelve people who died by suicide (16%) attended Accident and Emergency due to self-harm, suicidal thoughts or suicide attempts in the 12 months prior to death. The proportion was higher in women (33%, 5 suicides) than men (12%, 7 suicides).

Other risk factors

The reasons why people take their own lives can be complex and multi-faceted and, consequently, can be difficult to establish from the coroners file. The risk factors most frequently mentioned in the coroners' files are listed in Figure 8. Mental ill health was the most commonly cited (68%, 50 suicides), followed by drug or alcohol (32%, 24 suicides) and relationship problems (28%, 21 suicides).

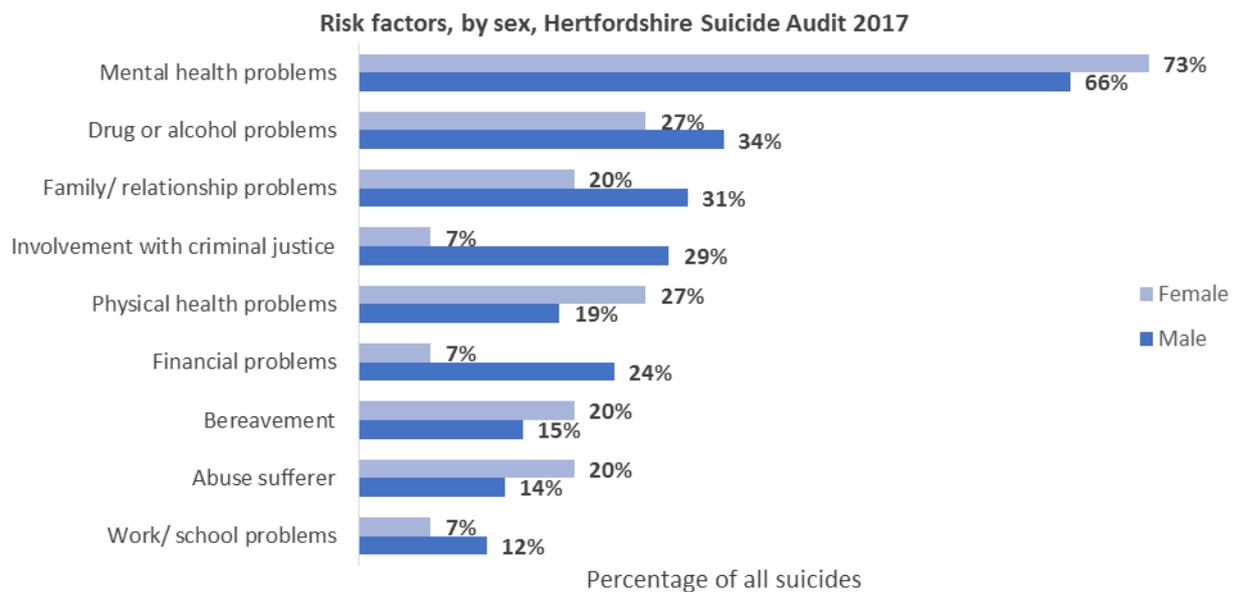
Although **mental ill health** is the most frequently mentioned risk factor, mental health issues may also be caused by life events such as bereavement or physical health problems, as well as being linked to employment and financial issues.



Source: Hertfordshire Coroner Service (N = 74 suicides)

PH.intelligence@hertfordshire.gov.uk

Figure 8: Risk factors



Source: Hertfordshire Coroner Service (N = 74 suicides)

PH.intelligence@hertfordshire.gov.uk

Figure 9: Risk factors, by sex

Differences between risk factors for men and women are shown in Figure 9. They are most pronounced for involvement with the criminal justice system (29% of men, 7% of women) and financial problems (24% of men and 7% of women). The smaller number of women means their proportions are more prone to fluctuations, making conclusions hard to reach. Alternatively, it may be that these factors were not recorded in their files.

Almost a quarter (24%, 18 suicides) of people who died by suicide were known to have been involved with the **criminal justice system** (this includes a history of prison, remand, arrest or chargeable offences). 12% (9 suicides) were in contact with the criminal justice system at the time of their death.

There was evidence of either history or current emotional, sexual, physical, financial or other type of **abuse** in 15% (11 suicides) of people who died by suicide. Of these, the largest proportions were for physical and other types of abuse (5%, 4 suicides, for each type of abuse). Bullying was the most reported other type of abuse. Some people experienced more than one type of abuse.

Files were checked to determine whether people who died by suicide were working for, or had a history of working for, the **armed forces**. This was not routinely recorded, and the numbers are too small to report.

Almost a third (32%, 24 suicides) of people who died by suicide had a record of a **previous suicide attempt**. 47% (7 suicides) for women and 29% (17 suicides) for men. Of these, over half (54%, 13 suicides) had evidence of attempting suicide more than once (86%, 6 suicides, for women, 41%, 7 suicides, for men).

One in five (20%, 15 suicides) people who died by suicide had a history of **self-harm** recorded. 33% (5 suicides) for women and 17% (10 suicides) for men. Of those who self-harmed, two-thirds (67%, 10 suicides) had reportedly done so on more than one occasion (80%, 4 suicides, for women, 60%, 6 suicides, for men).

Recommendations

- ◆ Suicide audits should be carried out every year for Hertfordshire.
- ◆ Hertfordshire's suicide prevention strategy should be refreshed drawing on data from this audit, and the forthcoming 2018 audit.
- ◆ Trends to be reviewed once the 2019 audit has been completed.
- ◆ The next audit (for 2018) should:
 - report the number of deceased people known to the local mental health trust separately from those known to trusts out of area
 - collect postcode data for the location of each suicide, to identify potential hotspots
 - review the list of risk factors, to ensure categories are meaningful and significant.
- ◆ The findings of this and future audits should be communicated in order to inform and support the work of partners

Conclusion

Each of the 74 deaths included within this audit represents a personal tragedy with potentially devastating effects on families, friends, colleagues, first responders, staff, the wider community and beyond. Nonetheless, statistically speaking, these are small numbers. Because of this there is a danger in drawing too many, or too definitive, conclusions on the basis of this data alone. In isolation this audit is, at best, indicative. As such the audit is intended to inform continued action on suicide and, alongside the use of ONS data, data from agencies such as Police, services and other agencies, is one source of information which should be taken into account by agencies working to reduce and prevent suicide.

This audit has been carried out using a newly developed methodology designed to be robust, repeatable, and as objective as possible. It is envisaged that applying this more rigorous process to future years' data will allow trends to be identified and more meaningful conclusions to be reached that will inform local suicide prevention plans. Data relating to suicides where the inquest was concluded in 2018 has been collected using this methodology. Following analysis, this will allow two years' worth of directly comparable, consistent data to be used to inform a revision of the Hertfordshire Suicide Prevention Strategy.

Appendix 1: Data collection template

Version 1.2 Year of Inquest*	Hertfordshire Suicide Audit Coroners Data Collection Record for*	*Name and Year of Inquest auto-complete
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Details of person completing form:		
Name	Organisation	
Date completed	ID No (to be completed by PH Analyst)	

Section 1: Demographics of deceased			
First Name	Surname	Place of birth	
Date of Birth	Date of Death	Inquest date	
Sex	Sex at birth	Postcode of usual address	Age at Death (automatically calculated)
Marital status	Sexual orientation	Religion	
Ethnicity	Registered disabled		
Carer			
Employment	Criminal justice system contact?		
Occupation	Details of contact with criminal justice system:		
Armed forces			
Evidence of gender reassignment?	Nature of evidence of intent to reassign gender		
Evidence of intent to reassign gender?			
Additional Notes:			

Section 2: Suicide details	
Conclusion	Location of suicide
Suicide note	Method of suicide
Additional Notes:	

If method of death was self-poisoning specify substance(s)- tick all that apply and complete adjacent columns. Only include if contributed to death.

Substance	Source of self-poisoning substance	Further details
<input type="checkbox"/> Alcohol		
<input type="checkbox"/> Analgesics		
<input type="checkbox"/> Prescription medication		
<input type="checkbox"/> Recreational drugs (inc. heroin)		
<input type="checkbox"/> Helium		
<input type="checkbox"/> Other poison*		
<input type="checkbox"/> Other poison*		
<input type="checkbox"/> Not known		

* eg weed killer, etc. - specify in further details

Additional Notes:	
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Substances listed in coroners toxicology report - see 'Toxicology' tab for details of drugs included under each heading

<input type="checkbox"/> None listed	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Barbituates	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Cannabinoids
<input type="checkbox"/> Stimulants	<input type="checkbox"/> Opiates/ opioids	<input type="checkbox"/> Phenethylamines	<input type="checkbox"/> Analgesics	<input type="checkbox"/> Antidepressants/ mood stabilisers
<input type="checkbox"/> Antiepileptics	<input type="checkbox"/> Antipsychotics	<input type="checkbox"/> Other therapeutic drugs		

Additional Notes:	
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Appendix 1: Data collection template (cont.)

Section 3: Contact with Primary Care									
Registered with General Practitioner (GP)? <input style="width: 100px;" type="text"/>									
Type any part of practice code, name, address or postcode in box below to select from list of Hertfordshire practices, or click arrow to scroll through <i>To change or delete a selected practice: select/ highlight all text > delete > start typing/ use scroll bar</i>									
<input style="width: 90%; height: 20px;" type="text"/> ▼									
If practice does not appear in dropdown above then type details manually below									
Code <input style="width: 100px;" type="text"/>		Practice name <input style="width: 980px;" type="text"/>							
Postcode <input style="width: 100px;" type="text"/>		Practice address <input style="width: 980px;" type="text"/>							
Date of last contact with GP/ primary care team before death: <input style="width: 150px;" type="text"/>						<input type="checkbox"/> Tick if date not known			
Reason for last contact with GP/ primary care team before death: <input style="width: 550px;" type="text"/>									
Additional Notes: <input style="width: 980px;" type="text"/>									
Had GP recorded mental health conditions? <input style="width: 80px;" type="text"/>				If yes, provide brief details <input style="width: 550px;" type="text"/>					
If yes, was treatment plan in place through Primary Care? <input style="width: 100px;" type="text"/>									
Additional Notes: <input style="width: 980px;" type="text"/>									
Section 4: Psychiatric history (see mental health trust records if available)									
Known to mental health services at time of death? <input style="width: 100px;" type="text"/>					Previous history of contact with mental health services? <input style="width: 100px;" type="text"/>				
If yes, what type of service(s)? - tick all that apply					If yes, what type of service(s)? - tick all that apply				
<input type="checkbox"/> Single Point of Access triage					<input type="checkbox"/> Single Point of Access triage				
<input type="checkbox"/> Initial assessment with a team					<input type="checkbox"/> Initial assessment with a team				
<input type="checkbox"/> Ongoing treatment in community service					<input type="checkbox"/> Ongoing treatment in community service				
<input type="checkbox"/> Specialist community team*					<input type="checkbox"/> Specialist community team*				
<input type="checkbox"/> Inpatient					<input type="checkbox"/> Inpatient				
<input type="checkbox"/> RAID					<input type="checkbox"/> RAID				
<input type="checkbox"/> Crisis team/ service (CAT, C-CAT, etc)					<input type="checkbox"/> Crisis team/ service (CAT, C-CAT, etc)				
<input type="checkbox"/> 136 assessment					<input type="checkbox"/> 136 assessment				
<input type="checkbox"/> Street/ police triage					<input type="checkbox"/> Street/ police triage				
<input type="checkbox"/> Other (give details below)					<input type="checkbox"/> Other (give details below)				
* (eg eating disorder, first episode psychosis)					* (eg eating disorder, first episode psychosis)				
Other (details) <input style="width: 250px;" type="text"/>					Other (details) <input style="width: 250px;" type="text"/>				
If known to mental health services, date of last contact: <input style="width: 100px;" type="text"/>					<input type="checkbox"/> Tick if date not known				
Psychiatric and learning disability diagnoses recorded - tick all that apply and provide further details in box below									
<input type="checkbox"/> None					<input type="checkbox"/> Drug misuse				
<input type="checkbox"/> Not known					<input type="checkbox"/> Personality disorder				
<input type="checkbox"/> Schizophrenia & other delusional disorders					<input type="checkbox"/> Adjustment disorder/ reaction				
<input type="checkbox"/> Bipolar affective disorder					<input type="checkbox"/> Learning disability				
<input type="checkbox"/> Depressive illness					<input type="checkbox"/> Autistic spectrum				
<input type="checkbox"/> Anxiety/ phobia/ panic disorder/ OCD					<input type="checkbox"/> Head injury				
<input type="checkbox"/> Eating disorder					<input type="checkbox"/> First episode psychosis				
<input type="checkbox"/> Dementia					<input type="checkbox"/> Other (specify below)				
<input type="checkbox"/> Alcohol misuse									
Full details of diagnosis (include ICD-10 code and description where available) <input style="width: 980px;" type="text"/>									
Please also list any ICD-10 codes (3 or 4 digit) given in notes below (e.g. F10, F43.2)									
ICD-10 code: 1	ICD-10 code: 2	ICD-10 code: 3	ICD-10 code: 4	ICD-10 code: 5	ICD-10 code: 6	ICD-10 code: 7	ICD-10 code: 8	ICD-10 code: 9	ICD-10 code: 10
<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>

Appendix 1: Data collection template (cont.)

Section 5: Contact with secondary care (A&E)

Had the deceased attended A&E in 12 months prior to death due to self harm, suicidal thoughts or suicide attempt?

Additional Notes:

Section 6: Other history

Had the deceased self-harmed?
If yes, on more than one occasion?

Had the deceased previously attempted suicide?
If yes, on more than one occasion?

Evidence of history of violence or abuse to the deceased - tick all that apply and complete adjacent columns

Type of abuse	Perpetrator	Brief details
<input type="checkbox"/> No evidence of abuse		
<input type="checkbox"/> Emotional abuse		
<input type="checkbox"/> Sexual abuse		
<input type="checkbox"/> Physical abuse		
<input type="checkbox"/> Financial abuse		
<input type="checkbox"/> Other (provide details)		

Additional Notes:

Were they known to drug and alcohol services?

Additional Notes:

Section 7: Risk factors

Evidence of? - tick all that apply	Brief details
<input type="checkbox"/> Recent bereavement (not suicide)	
<input type="checkbox"/> Suicide or attempt in the family	
<input type="checkbox"/> Suicide or attempt of a friend/ acquaintance	
<input type="checkbox"/> Life changing event	
<input type="checkbox"/> Significant life event	
<input type="checkbox"/> Financial problems	
<input type="checkbox"/> Drug/ alcohol misuse	
<input type="checkbox"/> Mental health condition(s)	
<input type="checkbox"/> Relationship Breakdown	
<input type="checkbox"/> Life changing illness or accident	
<input type="checkbox"/> Missing at time of death	
<input type="checkbox"/> Missing in the last 12 months	
<input type="checkbox"/> Witness of a traumatic event	
<input type="checkbox"/> Significant anniversary	
<input type="checkbox"/> Other (specify under brief details)	
<input type="checkbox"/> Other (specify under brief details)	

Appendix 2: Forensic toxicology groupings

Forensic Toxicology Tests

Screening Group 1 – Immunoassay

Type of drug	Screening cutoff (limit of detection)
Barbiturates	200 µg/L
Benzodiazepines	200 µg/L
Cannabinoids	50 µg/L
Cocaine metabolites	300 µg/L
Methadone	300 µg/L
Opiates	300 µg/L
Phenethylamines	300 µg/L

Record under stimulants

Record under opiates

Screening Group 2 - Gas chromatography-mass spectrometry

Screening 'cut-off' (limit of detection): 25 to 100 µg/L depending on the analyte

Analgesics

Diclofenac
Ibuprofen
Lidocaine
Naproxen
Nefopam
Paracetamol

Antidepressants

Amisulpride
Citalopram
Desipramine
Dothiepin
Fluoxetine
Imipramine
Mirtazapine
Nortriptyline
Paroxetine
Sertraline
Venlafaxine
Lithium

Antiepileptics

Carbamazepine
Lamotrigine
Phenytoin
Topiramate

Antipsychotics

Amisulpride
Clozapine
Olanzapine
Procyclidine
Quetiapine
Trazodone

Stimulants

Amphetamine
BZP
Caffeine
Cathine
Cocaine
Ephedrine
Ketamine
MDA
MDEA
MDMA
Mephedrone
Methamphetamine
Methiopropamine
Methylphenidate
Nicotine
Pseudoephedrine
TFMPP

Opiates/opioids

Codeine
Dempropoxyphene
Dihydrocodeine
Methadone
Morphine
Oxycodone
Petidine
Tramadol

Other therapeutic drugs

Alverine
Atracurium
Atropine
Chlorphenamine
Clomethiazole
Cyclizine
Diltiazem
Diphenhydramine
Promethazine
Propofol
Propranolol
Zolpidem
Zopiclone

Benzodiazepines

Chlordiazepoxide
Diazepam
Nordazepam

Appendix 3: Update to 2015/16 recommendations

The last suicide audit (carried out before this one) reported in February 2017. It covered 56 deaths by suicide where the inquests were completed in the financial year 2015-2016.

The data from the 2015-16 audit is not directly comparable to the data from this (2017) audit due to a change in the audit process and move away from financial years to calendar years.

7 recommendations were made following the 2015-16 audit, and the following is an update on progress made against each one:

1. Suicide audit to use calendar years

This has been adopted.

2. Collect race, ethnicity and sexuality data for each individual

The new data collection template has included these fields.

3. Increase local awareness of suicide rates in 20-29 year-old males

A Task and Finish group has been established within the Suicide Prevention programme with a specific focus on men and boys, with 20-29 identified as an age range requiring specific focus within the county.

4. Involvement of partners from the criminal justice system in the development of the suicide prevention strategy

The police are active partners in the suicide prevention network. Approaches are being made to develop ongoing links with HMP The Mount.

5. Suicide rates to be monitored at district level

This is being included in analysis of 2017 audit data.

6. Continue to support the role of GPs via Spot the Signs training

Spot the Signs project has been working on a variety of ways of increasing the number of GPs being reached by their training.

7. Monitor trends in the number of individuals in contact with mental health services at the time of death

This data is being captured via the new audit template. The introduction of the new process will enable monitoring of trends.