CARE HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE
29 October 2019

TITLE OF REPORT: Suicide; Every Life Matters – Evidence Gathering (Session 2)

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Summary
This report gives details of the evidence gathering session that will take place on 29 October 2019. The Committee will hear results of an Audit of Suicide and injury undetermined deaths in Gateshead for the 2018 calendar year which was conducted on 24, 27 & 30 September 2019. The Audit will identify key themes from the local data and identify risk factors and high-risk population groups for Suicide in Gateshead.

The views of the Committee are being sought on the evidence presented and the ongoing work on Suicide Prevention in Gateshead.

Background

1. Care Health and Wellbeing Overview and Scrutiny Committee have agreed that the focus of its review in 2019-20 will be Suicide.

2. In April 2013 public health transferred from the NHS and into local government. Suicide prevention consequently became a local authority led initiative working closely with the police, clinical commissioning groups (CCGs), Public Health England (PHE), NHS England, Coroners and Voluntary sector organisations.

3. Updated trend data shows a positive downward pattern with the release of the 2016 – 2018 figures in September 2019 as is shown in Figure 1, 2 & 3 below. Rates per 100,000 population are falling for the three categories; Persons, Males and Females, since the 2014-16 data reporting period. However as will be highlighted from the results of the Audit of Suicide and injury undetermined deaths in Gateshead for the 2018 calendar year and the performance in relation to the Risk Factors of Suicide as described by PHE, there is still lots of work to be done to ensure less Gateshead residents feel that the only way out of their situation is to take their own life.

Figure 1 - Gateshead Suicide trends 2001 – 2018 (All Persons)

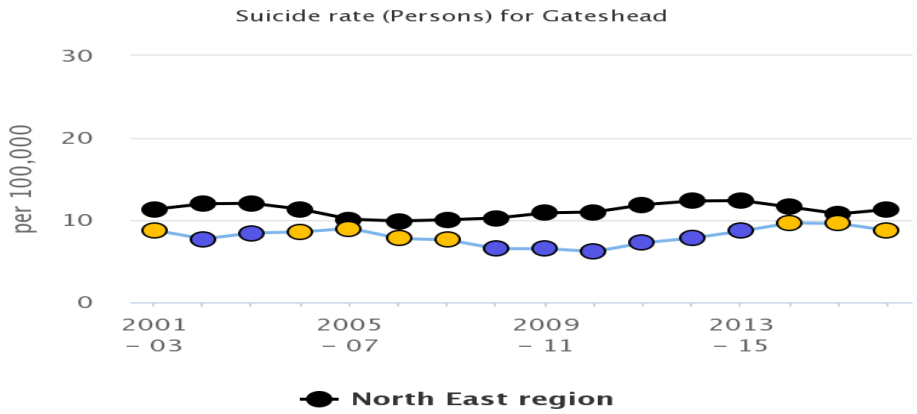


Figure 2 - Gateshead Suicide trends 2001 – 2018 (Male)

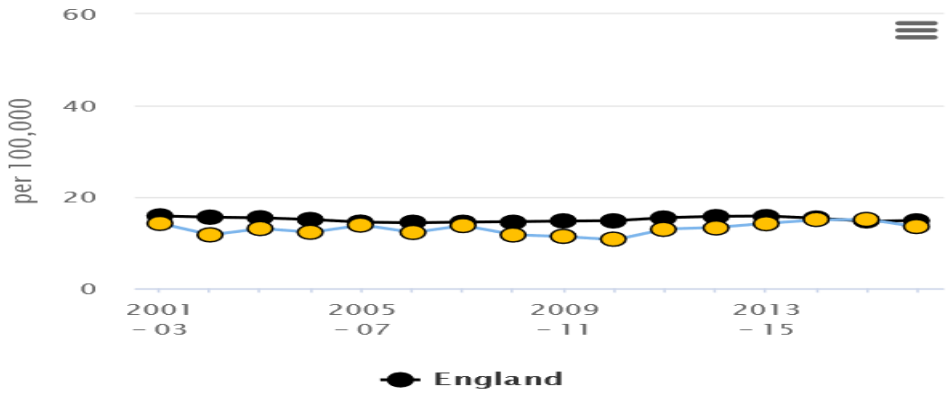
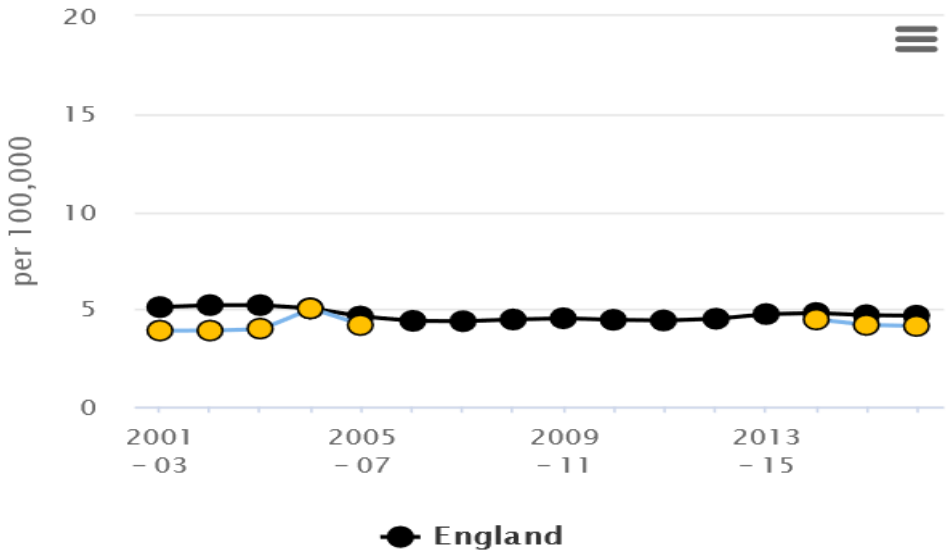


Figure 3 - Gateshead Suicide trends 2001 – 2018 (Female)



Purpose of this session

4. The first evidence gathering session provided a detailed overview of suicide from a legal/Coroners perspective and the impact of suicide from someone with lived experience, enabling information to be presented to provide members with insight into the key factors involved and the impact of suicide on a community. This was delivered on 10 September 2019, World Suicide Prevention Day.

5. This second evidence gathering session, delivered by members of the Public Health Team, will describe the process and findings of a local Audit of Gateshead data for 2018 on Suicide and undetermined injury. This was conducted on 24, 27 & 30 September 2019.

6. This Audit covers the full calendar year for 2018 for cases that have reached a verdict and the report will identify key themes from the local data and identify risk factors and high-risk population groups for Suicide in Gateshead.

The findings of the Audit will be reviewed to help inform local policy development.

Audit of Suicide and injury undetermined deaths in Gateshead for the 2018 calendar year

7. As identified above the Audit was carried out over a period of three days visit to the Coroner's office at Hebburn. The aims of the audit were to; identify local risk factors, groups at risk or localities with higher incidence, provide data for future monitoring of trends and to inform discussion about how the audit process could be carried out it a timelier way to identify emerging patterns.

8. There were 47 files reviewed in total and the main findings are shown in the following paragraphs along with recent data from PHE Fingertips Suicide Profile.

Risk Factors

9. A number of risk factors of suicide are known, these include: social isolation; certain mental health issues; bereavement; loss of employment; substance misuse; and deprivation. Furthermore, individual characteristics such as ethnicity, religion, sex (more common in men) and age may influence the risk.

10. The PHE Fingertips online suicide prevention tool collects data on a wide range of risk factors for Suicide, including:

    - Depression recorded prevalence (aged 18+)

    - Estimated prevalence of common mental disorders

    - Estimated prevalence of opiate and / or crack cocaine use.

- Long term health problem or disability, % of population
- Children in the Youth Justice system
- Children in care, and children leaving care
- People living alone
- Admission episodes for alcohol related conditions

11. For all of the above measures Gateshead has higher numbers than National (England) and Regional benchmark figures. As can be gathered from this extensive list of risk factors, there is a need for engagement of a wide range of partners in helping to reduce the risk of someone ending their own life.. The list of risk factors, or certain indicators on it, also reinforces the presentation by PS, the person with lived experience, at the last OSC meeting in September 2019.

Key Themes

12. The key themes emerging from the Audit were:

The high number 32 (68%) who **died in their own home** with a further 7 (14.9%) who died in someone else's home. This makes preventative initiatives targeting the high-risk area very difficult.

Another key theme was the number of these cases 30 (64%) that had died from self poisoning. Opiates and Benzodiazepines appeared most regularly, and Cocaine was often seen in the toxicology reports as a contributory drug.

Hanging, predominantly in their own home, was the second most common cause of death after self-poisoning with 8 (17%).

High risk population group

13. The key risk group seen in this, and other audits over the previous 4 years was being **Male**. Of all the Suicides and injury undetermined deaths in Gateshead for the 2018 calendar year 36(76.6%) were Male and 11(23.4%) were Female. This is in line with national data and why men are seen as the highest risk population group in Gateshead.

14. When looking at the marital status of the cases, 27 (57%) were **Single**. Again, this is in line with the findings from previous year's Audit and is linked to one of the other high-risk population groups, **Living Alone.** 19(40%) of the files audited the persons living arrangements identified as this.

15. Another high-risk population group is people who are unemployed with 21(45%) being identified as this.

16. Having **Relationship / Family problems** was seen as the biggest social risk factor, again in line with last year's data

Verdict

17. Looking at the verdicts for all the Suicide and undetermined deaths of Gateshead residents in 2018 there were only 3 (6.4%) that had a suicide verdict. The largest number 29 (62%) were classified Accidental/ Misadventure and a further 12 (26%) had a Narrative verdict. An explanation of these verdicts is shown in **Appendix 1**

Potential opportunities for intervention

18. Looking at the profile of the people who had died from Suicide and injury undetermined deaths in Gateshead for the 2018 calendar year there were several indicators identified which could potentially provide opportunities for preventative interventions. These once more will require partnership working across the health and social care system and include the following groups of service users:

    18.1. People with existing evidence of risk i.e. Alcohol/Drug use, Self-Harmers and those who have had previous suicide attempts.

    18.2. Review of prescribing practices. With the high number of deaths being linked to drugs use there is scope to ensure that individuals only obtain and continue to receive drugs for personal use.

    18.3. Working with Drug and Alcohol services to ensure their staff know the increased risk in their client group and where possible to provide Mental Health support alongside the therapy for the physical addiction.

    18.4. Working with GP Practice staff to raise the opportunity for intervention with 29/47 visiting their GP within the 3 months prior to death. However, all this group attended for a physical health problem.

    18.5. Working with providers of support for people with Depressive illness.

Issues to Consider

19. When considering the evidence outlined above the Committee may wish to consider the following:

    19.1. The number of people who are confirmed to have died as a result of Suicide is only a fraction of the people who are classed to have died from Suicide and injury undetermined deaths in Gateshead. The files included a range of verdicts from the Coroner including; Suicide verdicts, Narrative verdicts and Accidental/Misadventure verdicts. See **Appendix 1** for an explanation of each verdict.

19.2. Gateshead has lower than Regional rates of Suicide and similar rates to England.

19.3. Suicide is the leading cause of death among young people aged 20-34 years in the UK and it is considerably higher in men, with around three times as many men dying as a result of suicide compared to women. It is the leading cause of death for men under 50 in the UK. Those at highest risk are men aged between 40 and 44 years who have a rate of 24.1 deaths per 100,000 population. [1]

19.4. Suicide Prevention work impacting on Gateshead is being taken forward at Regional, Northumberland Tyne & Wear and Gateshead level.

20. Subsequent evidence gathering session will include presentations from Regional leaders and our partners from Newcastle Gateshead Clinical Commissioning Group and on the work at Integrated Care System (ICS) level and sub regional sub groups.

Recommendations

21. Overview and Scrutiny Committee is asked to consider the contents of the report and the Audit findings as a part of their review of suicide in Gateshead.

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[1] Office for National Statistics (2017). Suicides in the UK: 2016 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarri... [Accessed on 21/08/18].

Appendix 1

Definition of Verdicts

Point 1, Suicide verdicts is taken from The Crown Prosecution Service (CPS): Coroners Legal Guidance, at:
http://www.cps.gov.uk/legal/a_to_c/coroners/#a09

Points 2 – 4 are taken from Burnetts detailed explanation of inquest verdicts, at: https://www.burnetts.co.uk/publications/blogs/inquest-verdicts-explained

1. Suicide verdicts

When it is believed, on the basis of the factual evidence that the person genuinely intended to kill themselves. For this verdict to be returned there has to be clear evidence, for example a suicide note, which shows beyond reasonable doubt that it was definitely the person's intention to take their own life. If they did something that resulted in their death but there is not enough evidence that they intended to die, then this verdict cannot be returned.

2. Narrative verdicts

The Coroner can use a 'narrative verdict', which will set out the circumstances of the death in a detailed way based on the evidence that the Coroner has heard. For those attending an Inquest of a beloved one, it can sometimes be more satisfying to hear the Coroner's verdict in this form, as more of a detailed conclusion of events leading to the death is provided by way of the Inquest verdict. This is in preference to short form inquest verdicts such as; natural causes, misadventure, suicide, neglect and others.

3. Accidental Death

An accidental death is an unnatural death that is caused by an accident such as a slip and fall, traffic collision, or accidental poisoning. Accidental deaths are distinguished from death by natural causes (disease) and from intentional homicides and suicide. When a cause of death is listed as an accident rather than a misadventure, this implies no unreasonable wilful risk.

4. Misadventure

A death by misadventure, as recorded by coroners and on death certificates and associated documents, is one that is primarily attributed to an accident that occurred due to a risk that was taken voluntarily. For example, a death caused by an illicit drug overdose may be ruled a death by misadventure as the user took the risk of drug usage voluntarily. Misadventure is a form of unnatural death, a category that also includes accident, suicide, and homicide.