West Sussex Suicides Audit 2013-2015

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Introduction

Context of the report

Completing a suicide audit is a key recommendation of the 2015 All-Party Parliamentary Group on Suicide and Self-harm Prevention and essential to successful local implementation of the national suicide prevention strategy.

In 2014 the West Sussex Public Health department completed an audit which covered all West Sussex suicides and open verdicts likely to be suicides, registered at inquest during the period: 1st January 2011 to 31st December 2012. The information in this audit was used to inform the work of the West Sussex suicide prevention steering group.

This new audit covers the three year period 1st January 2013 to 31st December 2015 and aims to build upon the knowledge generated by the previous audit, ensuring the focus is on information that is not readily available using national data sources.

The percentages used in this report describe the proportions within the cases audited and they do not necessarily extrapolate to wider populations when making predictions. Confidence intervals and other statistical methods have not been applied, as no attempt is made to draw inference outside of the cases audited. Further, it is important to reflect on the successes in suicide prevention currently employed county-wide. This report does not identify the numbers who have been supported to overcome mental illness and suicide risk. These figures only describe the attributes and activities of those who finally took their lives and as such may appear to negatively reflect services or professionals, which is not the intention.

There are no formal recommendations contained within this report – the findings having been used to inform the West Sussex Suicide Prevention Strategy which will be published in the summer of 2017.

Suicides and open verdicts

It is important to note the contrast in the number of suicides between official Office for National Statistics annual reports and those identified by this suicide audit. Similarly, in previous West Sussex audits these numbers have varied because of the auditors' inclusion criteria and because of this, statistical suicide rates based on suicide audit data should be viewed with caution, whether higher or lower than previous years.

Suicide verdicts were agreed as any of those cases where the deceased is believed by formal inquest to have knowingly chosen to end their own life. They are typically characterised medically by the ICD10 codes X60-X84.

Open (or narrative) verdicts were agreed as those cases where the findings of the inquest could not ascertain with reasonable certainty that the subject had knowingly chosen to end their life, but it was likely, due to the evidence available. They are typically characterised by the ICD10 codes Y10-Y34.

The Office for National Statistics definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over.[1]

Criteria

Clear inclusion and exclusion criteria were established before the audit began. The coroner's team was asked for all cases of suicide or likely suicide (from open/narrative verdicts) which were filed after a final inquest date within 2013 or 2014 (2015 files were added later when it was agreed the third year was accessible).

Cases were excluded where the deceased was neither a resident of West Sussex nor was their suicide within the county boundaries, though the coroner may have them on file if they died near to the county, i.e. Havant, Portslade or Horley, or if they were admitted to hospital within the county before dying. Rare exceptions were made to include such cases where they had received significant support from West Sussex-based services during their life, despite living over the county lines.

Cases were also excluded where the auditors felt the open verdicts were not likely to be suicides, but accidental death or misadventure.

As a result of these criteria, the exact numbers audited will be a little less than those held on record by the coroner.

Methodology

There is no single agreed-on methodology for collecting suicide data. Rather, the auditing team followed examples of good practice and attempted to maintain consistency with previous local reports. Templates from 2010 were used to inform an initial structure of data collection and these were piloted against two real cases.

Traditional paper forms were replaced with an electronic database (Excel 2010) to which the auditors would input in real time. Where possible, data entry was restricted by use of dropdown menus for each cell, with options for free-text specifications or further notes within each section. In all, 125 cells of data were recorded over five sections for each individual, with further records to log the audit or keep notes.

[1] ONS Statistical release, 2016, accessed [2017] from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations

Outline of the data collected:

Section 1: Personal details	Demographic details
	Personal history/status
Section 2: Information relating to death	Events surrounding death
Section 3: Information relating to contact with Primary Care and community services	History of diagnoses
	Ongoing diagnoses
	Mental health assessments
	Treatments prescribed/followed
	History of self-harm/suicidal thoughts
	Other services used
	Reflections on mental health services
Section 4: Information relating to acute hospital services - other than psychiatric hospital	A & E or inpatient (non-psychiatric)
Section 5: Information relating to psychiatric history	History with psychiatric services
	Histories of specific indicators
Additional:	Are there lessons from which to learn?
	Further notes

Whilst attempts were made to only include data felt to be necessary, due to the potential range of demographics, circumstances, service use, personal history and lifestyles, parts of the audit structure were not suitable for many cases and some data is therefore of low fidelity and not included in this report. For context, *N*-values will be included when discussing findings.

The audit team was comprised of five members of the Public Health and Social Research Unit (PHSRU) of West Sussex County Council. At the coroner's convenience, dates were agreed when the team could access the case files in the coroner's office and these files had been manually selected by the coroner's team from their archives beforehand. Case files typically included a coroner's summary sheet; a toxicology report; an autopsy report; a police report of the circumstances of death; where available, a character reference describing the background of the individual from those close to them; copies of suicide notes and photos of the scene; any relevant physical or mental health service history, particularly if the individual was under the care of services around the time of their death; and copies of any inquests or investigations into the death. Some documents were not always present, meaning closer scrutiny was not always possible and some files contained little information for the auditing team to log. In particular, Primary Care and community services histories were often not available. Where relevant, the report describes figures in this context as overall numbers of a particular aspect may have been higher, should complete histories have been available.

The team viewed two files openly and discussed their interpretation of the findings and the database to improve interpersonal reliability. From then on, each team member selected casefiles in no particular order and examined it individually, logging data as they went. Discussion was encouraged and complicated cases were considered by all those present. Completed files were returned to the coroner's team for filing after each day. No names were recorded, though other personal information including postcode was added to the database for analysis. All data was stored on secure drives on the WSCC laptops.

Strengths and weaknesses

By predetermining the responses available for input in the form of drop-down menus, the auditors were forced to match the wide potential of each individual's life and their

circumstances of death to a rigid structure. This method has strengths and weaknesses which should be considered.

For effective and balanced analysis it was required that recorded data should be categorical and not the auditor's description of the case at hand. For example, if the method of death was left to open text input these would have to be combined post-audit on the basis of the analyst's interpretation of the auditor's description, taking up time and potentially misaligning data into new categories which may incorrectly capture the facts.

In contrast by forcing the auditor's hand there can be a loss of richness as compromises have to be made at the time to assign data to a category which may only roughly match the facts. The reader should therefore bear in mind that the data has been assigned a category as the only effective way to collect and analyse the data, rather than each category being a literal translation of the thousands of pages of information condensed here.

The previous West Sussex Suicide Audit (2014) states they only included cases of West Sussex residents (and those who had no fixed abode locally). This audit includes some cases where people have travelled into the county and died here and as such rates and base numbers should not be compared directly with previous works. For that purpose, it is recommended the reader use statistical releases available regularly from the Office for National Statistics.

Report format

The report has been split into four sections discussing the data:

- ***Firstly**, examining the quantitative demographic data and circumstances of death and to draw out any patterns.*
- ***Secondly,** further discussion around personal risk factors recognised in national research, such as self-harm or alcohol dependency.*
- ***Thirdly,** a summary of the physical and mental health problems and to what degree they were known to the support services available.*
- ***Fourthly,** how support services were accessed, if at all and how the individuals and/or their families negotiated these systems and if there were any further opportunities to safeguard the deceased.*

With these areas collated, the report will aim to summarise any lessons identified by service providers (where these were included in case files) and lessons which may aid in developing prevention strategies.

1. Demographic information and circumstances of death

Numbers and rates

For the three years 2013-15 inclusive, there were 213 suicides/likely suicides which met the agreed criteria. Of these, 190 were confirmed suicides and 23 were open or narrative verdicts which are likely to be have been suicides (Table 1.1).

Table 1.1, Audited West Sussex suicides, 2013-15

	Female	Male	Total
Suicide verdict	48	142	190
Open verdict	4	19	23
Total	52	161	213

Of the 213 cases, 185 were known residents of West Sussex with a valid postcode. Two were currently homeless with no fixable abode; seven did not have a postcode recorded; nineteen were from outside the county, with resident postcodes from elsewhere.

Rates per 100,000 varied at locality or commissioning area levels. Mid Sussex and Adur had lower annual averages than elsewhere, with Chichester, Arun and Horsham having higher rates (Table 1.2).

Table 1.2, Annual rates per 100,000 resident population

Area	Suicides (3 year count)*	Population (all ages)	Annual rate /100,000**
COASTAL CCG	118	430,100	9.1
CRAWLEY CCG	26	107,000	8.1
HORSHAM AND MID SUSSEX CCG	41	271,700	5.0
Adur	10	61,300	5.4
Arun	39	149,800	8.7
Chichester	30	114,000	8.8
Crawley	26	107,100	8.1
Horsham	34	131,500	8.6
Mid Sussex	23	140,200	5.5
Worthing	23	105,000	7.3
West Sussex	**185**	**808,900**	**7.62**

**Not all suicides are West Sussex residents, nor are they a sum of residents and those travelling into the county. Some post codes are missing from the files - these calculations are for West Sussex postcodes only.*

***Rates have not been age-standardised and higher rates may reflect an older resident population.*

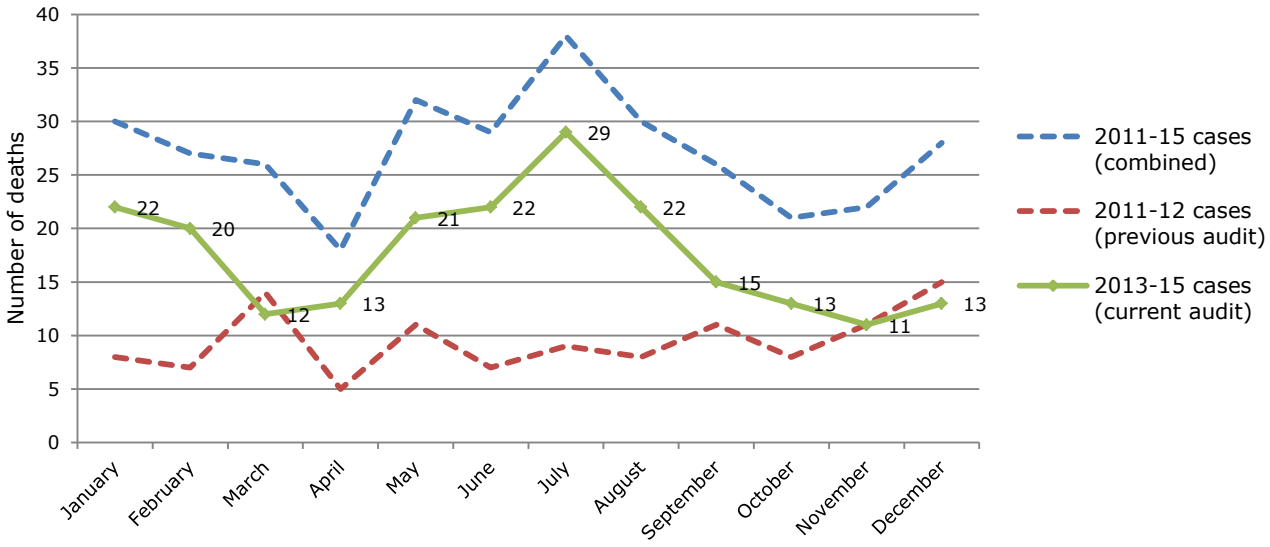
What is interesting to this table is the difference between Horsham district (8.6) and where it is divided between Horsham and Mid Sussex CCG (5.0) in the north and Coastal CCG (9.1) in the south. The Coastal rate is higher than all the localities within its boundary; the Horsham and Mid Sussex rate is lower than its localities. This dictates that the higher Horsham rate (8.6) is occurring disproportionately in the rural south and contributing to the rise in Coastal CCG's overall rate. Of the 34 deaths in Horsham district, 16 were in the less populated south/west; this mainly comprises the Chanctonbury GP locality. This higher rate may be due to the older age profile of this area, and it should be noted that one less suicide per year in this area would bring the rates down to county levels.

Time of year

Previous audits have examined seasonality and the month in which people died. Figure 1.1 shows results from the 2014 audit (in red) and results from this audit (in green). Above them is the combined numbers to give a five year total (in blue). These figures suggest there is a higher incidence in summer, potentially when there is more opportunity to find privacy outdoors during the longer days and warmer nights. However, there is no consistent increase in the proportion of deaths occurring out of the home during summer months to lend support to this, (57% in May; 55% in June; 45% in July; 32% in August).

This audit largely counters the peaks found in the previous audit (in spring and early winter). The conversation in the literature around seasonal variation of suicide appears to be ongoing and is markedly different from country to country; climate to climate. With small numbers it is not possible to confirm or deny the presence of seasonal variation, though it has been suggested that such effects in England and Wales have largely diminished in recent decades[2].

Figure 1.1, Seasonal differences and month of death (2011-15)



Following this, there was also no evidence to suggest proximity to birthdays was a protective or contributing factor. A random (even) spread of cases would predict four suicides each week (three years summed). This audit found three cases in the week before the deceased's birthday and six cases the week after. - One of these did end their life on their birthday. Similarly, 36 deaths were within a month of their birthday (on either side) and a random spread would expect to see 36.

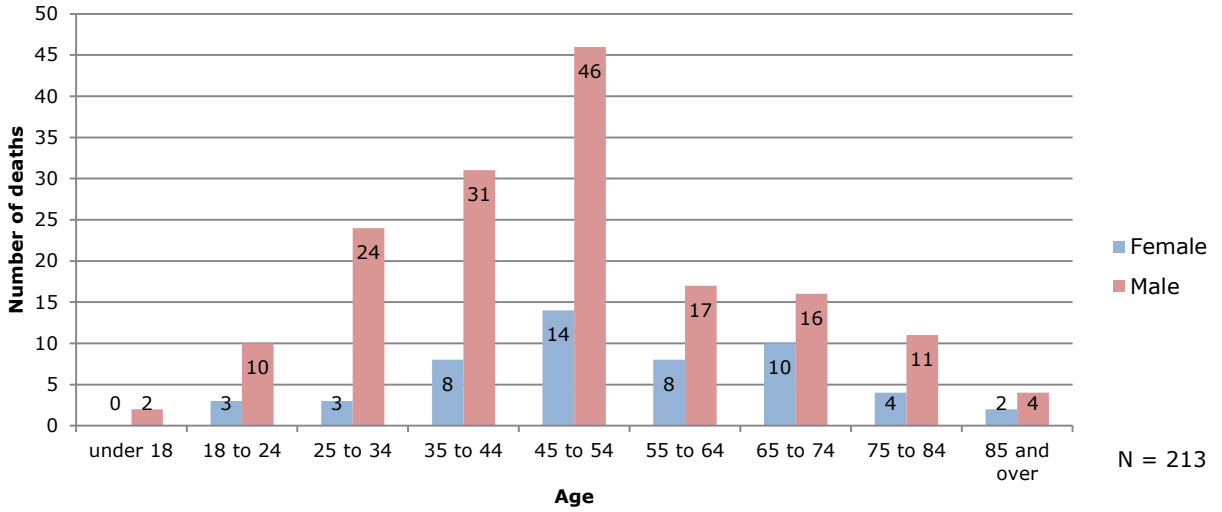
Demographics

The highest frequency of deaths was in early middle age, with nearly a third of male deaths and female deaths occurring between the ages of 45 and 54 (Figure 1.2). There were two deaths for under-18 year olds (both male) and fifteen deaths in under-25s. Only 27% of

[2] Yip PS, Chao A, Chiou CW. Seasonal variation in suicides: diminish or vanish. Experience from England and Wales. Br J Psychiatry, 2000;177:366–369.

female deaths were under the age of 45, compared with 42% of male deaths. One in three females were aged 65 or over, as were one in five males.

Figure 1.2, Number of deaths by age and gender, 2013-15



Ten percent of audited cases were from a minority background or foreign nationality. Six cases in particular were Polish and six more were from other White European backgrounds. Suicide numbers for minority groups are too small (i.e. two were from Black ethnic backgrounds) to compare to local populations.

Sexuality was discerned by examining the case files and was not often clearly stated. If a subject was married to, or historically in a relationship with, a person of the opposite sex, they were usually counted as 'heterosexual' for the purposes of the audit, unless other factors contended this. On other occasions sexuality was often described by family testimony. On some occasions sexuality was not possible to discern and was not known for 24 cases. Five cases were recorded as homosexual; 3 as bisexual and 181 as heterosexual.

Nearly half of the females were retired at the time of death, compared to a fifth of males, though there were a range of other working and non-working lifestyles (Table 1.3).

Table 1.3, Employment status at time of death

	Female	Male	Total
Working full-time	5	55	60
Retired	23	33	56
Unemployed	13	40	53
Long-term sick or disabled	4	7	11
Working part-time	2	4	6
Caring for family/partner	1	5	6
Housewife / househusband	3	0	3
Student full-time	0	4	4
Not known	0	6	6
Other	1	7	8
Total	52	161	213

One in three females deaths and males deaths were from people who lived alone. However, that is not to say that living with others was confirmed as a protective factor, as one in three female deaths and one in five male deaths were from those who lived with their spouses at the time of death. Ten percent lived with their parents (Table 1.4).

Further to this, one in four individuals had children aged under 18 who were still dependent on them (i.e. they were not estranged or had been taken into care). A further one in three had children who were not dependent on the deceased, or were adults.

Table 1.4, Living situation at time of death

	Female	Male	Total
Alone	18	55	73
With spouse / partner	19	31	50
With spouse / partner & child(ren)	4	23	27
With parents	1	21	22
With child(ren) over 18 only	1	2	3
With child(ren) under 18 only	1	1	2
With other family	0	3	3
With adults (non-family)	2	12	14
Other	4	6	10
Not known	2	7	9
Total	52	161	213

One in three was married at the time of death and over one in four was single (unmarried and not cohabiting). A further one in four was either separated or divorced (Table 1.5).

Table 1.5, Marital status at time of death

	Female	Male	Total
Married	21	49	70
Single	9	50	59
Divorced	10	22	32
Separated	4	21	25
Widowed	5	9	14
Co-habiting	1	7	8
Other (Specify)	2	3	5
Total	52	161	213

Causes of death

The most common cause of death for both males (43%) and females (42%) was by hanging or strangulation. Second to this was self-poisoning, more common in females (Table 1.3).

Table 1.3, Primary causes of death

	Female		Male		Total	
Hanging / strangulation	22	42%	69	43%	91	43%
Self-poisoning	14	27%	28	17%	42	20%
Jumping / laying before a train	3	6%	19	12%	22	10%
Jumping from a height	2	4%	8	5%	10	5%
Cutting / stabbing	2	4%	7	4%	9	4%
Drowning	4	8%	5	3%	9	4%
Carbon monoxide poisoning	1	2%	7	4%	8	4%
Suffocation	3	6%	4	2%	7	3%
Firearms	0	0%	4	2%	4	2%
Burning	0	0%	3	2%	3	1%
Jumping / laying before a road vehicle	0	0%	2	1%	2	1%
Helium	1	2%	1	1%	2	1%
Drilled track to the brain	0	0%	1	1%	1	0%
Unascertained	0	0%	3	2%	3	1%
Total	52	100%	161	100%	213	100%

**Examples of unascertained causes of death may be those who died next to multiple opened medication packs but the body decomposition had advanced, prohibiting toxicology confirmation.*

There is a notable difference in the age profiles of those who take their lives by different methods. Whilst hanging/strangulation roughly fits the overall age profile (partly due to large numbers contributing to the overall picture), self-poisoning occurs more than expected in the 65+ age cohort. This is partly due to increased access to medication intended for physical health problems. Inversely, a larger proportion of deaths from train/rail incidents occurred in under-35 year olds. Reasons for this are not clear, though lower access to medical prescriptions and increased physical mobility may explain some of the difference between the two.

The different motivations for suicide may also contribute to this and are discussed later in the report in Sections 2 and 3. For instance, older individuals might not have particular mental health problems but are instead choosing death instead of living with deteriorating health; this motivation for suicide was referenced many times in the case notes and highlights issues for adults' social care and palliative care.

Of additional note, over half of the suffocation deaths and the drowning deaths were in the over-65 age group.

Table 1.4, Main three causes of death by age group

	(N)	14-34 years	35-44 years	45-54 years	55-64 years	65+ years	Total
Hanging / strangulation	(91)	23%	20%	32%	13%	12%	100%
Self-poisoning	(42)	10%	31%	12%	12%	36%	100%
Jumping / laying before a train	(22)	41%	9%	36%	14%	0%	100%
All deaths	(213)	20%	18%	28%	12%	22%	100%

In particular, the access to the means of death varied from person to person and may have contributed to numbers for certain methods. Hanging and strangulation may be more common due to the relative access to the method. Many of the cases did not involve suspension off of the ground, but a ligature around the neck from behind, such as a belt, coat hanger or dressing-gown cord. All those who took their lives with a firearm were licensed owners who used their own shotgun/rifle.

The charity *'DIGNITAS'*[3] was referenced in one case as being principal in informing the individual of the available methods of suicide and an informational DVD was found amongst their possessions, with guidance on how to end your life by inhalation of helium, which the deceased had followed.

Rail deaths

West Sussex has three main rail lines: The Coastal line, the Arundel to Crawley line and the Brighton to London line through Mid Sussex. The nine following stations were identified as the location of a suicide: Balcombe (x2), Fishersgate, Hassocks (x2), Gatwick, Shoreham, Southwick, Wivelsfield (x2), East Worthing and West Worthing. In some cases the deceased was thought to have waited for a number of hours at the platform for the first train of the day.

[3] DIGNITAS, online at: http://www.dignitas.ch/

Rail crossings were also used by ten other individuals to access the railway near the following locations:

- Drayton Ln, Oving (x3)
- Goffs Ln, Ifield
- Horsham Road, Crawley
- Brook Ln, Littlehampton
- Eastern Ave, Shoreham
- Toddington Ln, Littlehampton
- Whyke Rd, Chichester
- Drift Ln, Bosham

(Locations may not be at exact crossing, as they are discerned from descriptive case notes.)

Location of incident

Most commonly people chose to end their lives at home, with 56% of events either in the house or elsewhere on the premises (Table 1.5). Next most common was secluded (wooded) areas, whether in the countryside or just out of site. For ease of analysis, Carparks, bridges, laybys, farm tracks and roadsides have been combined. These can be considered as 'in public' and not as secluded as wooded areas, though many were in the countryside or occurred at night. It is not known whether or not the particular carparks were likely to have attending staff.

Train stations and level crossings were a common location, accounting for 22 deaths in the audit period. Seven people died at the beach and most of these were from drowning. Whilst there were many other examples of locations, from parks to churches or whilst on holiday, these were not common and have been grouped together.

Table 1.5, Location of incident

	Female		Male		Total	
Home	32	62%	81	50%	113	53%
Home garage/shed/caravan	2	4%	4	2%	6	3%
Wooded area	1	2%	16	10%	17	8%
Carpark, bridge, layby, roadside (combined)	1	2%	16	10%	17	8%
Train stations	3	6%	9	6%	12	6%
Level crossings	0	0%	10	6%	10	5%
Beach	3	6%	4	2%	7	3%
Hospital/ward	1	2%	2	1%	3	1%
Gatwick Airport	0	0%	2	1%	2	1%
Other (single cases)	9	17%	17	11%	26	12%
Total	52	100%	161	100%	213	100%

Drug and alcohol use

Whilst they may not have been heavily intoxicated, one in three males was believed to have consumed alcohol around the time of death, as shown in toxicology reports. Similarly, one in seven of all deaths were whilst under the influence of non-prescribed substances (Table 1.6). This does not include overdoses of their own prescribed medication, but may include cases where they have accessed someone else's medication (i.e. those which are opiate-based).

Table 1.6, Under the influence of alcohol/non-prescribed drugs at time of death (ATD)

Alcohol ATD	Female		Male		Total	
Yes	8	15%	58	36%	66	31%
No	41	79%	80	50%	121	57%
Not known	3	6%	23	14%	26	12%
Total	52	100%	161	100%	213	100%
Non-prescribed/illicit drugs ATD						
Yes	9	17%	25	16%	34	16%
No	37	71%	113	70%	150	70%
Not known	6	12%	23	14%	29	14%
Total	52	100%	161	100%	213	100%

Key points

- For the years 2013-15 inclusive, there were 190 confirmed suicides and 23 open verdicts likely to be suicides. Combined, there were 52 females and 161 males included in the audit.
- Local rates varied around the 8 per 100,000 level and could be influenced by the numbers of persons living in area which fit the age-profiles of higher suicide prevalence. – These rates should not be directly measured against other data sources.
- Seasonal variations show a higher prevalence in summer months, though it is possible that this is random error found in low sample numbers.
- Nearly a third of male deaths and female deaths occurred between the ages of 45 and 54. Roughly half of female deaths and a fifth of male deaths occurred in those aged 65 and over.
- One in three individuals lived alone at the time of death and one in four lived with their spouse or partner.
- The most common means of suicide was by hanging or strangulation (43%); next to this was self-poisoning (20%), more popular in older females, and impacts with a train (10%), more popular with younger males.
- Rail crossings are as common for suicide as rail stations (together accounting for 10% of deaths).
- Over half of suicides occur in the home or elsewhere on the premises.
- Nearly one in three deaths occurred after consuming some level of alcohol. One in seven had taken illicit or non-prescribed drugs.

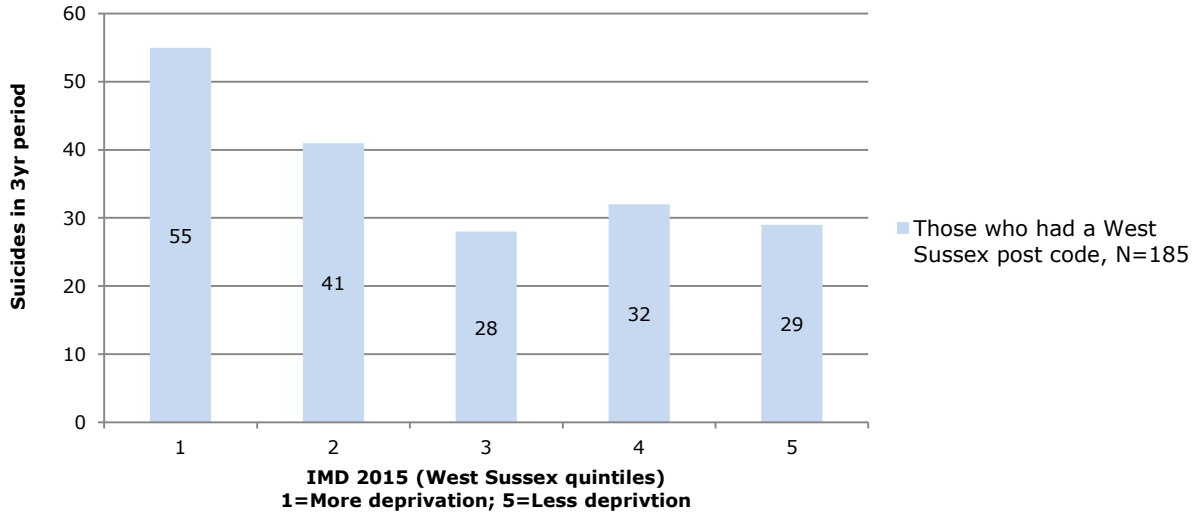
2. Personal circumstances and risk factors

This section attempts to describe different individual circumstances or lifestyles which have commonly been linked to higher risk of suicide. It should be noted that many aspects coincide with others described in the section, such as substance misuse and deprivation, or divorce and criminal investigations and separate figures or tables may be describing the same individuals.

Deprivation

Post code analysis shows that a higher than expected proportion of the suicides in this audit were from West Sussex residents living in the most deprived 20% of the county (Figure 2.1). Whilst there are a roughly equal proportion in more affluent areas, this data suggests those from more deprived areas are more at risk of suicide. – Locally, these areas are more concentrated in central areas of Bognor Regis and Worthing, and western areas of Littlehampton and Crawley.

Figure 2.1, Suicides by deprivation



Throughout the audit, debt and financial difficulties were believed to be drivers in building stress and anxiety in some individuals in the days or weeks before their death. This ranged from benefit sanctions, to mounting business debts; from lifelong impoverishment to losing court cases.

Perceived opportunities

Examples of financial difficulties included an individual who lived alone and was unemployed and when he was found at his home by police he had left no suicide note, but instead an open copy of a bank statement showing a near empty account and a copy of an eviction notice. Another was a young man who cited in his suicide note that a lack of money, job, partner and perceived future were his primary drivers to suicide. This is similar to another young man who, despite having many good relationships with friends and family members, specifically referenced always 'being skint' and having no real opportunities; despite his young age, he felt that he had worked hard and his life had 'amounted to nothing'. A third young man gave similar reasons. Despite being only 21, he felt that his life had no direction or promise. One older man had become destitute because of his unwillingness to apply for housing and income

support as his physical health had deteriorated in recent years. He resorted to suicide, with his savings used up and being due to be evicted the following morning.

In total, the auditing team counted 15 cases (7%) between the ages of 21 and 65 where financial burdens, loss of benefits/eviction, or a perceived lack of opportunities were described as a primary driver for their suicide.

Historic drug and alcohol misuse

One in four cases described lifestyles or past problems that were interpreted as having a history of alcohol misuse. This was implied when an individual was cited as being a heavy and regular drinker to the point where it would either negatively affect their physical or mental health or cause problems for their social/personal relationships. Similarly, one in four had some history of drug misuse. This refers to any noted use of controlled substances (assuming that minor or one-off use of no consequence would not have been included in the case files).

Table 2.1, History of alcohol or substance misuse

History of alcohol misuse	Female		Male		Total	
Yes	7	13%	52	32%	59	28%
No history or not known	45	87%	109	68%	154	72%
Total	52	100%	161	100%	213	100%
History of drug misuse						
Yes	9	17%	42	26%	51	24%
No history or not known	43	83%	119	74%	162	76%
Total	52	100%	161	100%	213	100%

Roughly half of those with a history of alcohol misuse were believed to have been drinking alcohol near the time of death (28). Whilst a larger number of those found to have been drinking had no history (38), this was a smaller proportion of the total 'no history' group (Table 2.2).

Table 2.2, Alcohol and historic use combined

	Any history of alcohol misuse		
Alcohol ATD	Yes	No history/Not known	Total
Yes	28	38	66
No history/Not known	31	116	147
Total	59	154	213

Similarly, roughly half of those with some history of drug-misuse were believed to have taken drugs not prescribed to them near the time of death (23). A much smaller number of those with no known history (11) had taken some non-prescribed substance near the time of death (Table 2.3).

Table 2.3, Non-prescribed drugs and historic use combined

	Any history of drug misuse		
Non-prescribed drugs ATD	Yes	No history/Not known	Total
Yes	23	11	34
No history/Not known	28	151	179
Total	51	162	213

History of violence to the deceased

Twenty three cases were identified where there was reason to believe the deceased had been a victim of violence in the past, either from a spouse/family member or otherwise. Of these 11 were female (21%) and 12 were male (7%). This equates to roughly one in ten of all suicides (where known; some cases may have been lacking histories required to identify violence).

Family history

Family histories were examined for mental illness, self-harm and suicide to identify any links. Where cases identified spouses or non-genetic relatives, these were not included in the totals.

Roughly one in five females and one in fourteen males had a family history of mental illness described in the casefiles. Relatively few individuals had had a family history of self-harm, though the majority of cases held no reference to this one way or the other. Similarly, twelve cases described a family member as previously taking their own life. Other cases reviewed did describe a friend's or spouse's suicide, though these were not counted within this field.

Table 2.4, Family history

Family history of mental illness	Female		Male		Total	
Yes	10	19%	12	25%	22	10%
No history or not known	42	81%	149	75%	191	90%
Total	52	100%	161	100%	213	100%
Family history of self-harm						
Yes	2	4%	6	4%	8	4%
No history or not known	50	96%	155	96%	205	96%
Total	52	100%	161	100%	213	100%
Family history of suicide						
Yes	1	2%	11	7%	12	6%
No history or not known	51	98%	150	93%	201	94%
Total	52	100%	161	100%	213	100%

Self-harm

One in three files described a history of self-harm. For the audit, incidences of self-harm included all physical bodily damage as well as previous suicide attempts and overdoses believed to be intentional. Some were unknown to service providers and professionals and were only discerned from case notes or testimony from friends/relatives.

Over half of under-25s had known to be self-harming at some point and this prevalence tended to decrease with age. Counts from the older individuals were mainly failed suicide attempts.

Table 2.6, History of self-harm

Known history of self-harm	14-24	25-34	35-44	45-54	55-64	65-74	75 +	Total
No history or Unknown	6	17	25	43	16	17	16	140
Known, but not recent (prior to past year)	5	1	2	6	2	2	2	20
Known but only recent (only in past year)	**2**	**1**	**5**	**2**	**4**	**5**	**2**	**21**
Ongoing (prior to and during last year)	**2**	**8**	**7**	**9**	**3**	**2**	**1**	**32**
Any self-harm (total)	(9)	(10)	(14)	(17)	(9)	(9)	(5)	(73)

Police and legal pressures

Up to 5% of the deaths audited concerned individuals being investigated for crimes. Many of these were sex-crimes or relating to child pornography or grooming. Other crimes, such as financial fraud or embezzlement were also identified, mainly amongst businessmen with families or spouses.

Separation from loved ones or bereavement

There were a number of cases (4%) where an individual (typically a father) was estranged from their children and not allowed access. This was often either due to a safeguarding decision or because the mother/former spouse had either moved away or there was an ongoing legal case for access. In any event, the loss of access to children was seen to be a great burden on the wellbeing of these individuals and no common reference is made to counselling support to cope with this loss; particularly those where social services had prevented access to a child and the father was known to them.

Distinct from this pressure was that of divorce, significant breakups or bereavement of a spouse of family member. From an in depth analysis of those in the 34 to 65 age range, 28 cases were identified where the individual was going through a separation, a divorce or had recently lost a loved one. This would amount to 23% of the 124 cases in this age range.

The loss of these protective factors were seen as main drivers in the deaths of these individuals, who were, in many cases, also experiencing poor mental health, financial troubles, or substance abuse.

Key points

- A greater than average proportion of individuals were from more deprived areas of the county. Debt, financial difficulties and a perceived lack of opportunities were also cited as a driver for 7% of individuals.

- One in three men had a history of alcohol abuse and one in four a history of drug misuse (some of these may be the same individuals).

- One in five females was known to have been subject to violence in the past.

- One in ten individuals was known to have had a linear family history of mental illness and one in five had a linear family history of suicide.

- One in three cases described a history of self-harm, though not all these were known to services.

- Roughly 5% of cases were currently being investigated or were on bail for serious crimes; many of which could carry significant prison sentence if found guilty.

- Divorce, separation or bereavement contributed to 23% of the main 34-65 year old age group. Further, there were a number of cases where individuals took their life after losing access to their children.

3. Physical and mental health problems

This section attempts to describe the known physical and mental health concerns which individuals had and the range of services with which they had contact.

Physical health problems

Many of the cases referred to significant and ongoing health conditions which affected the deceased's life in some way. In particular joint or mobility-related pains were present in over 10% of all cases. In a number of cases, these conditions directly contributed to the decision to take one's life, as the pain or discomfort, or loss of quality of life/independence outweighed the hope that quality of life would improve. Separate to this were those with a terminal diagnosis, who had chosen to end their life before their health deteriorated further. Table 3.1 shows only those most common physical conditions or diseases. In all, 94 cases (44%) had ongoing physical health problems or disabilities noted by the auditors.

Table 3.1, Most common physical health problems

	14-24	25-34	35-44	45-54	55-64	65-74	75 +	Total
Back, Joint or Arthritic Pain	2	0	6	3	3	2	7	23
Cancers (any, including in remission)	0	0	0	1	2	3	6	12
Diabetes	0	0	1	3	2	3	1	10
Hypertension	0	0	0	0	1	2	6	9
Cardiovascular diseases/Atherosclerosis	0	0	0	0	0	3	5	8
COPD/Respiratory diseases (Not including cancers)	0	0	0	0	1	4	2	7

Of the 21 deaths from those aged 75 or over, 14 were seen to be primarily driven by a continuing decline in health, where they felt their standard of living had been significantly reduced. Although all 21 had serious health conditions which would have affected their wellbeing in some way, some were more motivated by grief or loneliness. Amongst those aged under 75, a further eight cases were attributed to terminal health declines/diseases, the youngest being 57; putting the total to 22 (10% of total deaths).

General Practice

As seen above, nearly half of all cases were known to have an ongoing physical health complaint.

For 122 cases, the date of the last contact with their GP could be discerned. The remaining 71 had either incomplete or no GP records, despite some of them having serious or terminal health problems. Of those whose records were present, 27 deaths occurred within a week of seeing their GP last (13% of all cases). Furthermore, 81 deaths occurred within a month (31 days) of seeing their GP last (31% of all cases).

Of the 27 who saw their GP in the week before they died, 17 appointments were for mental health problems (8% of all cases). Of those seeing their GP in the month before they died, 41 were known to be for mental health problems (19% of all cases). Sixty one individuals had

visited their GP in the last year for a mental health problem (the last time they visited their GP), amounting to 29% of all cases.

Nineteen individuals had seen their GP at least three times for mental health problems in last year before their deaths (9% of all cases).

Diagnoses of mental illness

An attempt was made to record the types of mental health assessments carried out, though records were not consistently included to a level which could prove reliable. Some level of mental health assessment was documented for 25 females and 39 males (30% overall). Other assessments may have been completed and not included in coroner's files.

Where it could be discerned from the case files, 99 individuals were described as having a depressive illness (46%). Other common problems were anxiety disorders or phobias (18%) and many examples of substance abuse were also noted. Table 3.2 lists the range of mental health problems identified, though with many individuals suffering from multiple problems, this table exceeds *n=213*. The table also includes counts of those with a known learning disability or head injury. These numbers can also include diagnoses from secondary care or other mental health professionals. In all, 136 individuals were recorded as having some level of mental health illness (64%).

Table 3.2, Individuals with each diagnosis

	Female	Male	Total
Depressive illness	28	71	99
Anxiety disorder / Phobia	11	27	38
Alcohol misuse	3	24	27
Drug misuse	4	15	19
Schizophrenia	3	15	18
Personality disorder	8	7	15
Bipolar Affective disorder	5	6	11
Eating disorder	6	2	8
Adjustment disorder	1	4	5
Insomnia	0	4	4
Gender Identity Disorder	0	1	1
Psychosomatic tinnitus	0	1	1
Seasonal Affective Disorder	0	1	1
Learning disability	1	2	3
Head Injury	0	5	5
None	15	58	73

Suicidal thoughts

Many of the cases described a known suicidal plan or intent, or had admitted to considering it recently (Table 3.3). One in five of those under the age of 35 had admitted "clear intent or plans" to a professional. This compares with one in thirty for those aged 55 or over. This contrast was seen throughout the audit, where older individuals tended to keep their thoughts and plans more secret, unless they had historic mental health problems and were already engaged with services. Overall, three quarters of individuals had expressed no thoughts, plans or intention of suicide to a professional in the weeks or months before their death.

Table 3.3, Known suicidal thoughts or intentions

	Female		Male		Total	
Clear intent or plans documented	8	15%	10	6%	18	8%
Thoughts, ideas but not plans or intent documented	9	17%	27	17%	36	17%
No thoughts, plans, intent of suicide documented	35	67%	124	77%	159	75%
Total	52	100%	161	100%	213	100%

Expanding this, the audit looked for the state of play at the deceased's last primary care contact. In all, 11 females and 20 males were known to have expressed suicidal thoughts or plans with their GP at their last primary contact before their death (15% of all cases); this number may be higher with completed patient records. Sixteen of these were within two months (61 days) of their death, amounting to 8% of all cases.

The audit also asked if suicidal thoughts were included in Primary Care patient notes anywhere in the six months before death. Forty nine individuals (23%) had such notes made in their records. Similarly, there were 29 cases where suicidal thoughts were documented in the patient's history and the individual had met with their GP within two months before their death.

Suicidal actions

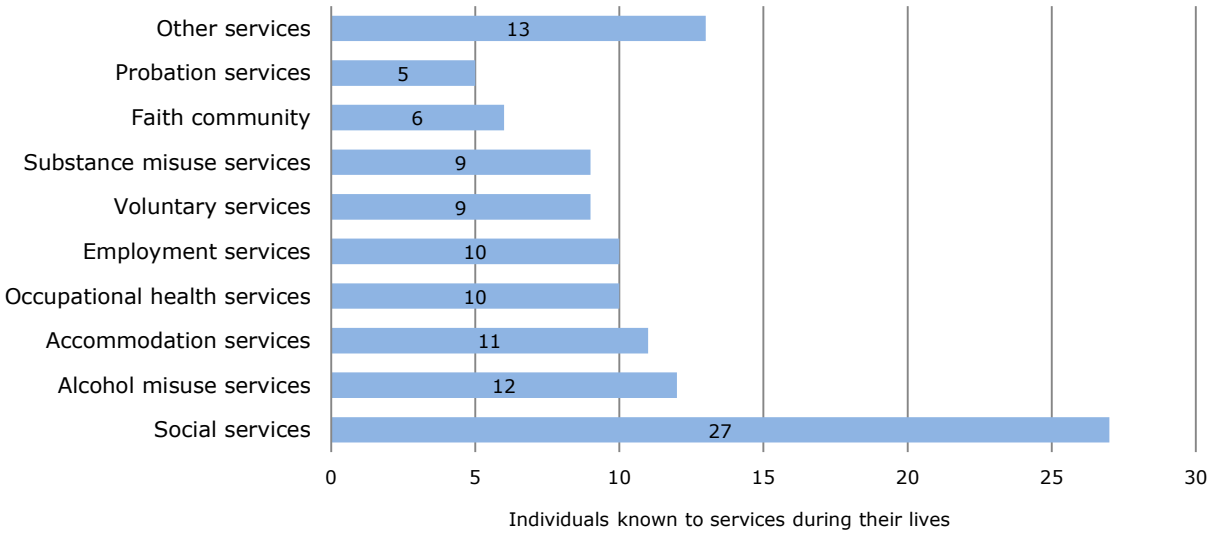
From the case notes it was possible to discern that 19 females (37%) and 40 males (25%) had attempted suicide previously, before the successful attempt which caused their death. Of these, 23 were attempted in the individual's home, 13 were in public places and 23 were not specified. Those in public places mainly included car parks and bridges and secluded wooded areas, with a range of other individual locations. When analysed with age, there were no clear patterns and numbers roughly matched the wider age profile. For the majority of cases, the method of attempted and failed suicide did not match the later successful method.

Known to other community services

Where records were kept, it could be seen what involvement other support services had with individuals in the period before their death, such as substance misuse services or accommodation services, rather than mental health or primary care services. There was no fixed time limit on how recently an individual had been involved, but only that it was still relevant to their lifestyle or personal history. Some of the counts for a service involvement in Figure 3.1 concern an individual utilising multiple services.

Twenty seven individuals were known to have been involved with Social Services, either as one in need of support or as a principal family member. Many of these were parents who had lost contact with their spouse/children and may therefore have not been the point of interest for the Social Worker. The theme of a parent struggling after losing contact with their family and/or their home was seen on multiple occasions in the audit.

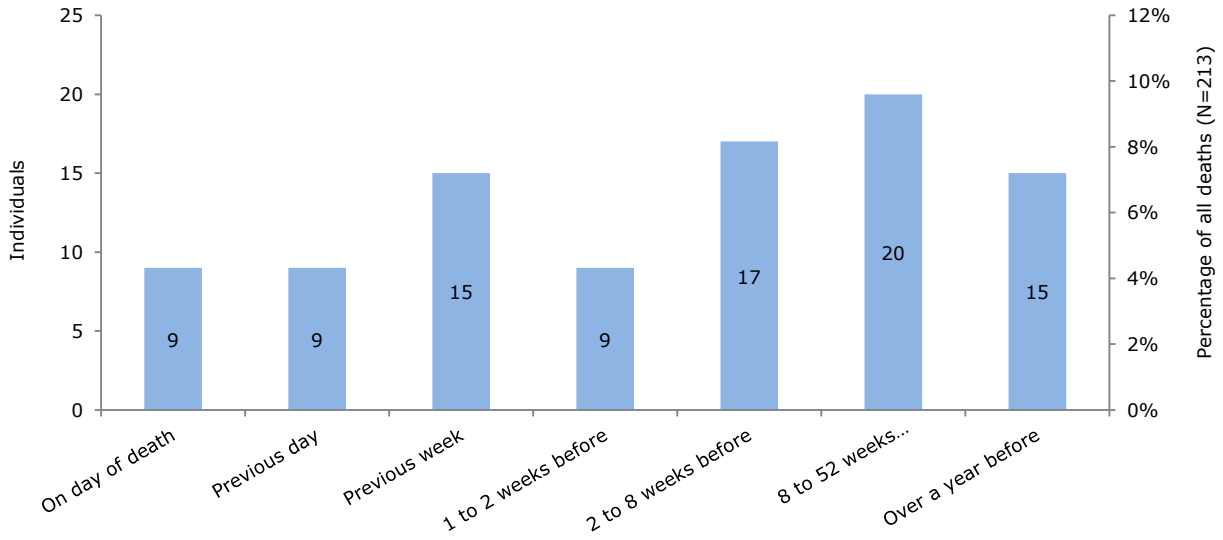
Figure 3.1, Individuals known to services during their lives



Those using services tended to match the age profile of the total numbers, though with very few over the age of 60 and slightly more represented at the younger end of the scale.

Where it could be discerned, the date of the last involvement with mental health support services was recorded for 94 individuals. Due to inconsistencies in the data it was not possible to identify the exact type of service for all individuals, though these were typically secondary care services and ranged from community mental health teams to crisis support and inpatient care. Fifteen of these were seen more than a year before their deaths, though 18 were seen either on the day or the day before their death (8%).

Figure 3.2, Last seen by mental health services before death



Accident and Emergency

From the information available, 60 individuals were known to have been admitted to A&E or hospital in the year before their deaths (28%), with 3 further cases over a year previous. Whilst some of these were not involving emergencies, further analysis shows that 26

individuals were admitted to A&E/Hospital because of a failed suicide attempt or strong desire to end their life. Although records are incomplete, sufficient data exists to show that 9 individuals were discharged from Hospital within the month before their death, after having being admitted for a suicide attempt.

Key points

- Joint or mobility-related pains were present in 10% of the cases and 5% had been suffering from (or diagnosed with) cancer.
- Two in three deaths in the over-75 age group (7% of all deaths) were seen to be primarily driven by an ongoing decline in physical health.
- Eighty one deaths (31%) occurred within a month of last seeing their GP. Nineteen individuals had seen their GP at least three times for mental health problems in the year before their death.
- The most common mental health diagnoses were depressive illnesses (46%) and anxiety disorders or phobias (18%). In all, 64% had some level of mental health illness recorded.
- Deaths in younger individuals were more likely to be mental health-related and individuals were more likely to have told a professional about their plans to take their life, than older individuals. One quarter of all individuals had been known to tell a professional about their thoughts or plans.
- Fourteen percent of individuals were known to have suicidal plans or thoughts by their GP and had met with their GP within two months before their death.
- Over a quarter of individuals had previously attempted suicide at some point.
- Eighteen individuals (8%) were seen by mental health services either the day before or on the day of their deaths.
- Nine individuals were known to have been discharged from A&E or hospital within the month before their deaths, after being admitted for a suicide attempt.

4. Accessing support

This section attempts to summarise the common issues in the service user to professional interface and how accessing care and models of care might learn from these past years of suicides. These are not intended to communicate the severity or scale of an issue through the number of individuals it affected; only to illustrate how it was significant to some. In this, exact numbers have not been reported and most examples refer to only a small portion of the overall deaths. – As described in the introduction, this section does not touch on the many successes which have helped people to overcome their mental illnesses or suicidal impulses.

Stigma

Whilst many individuals came forward and approached professionals for support with mental health problems, some cases described individuals who refused to ask for help or treatment. They were ashamed of what this would mean for their self-image. They chose to 'self-medicate' with alcohol or illicit drugs or attempted to ignore their problems all together.

Training and diagnosis

Diagnostic categorisation of mental illness is not always simple and/or clear and presentations may change over time. Cases have described GPs who later admitted they required focused mental health training in order to identify problems during a mental health assessment and misdiagnosis have at times resulted in ongoing problems for some individuals seeking support for mental health problems. Particularly, as described above in Section 3, many individuals had a consistent relationship with their GP for physical health concerns, but did not receive a mental health assessment or emergency referral where appropriate, in hindsight.

In a handful of cases, the referral to mental health support was made, but the individual took their own life before the appointment could be met (often within two weeks). In these cases, an emergency referral may have been more appropriate.

A reliance on self-report (I'm fine)

Similar to the discussion for mental health training is the common reliance on self-report conversations, at primary and secondary care level. The audit identified many cases where an individual was asked if they felt they were likely to take their life. If the individual said they weren't, then they were deemed not to be at immediate risk. This logical process was seen to miss many individuals who, in hindsight, were in fact high risk and who went on to take their life shortly afterwards. Many of these cases appeared to describe individuals who were either resigned to take their life, (therefore keeping it secret from others), or who were not sufficiently engaged with support services to admit to their plans or intentions.

Flexible care plans

Younger individuals were often found to want more flexibility in their mental health support and this clashed with fixed care plans. Primarily this focused on a desire to avoid medication where possible and instead use behavioural therapies to learn to cope with their problems and also to overcome them cognitively. Examples were seen where young individuals were told they could not access CBT therapies on the NHS without first agreeing to pharmacological medications. From this they chose to disengage and were allowed to do so by mental health

teams. Some sought private behavioural therapies at their own or their parents' expense, though this was not sustainable for average-income families. Others sought alternative therapies such as meditation and healthy lifestyle programmes.

Other examples of inflexible care included a case where an individual had acute anxiety and would not speak over the phone, which was the way in which mental health providers said the individual could contact the team if they required further/emergency support and the way in which the team would attempt to book appointments. As a result the individual did not receive the support they required, at times when it was most needed.

Sometimes accessing one service was a prerequisite of receiving another, such as substance use counselling as a condition of receiving mental health treatment, due to ongoing substance abuse. Examples were seen where an individual would not access one part of the care plan and were therefore allowed to disengage.

Disengagement

Issues arose when patients disengaged from their services over disagreements of treatment or care plans. Mental health resources have been under pressure for a number of years and some individuals who were not prepared to follow the complete care plan were told that they were not eligible for further support.

The individuals in the audited case files then dropped off the service-radar, as many did not have strong relationships with their GPs. On the contrary, in some cases when a patient disengaged or was discharged from hospital they were told by professionals to seek further advice from their GP, without knowing whether or not the patient was registered anywhere, or their likelihood to do so. Further, they were advised that, should they want to re-continue with mental health support, they should consult their GP and gain a new referral, or contact crisis support if they are in need of emergency interventions. In many cases, the GP who originally referred the individual did not seek confirmation from the individual as to why they disengaged or what alternatives could be put in place. Furthermore the GPs did not always know that an individual was no longer receiving treatment.

Building relationships

In a number of cases, individuals with paranoia or anxiety-based conditions were unable to maintain engagement or accept treatment as their supporting professional changed periodically. Paradoxically, it was the severity of their condition which prevented them from accessing treatment or support and it is possible that the mental health teams did not have the resource to gradually develop relationships with these individuals. Examples were given of individuals who would deny the severity of their problems to their family members so they would not be expected to go into inpatient care. Other examples were seen of individuals having over a dozen professionals handle their treatment over the course of a year, with minimal consistency. When this happened, the patient would grow despondent from relaying the same story from the beginning; poor user-professional relationships appeared a primary driver for patient disengagement.

Further issues arose around individuals who did not maintain a steady relationship with their GP and if they moved to a new surgery they often did not detail their complete mental health histories and circumstances. Similarly secondary care professionals were not always aware of an individual's personality and they were often at odds with the patient's family, who would

insist that "something was wrong", or that the individual was faking their way through the mental health assessments in order to appear less ill and therefore receive a discharge.

Deteriorating health and terminal illness

As described in Section 1, the main driver of suicide in the over 75s was from deteriorating physical health. These individuals had ongoing relationships with the primary care provider and some also received social care support to cope with a disability. In these cases it was not clear that any mental health assessments were considered. Bereavement of friends or spouses was frequently referenced also.

Separate to this were the cases where an individual had recently received, - or was expecting to receive, - a diagnosis of terminal illness. These cases, combined with those above, describe individuals with either little knowledge or little interest in available palliative care packages and instead chose to end their life before deteriorating further. Many of these individuals had families, relatives or friends and resorted to leaving suicide notes of sentiment, rather than taking time to discuss farewells with loved ones. This raises issues around palliative care and adults' social care. No reference was made in the case files to mental health support offered for these cases.

It should be noted that in some cases, loneliness and isolation were also driving factors in these suicide decisions. Many older individuals lived alone and described having little social interaction beyond their neighbour or a close friend/relative.

Invasive treatments and serious injuries

A few cases were identified where an otherwise happy individual was required to receive treatments for serious conditions, such as radiotherapy for cancer and instead chose to end their life rather than go through with an invasive procedure. No reference was made in the case files to mental health or resilience support at these times.

Similar to these were the cases where an individual had received a permanent injury, for example, from a road traffic accident or surgical complication. Whilst physical support or social care is described in the case notes, the loss of complete mobility or independence was a factor in both younger and older individuals' suicides. In these cases mental health referrals did not appear to be commonplace. Generally there appeared to be little written consideration in the case files of the risk of deteriorating mental wellbeing in those with chronic conditions which caused them ongoing pain.

Support for carers

There were eight individuals counted who were known to be a primary carer for a relative or spouse. These duties were described as a main driver in their deterioration and some were openly requesting further support in their duties. In some cases the individual knew they were not coping and that their mental health was deteriorating, but were unable to obtain sufficient respite from their role to address on their own wellbeing. In particular, one had asked that his wife be taken into residential care but this was refused and his took his life shortly afterwards. In other cases, the individual was known to mental health services but had disengaged.

Service capacity

A number of deaths had occurred in the space between the 'seven day follow-up' and the 'one month follow-up' after a patient was discharged from inpatient care. In one case this initial follow up occurred the day after discharge and the individual had no contact then for two weeks (by which point they took their own life). Similarly, at the other end of the system, some deaths occurred between the initial referral and the first appointment, often booked for two weeks ahead. One of these was from an individual with a known history of suicide attempts.

Concerning treatment, there was a sense from the families of the deceased in their witness testimonies that Cognitive Behavioural Therapy (CBT) could not cope with demand and was being kept for very prescript cases. One case described an individual's request for CBT to be provided in line with the medication, *"as per NICE guidelines",* though this was declined due to it *"being a limited resource".*

In Accident and Emergency, staff may not have had time to give appropriate attention to those with mental health risks. Two cases in particular referenced patients able to walk out and leave after being admitted for mental health concerns. The individuals were described in case notes as appearing safe and quiet, before they walked out.

Over-medicalisation

There was a recurring theme from the witness testimony from friends and family in the coroner's files concerning their fears of over-medicalisation. This was a perception that GPs and mental health professionals go to pharmacological medication as the first response to a mental health concern, even if it is relatively slight; if this does not address the problem in the short term, the medication may be changed. There were a few examples of individuals reporting that they felt like guinea-pigs whilst their doctors "tried out" different drugs on them, and whilst mental health pharmacology can require adjustments, in these instances the individual lost confidence in their treatment and disengaged through a lack of trust in the profession.

Further issues existed around repeat prescriptions which were not updated and re-assessed frequently enough and lead to some patients disengaging from the medication programme but still collecting their prescription; this was later be used to initiate a fatal overdose. Where this has occurred in GP practices lessons have been learned, but it is not known if these lessons are universally known.

Key points

- Stigma around asking for mental health support still exists and has contributed to some of the deaths discussed here.
- Mental health misdiagnoses have occurred and in a few cases, GPs or professionals have later reported wanting further training or support for mental health assessments and treatments.
- Whilst self-report conversations are important to exploring mental health problems and suicidal ideations, a reliance on this has led to some of these cases being misdiagnosed as not at immediate risk.
- A small number of cases described individuals who disengaged with services because they did not fit with the care plans on offer, be this prescribed treatments or methods of communication.
- Patients are able to disengage from services without establishing alternative support or monitoring. It is assumed that they will go to their GP if they want to receive future mental health referrals.
- There were a number of cases where individuals with poor mental health were not able to engage with professionals due to a lack of trust. This happened when a previously trusted professional moved on or when the providers did not have the capacity to build relationships with vulnerable individuals.
- Loss of independence was the main driver of suicide in the over 75s. This was as a result of deteriorating physical health and a decreased standard of living. This included those with a recent diagnosis of terminal illness or a serious injury resulting in disability.
- A small number of individuals were so concerned about invasive treatments or surgeries that they took their own life instead.
- Some individuals acting as full time carers were unable to address their own emotional deterioration due to caring responsibilities and this contributed to their death.
- A number of deaths could be attributed to services with insufficient resources to maintain supervision with patients at risk, or to provide CBT or support to all those who might benefit from it.
- Many cases described concerns over the medicalisation of conditions and a default use of pharmacological prescription for both minor and serious conditions.

Scope and Overview

The findings in this report have been recorded in a way as to not suggest solutions or recommendations; nor to praise what is working well or to criticise shortcomings in service provision. The West Sussex Health and Wellbeing Board, Suicide Prevention Board and the NHS Transformation Boards will co-develop strategies with partners and stakeholders to tackle suicide in West Sussex, by absorbing these findings into agreed documents alongside national evidence and strategies and local commissioning and development plans and consultations.

Encouragingly, it can be seen from this audit that there are many possibilities for developing existing services and partnerships which could show real benefits to individuals. These include the following points which can be considered:

- Mental health workers can benefit from having more time to build and maintain trusting relationships with those suffering from mental health illness, particularly when paranoia and anxiety are creating barriers to engagement.

- Considerations could be made to prolong support or monitoring for those who are recently out of crisis or have been discharged from inpatient facilities.

- General Practitioners may be happy to receive more training and support around dealing with mental health problems or diagnoses.

- Children and spouses are a significant protective factor for those with mental health problems or poor emotional wellbeing and individuals should be supported when these protective factors are absent, whether through a social order or bereavement.

- Whilst the law presumes innocence for those charged with a crime, there are significant stresses on those being investigated or charged with a serious offense and local police are in a key position to recognise those who may be vulnerable.

- Loss of independence and standard of living is a primary driver of suicides in older individuals, particularly when combined with loneliness or a loss of a spouse or other protective factor. A discussion is needed around whether more can be done to support these individuals emotionally, during a time of reducing adult social care and day centres.

Though much has been discussed in this report, there remain more opportunities from the existing data to focus on particular cohorts, such as ‘Under 35s’ or ‘over 75s’. This data will be held with the Public Health and Social Research Unit on secure drives and can provide focused insight should it be needed to advise on service review, design or commissioning.