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Hertfordshire Suicide Audit 2018

Hertfordshire Public Health
Evidence & Intelligence

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Hertfordshire

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 2018. The audit uses information from files held by the coroner service and has been carried out to a new, more robust and repeatable methodology introduced for the 2017 audit. The 95 deaths included in the 2018 audit were given a Coroner's conclusion between 1 January and 31 December 2018, with the majority of deaths occurring in 2017 (51%) and 2018 (44%).
- 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 95 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 74 included in the 2017 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 2015-2017 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 the last ten years.

Key findings from 2018 audit

- Men aged 30-49 years old made up the highest proportion of people dying by suicide in the 2018 Hertfordshire Suicide Audit, a slightly younger profile than nationally and the previous 2017 audit.
- Mental health issues were the most common risk factor mentioned in coroner's files.
- Over a quarter of people included in the audit:
  - were known to a mental health service at the time of death
  - discussed mental health issues with a member of their GP practice in the four weeks leading up to their death.
- Over a third of people who died by suicide were known to have made a previous suicide attempt.
- Almost 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 as part of Hertfordshire's commitment to suicide prevention.
- 3-year age standardised rates trends should be reviewed once the 2019 audit has been completed.
- The findings of this audit and future audits will be shared with the suicide prevention network to inform the development of the suicide prevention strategy, which will support partnership working.

Authors: Claire Tiffany (Senior Public Health Analyst) and Maneka Kandola (Health Improvement Lead), Public Health, Hertfordshire County Council. Contact email: PH.intelligence@hertfordshire.gov.uk.

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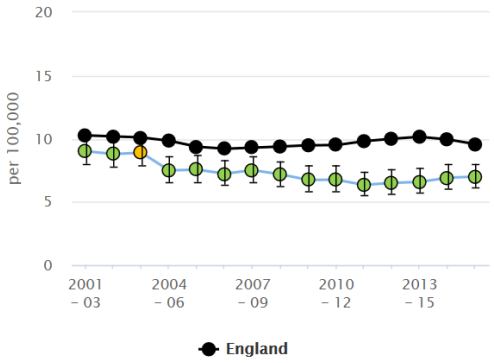
Introduction

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 2017[2]), 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 Profile[3]

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 2018, inquests were concluded by the Coroner on 95 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 5)

National guidance[7] 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 Team), 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 2018, is the second 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. Appendix 3 provides an update on recommendations from the 2017 audit.

Accordingly, this report will comprise analysis of the 2018 data. As an audit, it will not attempt to draw specific 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

95 deaths by suicide with a Hertfordshire Coroner Service inquest concluding in 2018 were identified for the audit. 94 deaths were recorded as suicide (intentional self-harm) and one as injury or poisoning of undetermined intent.

The 95 inquests concluding in 2018 included deaths occurring between September 2015 and September 2018 with 51% occurring in 2017 and 44% in 2018. The median length of days between the date of death and inquest

[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

conclusion was 196 (28 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 the calendar year of the date the death was registered.

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 eight 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 six local authority public health staff on-site at the coroner's office during February 2019. 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, breakdowns by sex may not always be 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 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.

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

Summary of audit findings

The summary below is based on the 95 suicides with a Hertfordshire Coroner Service inquest concluding in 2018.

Demographics

- Around three-quarters (76%) of the 95 suicides included in the audit were by men.
- 43% of people who died by suicide were aged 30 to 49 years old.
- The highest suicide rate was among men aged 30 to 44 years old.
- There were 11 suicides by young people aged under 25, and 12 by people aged 80 years or over.
- 8% of the people included in the audit lived outside of Hertfordshire.
- 79% were born in the UK (22% in Hertfordshire).
- Around a quarter (26%) of people dying by suicide were married.
- 36% were employed, whilst 19% were unemployed and 25% were retired.

Circumstances of death

- Around half (52%) of suicides were by hanging, strangulation or suffocation. The second most common method of suicide was self-poisoning (19%), followed by deaths on the railway (9%), although there were marked differences by sex.
- Most suicides took place at the individual's home (59%). The next most common location was woodland or park (16%), followed by railway (9%).
- Around half (53%) left a suicide message.

Contact with primary care

- 69% of people who died by suicide had a mental health issue or condition recorded by their GP practice.
- Around a quarter (28%) 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 ten (11%) 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

- 28% of people who died by suicide were known to a mental health service at the time of death.
- Around half (52%, 14 suicides) of those in contact with a mental health service were in touch during the week leading up to their death, almost three-quarters (74%) 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 at the time of death.

Accident and Emergency attendance

- 17% 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.
- 40% of people who died by suicide were reported to have made a previous suicide attempt and 14% had a history of self-harm.
- A fifth (22%) 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 95 suicides included in the audit, 76% (72) were men and 24% (23) 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]

43% of the 95 of people dying by suicide were 30 to 49 years old (Figure 2). Over a third (36%) were men aged 30 to 49 years old. The highest rate per 100,000 population in men was in the 30 to 44-year age group, whilst for women it was highest among 75 and over (Figure 3). Nationally rates are highest for in the 45 to 59-year age group for both sexes. Caution should be taken when looking at age-specific rates of relatively small populations over a one-year period, as they are prone to fluctuations year on year.

The average age of people who died by suicide included in this audit was 47 (45 for men and 51 for women). There were 11 suicides by young people aged under 25, including two aged under 18. There were 12 suicides by people aged 80 or over.

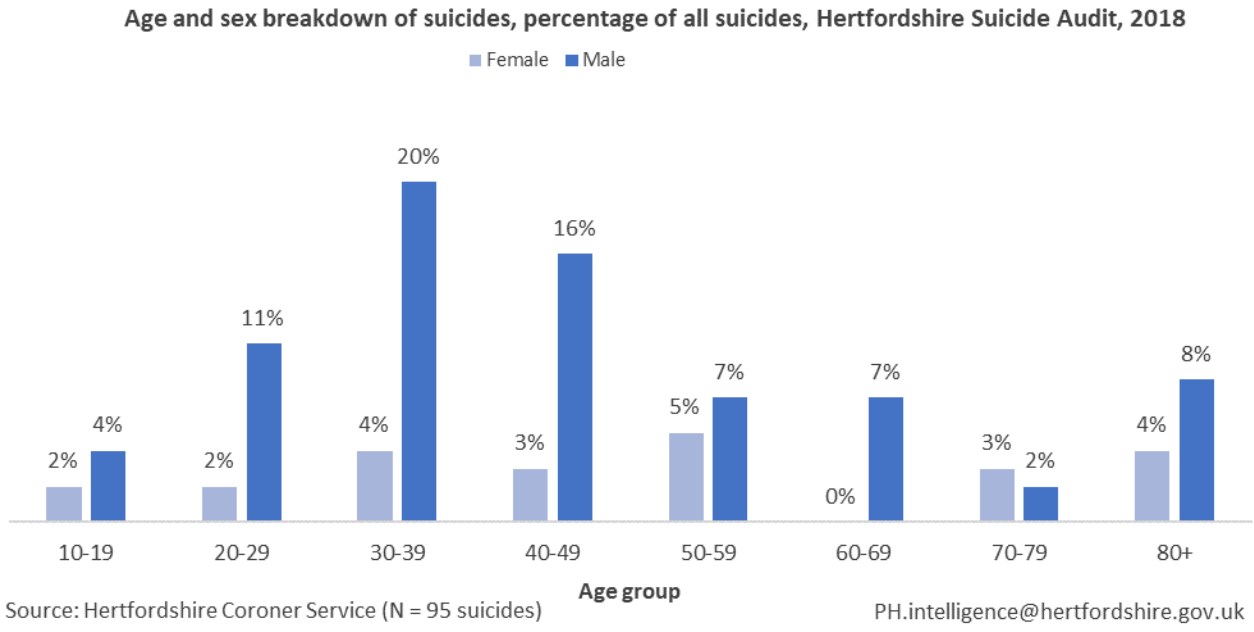
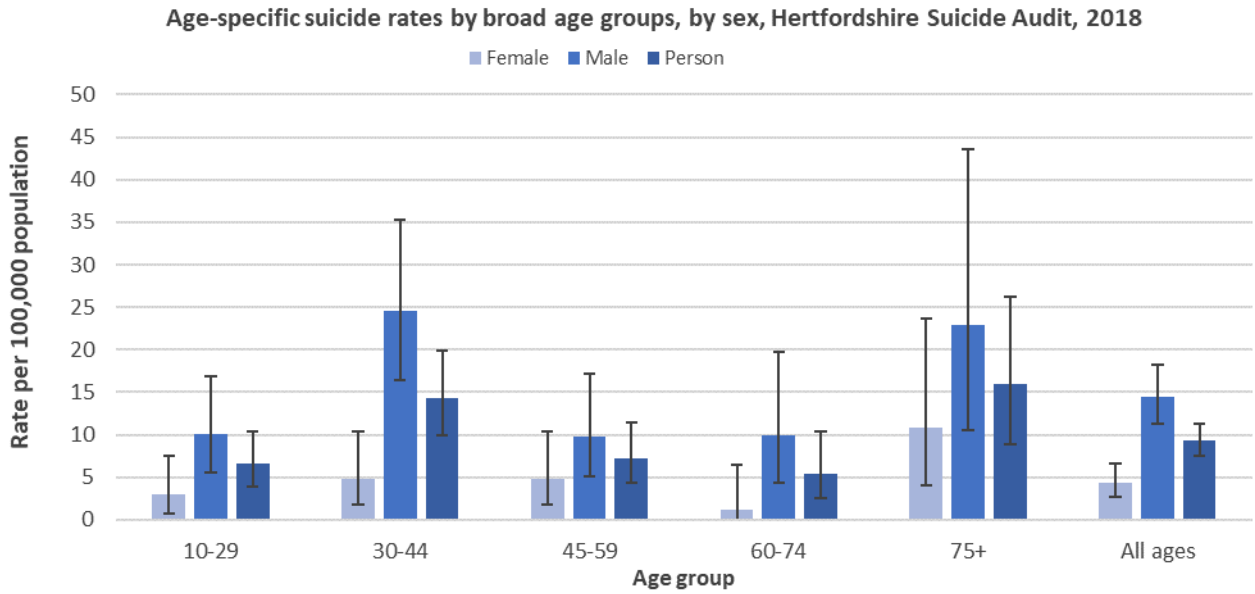


Figure 2: Age and sex breakdown of suicides

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



Source: Hertfordshire Coroner Service (N = 95 suicides), ONS MYE 2017 PH.intelligence@hertfordshire.gov.uk

Figure 3: Age- specific suicide rates by sex

Marital status

45% of individuals were recorded as single, with 26% married, 20% divorced and 7% widowed (although 'single' includes people who are in a relationship, but not married).

Employment status

36% of individuals were identified as in employment, with 19% unemployed, 25% retired and 2% unable to work due to illness or disability. The remainder were either full-time students (7%) or homemakers (5%) or missing employment status (5%).

Place of birth

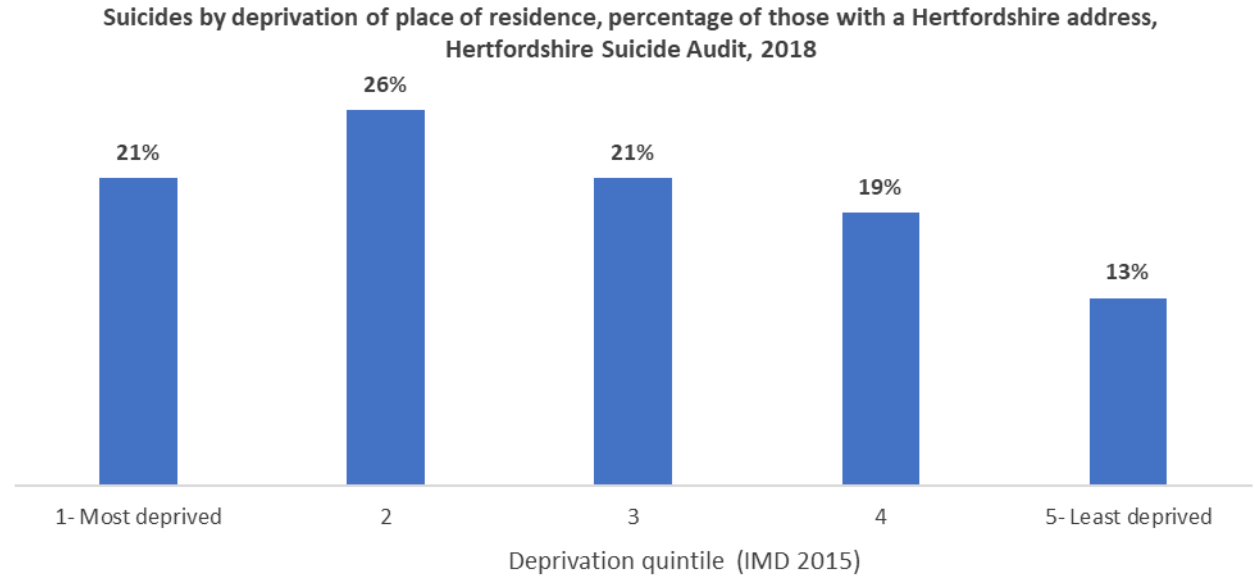
79% of people who died by suicide were born in the UK (22% Hertfordshire, 31% London, 26% rest of UK) and 20% were born outside of the UK. One record was missing place of birth. For comparison purposes the 2011 Census recorded 13% of people (all ages) living in Hertfordshire as being born outside of the UK.[11]

[11] Herts Insight (2019). *People and place profile*. www.hertfordshire.gov.uk/microsites/herts-insight/topics/population.aspx

Place of residence

Hertfordshire addresses were recorded as the usual place of residence for 85 (89%) of the 95 suicides. Eight addresses (8%) were linked to a postcode outside of Hertfordshire and two suicides (2%) were recorded as no fixed abode.

Fewer suicides occurred amongst people living in the least deprived areas of Hertfordshire (13%), based on local quintiles (fifths) of deprivation. The highest proportion (26%) was amongst people living in the second most deprived quintile (Figure 4).



Source: Hertfordshire Coroner Service (N = 85 suicides) PH.intelligence@hertfordshire.gov.uk

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 9 per district), the confidence intervals are wide, and we cannot say that these differences are statistically significant.

There were 41 suicides in the audit with an address in NHS East and North Hertfordshire CCG (ENHCCG), a crude rate of 8.3 per 100,000 population, and 43 in NHS Herts Valleys CCG (HVCCG), a crude rate of 8.4 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.[12] [13]

[12] Office for National Statistics (2018). *Suicides in England and Wales by local authority.* www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
[13] Public Health England (2019). *Suicide Prevention Profile*. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

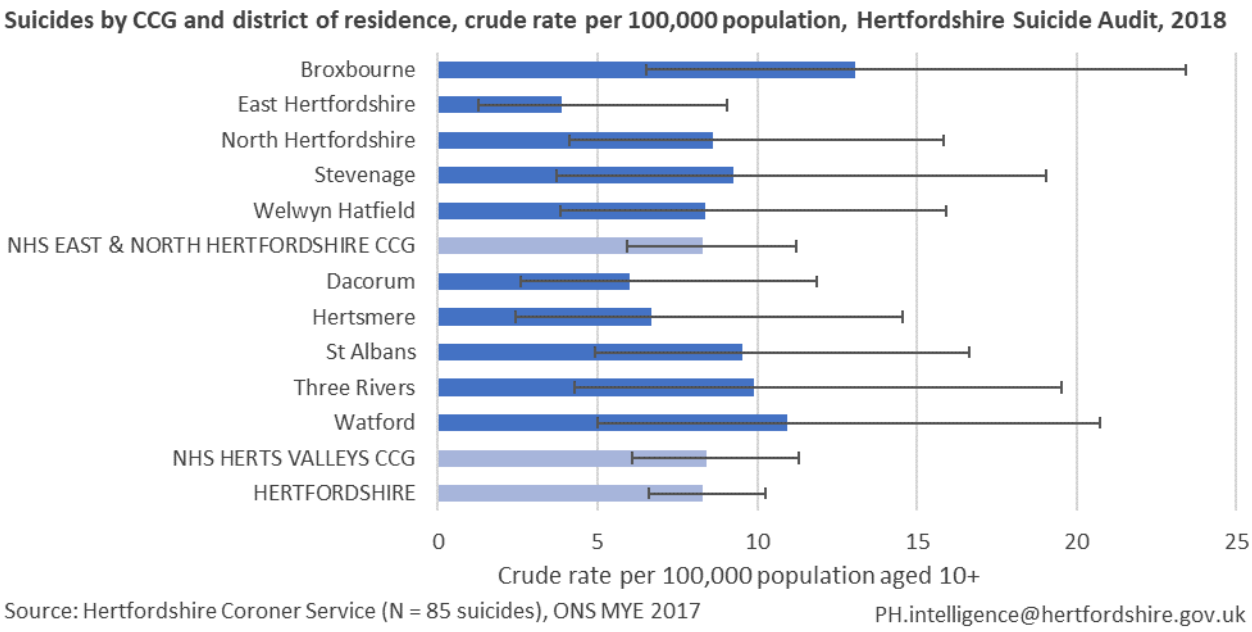


Figure 5: Suicide rates by Clinical Commissioning Group (CCG) and district

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."[14]

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 15% of suicides had sexual orientation or religion recorded. Although ethnicity was recorded in 45% of suicides, they could not always be matched to 2011 Census categories[15] (e.g. 'Caucasian' or 'British' could not be mapped to Census categories), resulting in availability in only 38% 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)	38%
Religion	12%
Sexual orientation	14%
Gender identity (reassignment or intent)	2%
Disability	35%
Carer	36%

Table 1: Data completeness, percentage, of equality characteristics, Hertfordshire Suicide Audit, 2018
Source: Hertfordshire Coroner Service (N = 95 suicides)

[14] Carers Trust (2019). *About carers*. https://carers.org/what-carer
[15] 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

The most common method of suicide was hanging, strangulation or suffocation, accounting for 52% of suicides included in this audit (49 suicides). Nationally this was the most common method used by both men and women in the UK (60% and 42% respectively)[16]. Within this audit it was the most common method for men (60%, 43 suicides), whilst for women it was the second most common method (26%, 6 suicides) after self-poisoning (see Figure 6).

The second most common method was self-poisoning (19%, 18 suicides). Nationally this was the second most common method used by both men and women in the UK (18% and 38% respectively). Within this audit it was the fourth most common method for men (7%, 5 suicides), whilst for women it was the most common method (57%, 13 suicides).

Of the 18 suicides by poisoning, the following substances were identified as contributing to the death (a suicide may have more than one contributing substance):

- prescription drugs (15 suicides, at least 7 involved drugs prescribed for the person who died by suicide)
- carbon monoxide (3 suicides)
- alcohol and/ or recreational drugs (2 suicides)
- over the counter medication (2 suicides)

Suicides on the railway was the third most common method accounting for 9% of suicides (9 suicides). All nine suicides were men and it was their second most common method (13% of suicides by men). The suicides took place at, or near, eight railway stations in Hertfordshire and involved seven residents of Hertfordshire. Nationally, it is reported around 4.5% of suicides in the UK take place on the railway.[17]

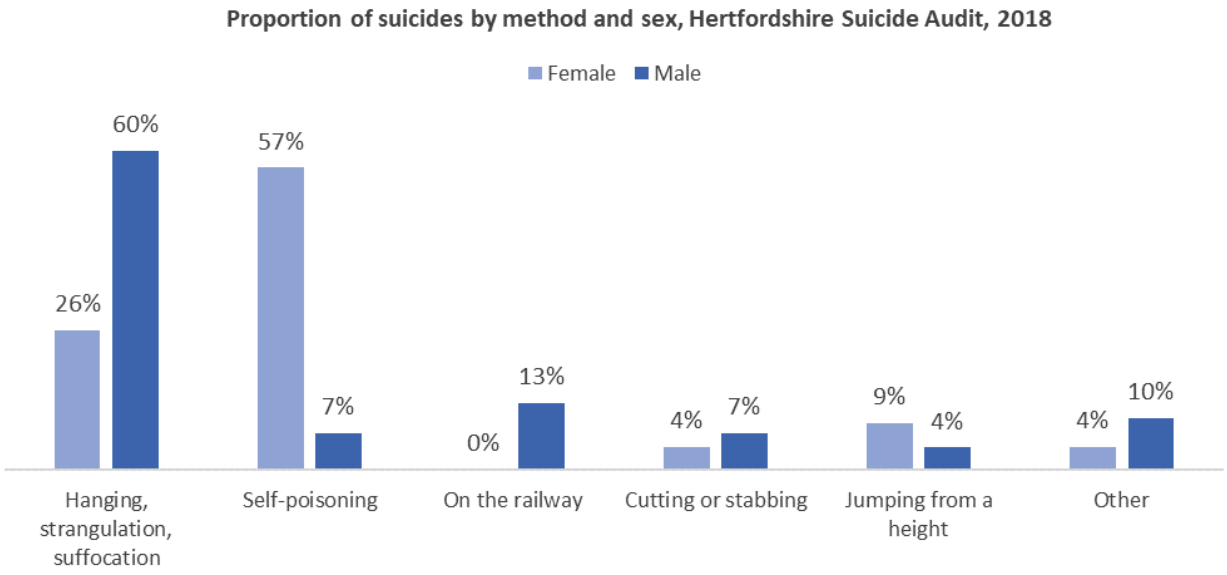


Figure 6: Suicides by method and sex

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

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

Location of suicide

Over half (59%) of people who died by suicide took their own life at home (50% of men and 87% of women). The next most common location was woodland or park (16%) followed by railway (9%). There were no hotspots identified when looking at non-residential locations such as woodlands and parks. There were two suicides at, or near, one railway station in Hertfordshire.

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 over half (53%) of suicides (65% of women and 49% 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 40% of suicides. Several 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 22% of suicides (21 suicides). Opiates include pain killers such as codeine and morphine, as well as heroin and methadone.
- Stimulants were recorded in 12% of suicides (11 suicides). Stimulants include amphetamine, cocaine, MDMA (ecstasy), etc.
- Cannabis was recorded in 4% of suicides (4 suicides).

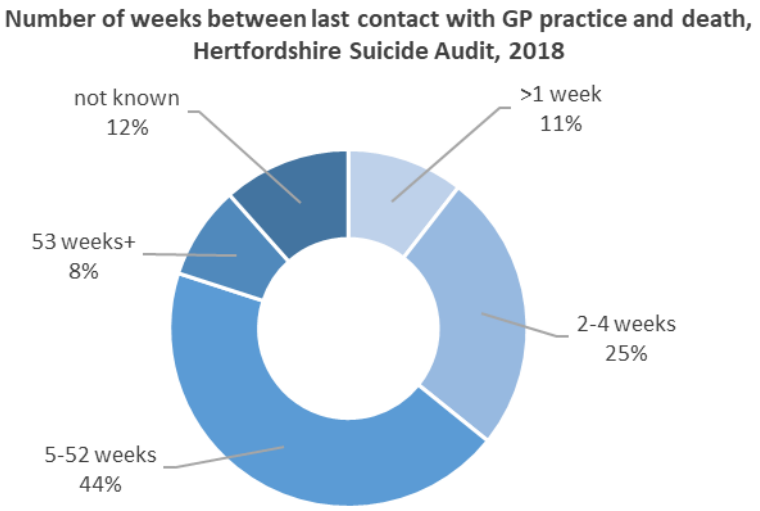
Contact with health care services

Primary care

95% of people who died by suicide were registered with a GP practice (84% with a GP practice in Hertfordshire). Five people (5%) were not registered with a practice.

Date of last contact with GP practice was missing for 11 (12%) of the 95 suicides. As shown in Figure 7, of the 95 suicides, it was known that:

- over three-quarters contacted their practice in the 12 months prior to their death (80%, 76 suicides)
- around a third contacted their practice in the four weeks prior to their death (36%, 34 suicides)
- around one in ten contacted their practice in the week prior to their death (11%, 10 suicides)



Source: Hertfordshire Coroner Service (N = 95 suicides) PH.intelligence@hertfordshire.gov.uk

Figure 7: Number of weeks between last contact with GP practice and suicide

Last contact with the primary care team was known to be in relation to a mental health issue for half (51%, 48 suicides) of all people who died by suicide; 54% (39 suicides) for men and 39% (9 suicides) for women. Details of the reason for last contact with the primary care team was missing for 15 suicides (16%).

GP recorded mental health issues and conditions

There was evidence of GP recorded mental health issues or conditions for 69% (66 suicides) of people who died by suicide, 78% (18 suicides) for women and 67% (48 suicides) for men. Of these, 73% (48 suicides) had a treatment plan in place through primary care (61% for women and 77% for men). The most commonly recorded mental health issues and conditions were depression, anxiety, stress and psychotic disorders.

Over a quarter (28%, 27 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 (22% of women and 31% of men). Seven people (7%) had discussed mental health issues with their primary care team in the week leading up to their death.

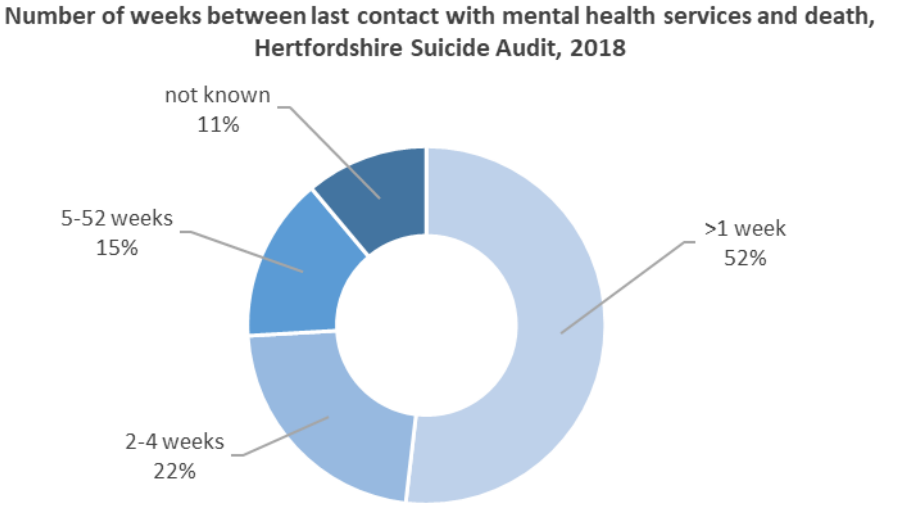
Mental health services

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 service in response to a request from the coroner.

Over a quarter (28%, 27 suicides) of people who died by suicide were known to a mental health service at the time of death, with similar proportions for men (29%) and women (26%). Of these 27 suicides, 23 were known to Hertfordshire Partnership University NHS Foundation Trust.

As shown in Figure 8, of the 27 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 (89%, 24 suicides)
- 74% had been in contact in the 4 weeks prior to their death (20 suicides)
- half were in contact in the week leading up to their death (52%, 14 suicides)
- the date of last contact with a mental health service was not recorded in coroner files for 11% (3 suicides)



Source: Hertfordshire Coroner Service (N = 27 suicides) PH.intelligence@hertfordshire.gov.uk

Figure 8: Number of weeks between last contact with mental health service and suicide, known to a mental health service at the time of death

48 people who died by suicide (51%) had a history of contact with mental health services, with a higher proportion among women (65%, 15 suicides) then men (46%, 33 suicides). 59 people (62%) were identified as having been known to a mental health service at some point in their life (either before or at time of death). This means some people known to mental health services at time of death had no previous history (for example if they were referred to mental health services very shortly before they died but with no previous history of contact recorded).

35 (59%) of the 59 people who died by suicide and had been in contact with a mental health service had details of one or more diagnosis recorded in the coroner files. Of these, 22 (63%) had two or more diagnoses recorded. This includes 8 people with three diagnoses and one with four.

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

- depression (39%, 23 suicides)
- anxiety (24%, 14 suicides)
- schizophrenia and/ or personality disorder (15%, 9 suicides).
- drug misuse (10%, 6 suicides)

Alcohol and drug services

There was evidence that 14% (13 suicides) of people who died by suicide included in the audit were known to a drug or alcohol service. In line with the higher proportion of male suicides, the majority were men. 11% (10 suicides) were known to the local drug and alcohol service.

Accident and Emergency attendances

Sixteen people who died by suicide (17%) 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 (22%, 5 suicides) than men (15%, 11 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 9. Mental ill health was the most commonly cited (85%, 81 suicides), followed by relationship problems (44%, 42 suicides) and drug or alcohol (41%, 39 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.

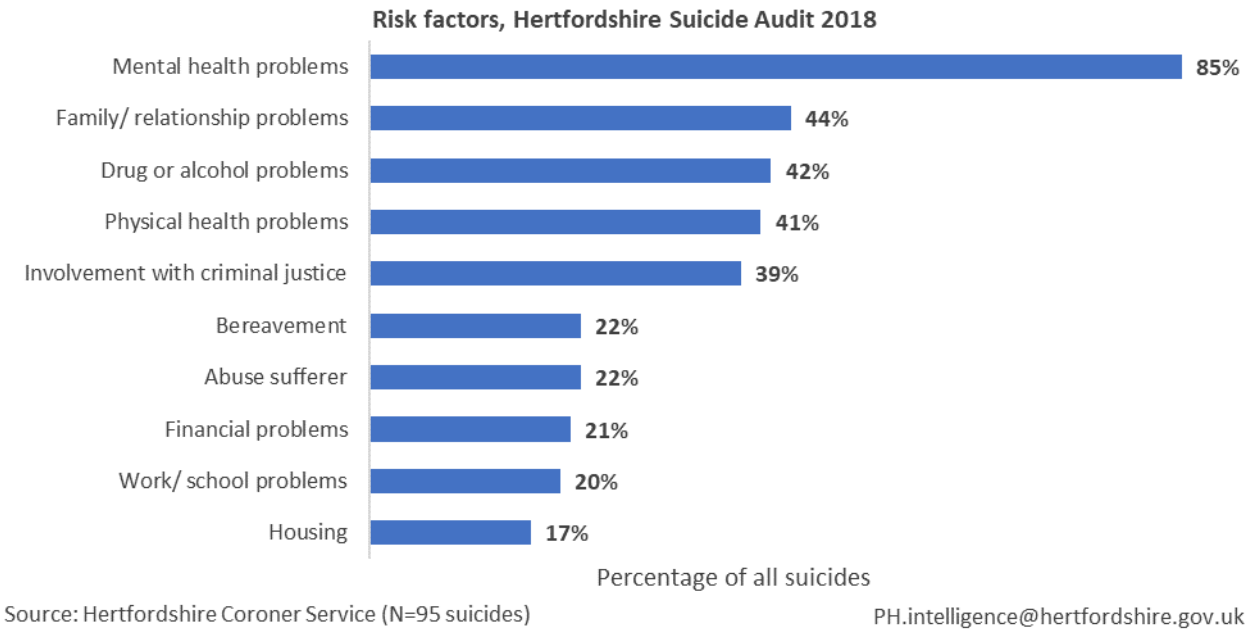


Figure 9: Risk factors

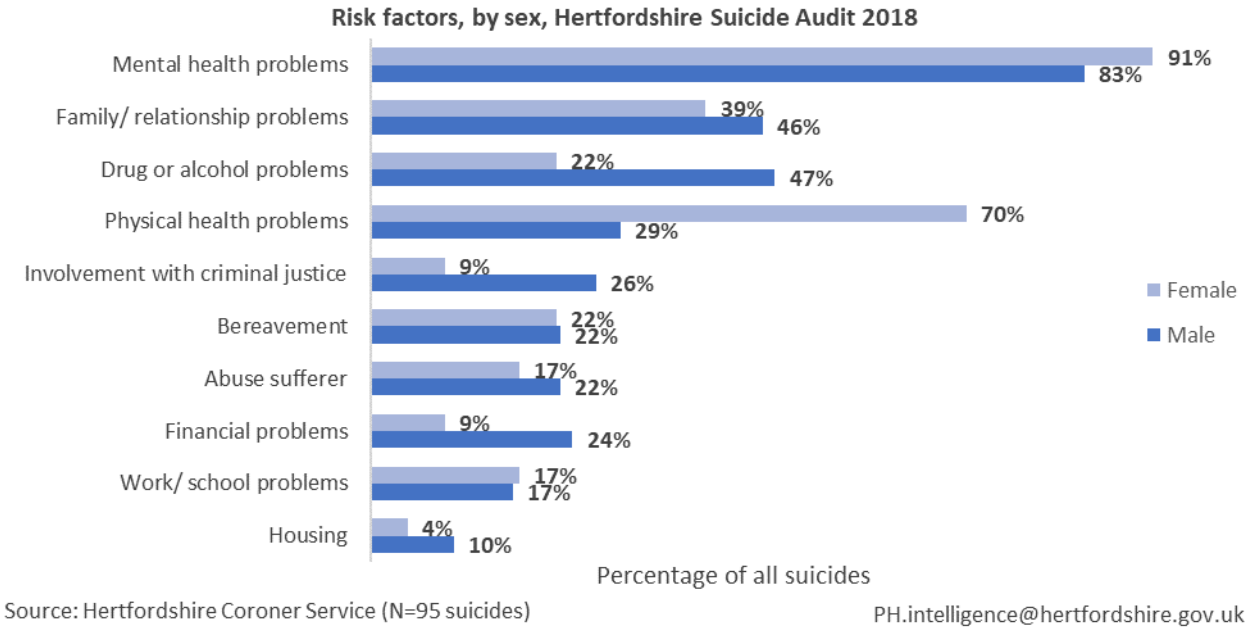


Figure 10: Risk factors, by sex

Differences between risk factors for men and women are shown in Figure 10. They are most pronounced for physical health (70% of women, 29% of men), financial problems (9% of women, 24% of men) and involvement with the criminal justice system (9% of women, 26% of men). 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.

Over a fifth (22%, 21 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% (11 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 20% (19 suicides) of people who died by suicide. Of these, the largest proportions were for physical and emotional types of abuse (14%, 13 suicides and 8%, 8 suicides respectively). 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.

Over a third (40%, 38 suicides) of people who died by suicide had a record of a **previous suicide attempt**. 48% (11 suicides) for women and 38% (27 suicides) for men. Of these, over half (53%, 20 suicides) had evidence of attempting suicide more than once (64%, 7 suicides, for women, 48%, 13 suicides, for men).

More than one in eight (14%, 13 suicides) people who died by suicide had a history of **self-harm** recorded. 22% (5 suicides) for women and 11% (8 suicides) for men. Of those who self-harmed, almost half (46%, 6 suicides) had reportedly done so on more than one occasion.

Conclusion

Each of the 95 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.

It should be noted that, 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 prevention 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 2017 and 2018 have been collected using this methodology allowing two years' worth of directly comparable, consistent data to be used to inform a revision of the Hertfordshire Suicide Prevention Strategy.

Recommendations

- Suicide audits should be carried out every year for Hertfordshire.
- 3-year age standardised rates trends to be reviewed once the 2019 audit has been completed.
- The findings of this audit and future audits will be shared with the suicide prevention network to inform the development of the suicide prevention strategy, which will support partnership working.

Appendix 1: Data collection template

Version 2.0
*Year of Inquest**

Hertfordshire Suicide Audit, Coroners Data Collection Record for:*

**Name, Inquest Yr, DoD all auto-complete*

Details of person completing form:

Name		Date completed	

Section 1: Demographics of deceased

First Name		Surname		Place of birth	
DateOfBirth		DateOfDeath		Inquest date	
Sex		Sex at birth		Postcode of usual address	
				Age at Death (automatically calculated)	
Marital status				Sexual orientation	
Ethnicity				Religion	
Carer				Registered disabled?	
				Evidence of gender reassignment?	
Employment				Evidence of intent to reassign gender?	
Occupation				Nature of evidence of intent to reassign gender	
Armed forces					

Additional Notes:

Section 2: Suicide details

Conclusion		Suicide location: Type	
Suicide note		Suicide location: Postcode	
Suicide method		Suicide location: Place	

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
☐ Alcohol		
☐ Over the counter medication		
☐ Prescription medication		
☐ Recreational drugs (inc. heroin)		
☐ Other poison*		
☐ Other poison*		
☐ Not known		

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

Additional Notes:

Is toxicology report present in the file?

If yes, detail substances listed- see 'Toxicology' tab for details of drugs included under each heading

☐ None listed	☐ Alcohol	☐ Barbituates	☐ Benzodiazepines	☐ Cannabinoids
☐ Stimulants	☐ Opiates/ opoids	☐ Phenethylamines	☐ Analgesics	☐ Antidepressants/ mood stabilisers
☐ Antiepileptics	☐ Antipsychotics	☐ Other therapeutic drugs		

Additional Notes:

Appendix 1: Data collection template (cont.)

Section 3: Contact with Primary Care

Registered with General Practitioner (GP)?

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

To change or delete a selected practice: select/ highlight all text> delete> start typing/ use scroll bar

If practice does not appear in dropdown above then type details manually below

Code **Practice name**

Postcode **Practice address**

Date of last contact with GP/ primary care team before death: ☐ **Tick if date not known**

Reason for last contact with GP/ primary care team before death:

Additional Notes:

Had GP recorded mental health conditions? **If yes, provide brief details**

If yes, was treatment plan in place through Primary Care?

Section 4: Psychiatric history (see mental health trust records if available)

HPFT= Hertfordshire Partnership University NHS Foundation Trust (local mental health trust)

Known to mental health services at time of death?

If yes, what type of service(s)? - tick all that apply

- ☐ Single Point of Access triage
- ☐ Initial assessment with a team
- ☐ Ongoing treatment in community service
- ☐ Specialist community team*
- ☐ Inpatient
- ☐ RAID
- ☐ Crisis team/ service (CAT, C-CAT, etc)
- ☐ 136 assessment
- ☐ Street/ police triage
- ☐ Other (give details below)

** (eg eating disorder, first episode psychosis)*

Other (details)

Previous history of contact with mental health services?

If yes, what type of service(s)? - tick all that apply

- ☐ Single Point of Access triage
- ☐ Initial assessment with a team
- ☐ Ongoing treatment in community service
- ☐ Specialist community team*
- ☐ Inpatient
- ☐ RAID
- ☐ Crisis team/ service (CAT, C-CAT, etc)
- ☐ 136 assessment
- ☐ Street/ police triage
- ☐ Other (give details below)

** (eg eating disorder, first episode psychosis)*

Other (details)

If known to mental health services, date of last contact: ☐ **Tick if date not known**

Current/ historic psychiatric/ learning disability diagnoses RECORDED BY MENTAL HEALTH SERVICES ONLY- tick all that apply and provide further details below

- ☐ None
- ☐ Not known
- ☐ Schizophrenia & other delusional disorders
- ☐ Bipolar affective disorder
- ☐ Depressive illness
- ☐ Anxiety/ phobia/ panic disorder/ OCD
- ☐ Eating disorder
- ☐ Dementia
- ☐ Alcohol misuse
- ☐ Drug misuse
- ☐ Personality disorder
- ☐ Adjustment disorder/ reaction
- ☐ Learning disability
- ☐ Autistic spectrum
- ☐ Head injury
- ☐ First episode psychosis
- ☐ Other (specify below)

Full details of diagnosis (include ICD-10 code and description where available)

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

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?

Additional Notes:

Evidence of history of violence or abuse to the deceased?
If yes, tick all that apply below

Type of abuse	Perpetrator	Brief details
☐ Emotional abuse		
☐ Sexual abuse		
☐ Physical abuse		
☐ Financial abuse		
☐ Other (provide details)		

Additional Notes:

Were they known to drug and alcohol services?

Additional Notes:

Evidence of criminal justice contact?

If yes, tick all that apply below	Brief details
☐ In prison at time of death	
☐ Under arrest/awaiting court case/sentencing/ on probation at time of death	
☐ History of being in prison	
☐ History of offences/ convictions/ probation	
☐ History of cautions/ warnings	
☐ Other (specify under brief details)	

Additional Notes:

Section 7: Risk factors

hover over cells below for comments

Evidence of: *(tick all that apply)*	Brief details
☐ Mental health problems	
☐ Physical health problems	
☐ Drug/alcohol use	
☐ Work/school problems	
☐ Family/ relationship problems	
☐ Financial problems	
☐ Involvement with criminal justice system	
☐ Housing problems	
☐ History of self-harm/suicide attempt	
☐ Abuse sufferer	
☐ Experience of bereavement/other loss	
☐ Significant anniversary	
☐ Other (specify under brief details)	
☐ Other (specify under brief details)	

Section 8: Any other notes relevant to analysis or for attention of Public Health Evidence and Intelligence team

Additional Notes:

Appendix 2: Forensic toxicology groupings

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

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	← Record under stimulants
Methadone	300 µg/L	← Record under opiates
Opiates	300 µg/L	
Phenethylamines	300 µg/L	

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

Antiepilectics
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
Dihydrocodelne
Methadone
Morphine
Oxycodone
Petildlne
Tramadol

Other therapeutlc drugs
Alverine
Atracurium
Atropine
Chlorphenamine
Clomethiazole
Cyclizine
Diltiazem
Diphenhydramine
Promethazine
Propofol
Propranolol
Zolpidem
Zoplclone

Benzodiazepines
Chlordiazepoxide
Diazepam
Nordazepam

Appendix 3: Update to 2017 recommendations

The last suicide audit (carried out before this one) reported in April 2019. It covered 74 deaths by suicide where the inquests were completed in the calendar year 2017 (1 January to 31 December 2017).

Five recommendations were made following the 2017 audit, and the following is an update on progress made against each one:

1. **Suicide audits should be carried out every year for Hertfordshire.**
   This has been adopted. Data is collected and analysed annually based on the calendar year of the inquest. It is planned for future audits to be published in the spring following the calendar year of inquests.

2. **Hertfordshire's suicide prevention strategy should be refreshed drawing on data from the 2017 and 2018 audit.**
   Work has begun to refresh the Hertfordshire Suicide Prevention Strategy and approach in collaboration with partners in Suicide Prevention Network, the aim is to complete this work in 2020.

3. **Trends to be reviewed once the 2019 audit has been completed.**
   To be carried out in next audit.

4. **The 2018 audit 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.**

   All above have been adopted in this audit.

5. **The findings of this, and future audits, should be communicated in order to inform and support the work of partners.**
   The audit has been published on the Hertfordshire Health Evidence website[18] and shared with members of the suicide prevention strategy as well as going to Hertfordshire County Council Public Health Panel.

[18] https://www.hertshealthevidence.org