Berkshire Suicide Audit 2014/15 – 2017/18

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Executive Summary

The latest audit was conducted to;
- Provide retrospective intelligence, updating the previous audit (2012/13-2013/14)
- Align local intelligence with national evidence
- Update and inform the Berkshire Suicide Prevention Strategy (2017-2020) and local action plans.
- Enable the Berkshire Suicide Prevention Group to prioritise actions in order to achieve the Berkshire Suicide Prevention Strategy ambition of reducing suicide by at least 25% by 2020 in Berkshire (33 over a 2 year period, compared to 2016/17-2017/18)

Auditors reviewed the Berkshire Coroner's inquest files. The inclusion criteria were:
a) All cases of suicide or likely suicide (open/narrative verdicts were screened) in Berkshire with a final inquest date between 1st April 2014 – 31st March 2018
b) Deceased died in Berkshire
c) Incident leading to death occurred in Berkshire

Overview

Berkshire has a similar age-standardised suicide rate per 100,000 population (aged 10+) compared to England and the South East.

241 cases were included in the audit. 87% were suicide verdicts, 7% were open verdicts and 6% were narrative verdicts. 94% of those individuals whose death was included in this audit were Berkshire residents, 5% lived out of area and <5% had no fixed abode.

In the latest audit, there was no significant difference between the age-standardised suicide rates across the six unitary authorities within the county of Berkshire.

79% of the individuals included in the audit were born in the UK and 7% were born in Poland. These figures are comparable to Berkshire's demographic profile and the variation between the overall population and that of those included in the audit is not statistically significant.

Section 1: demographics and characteristics

The gender profile of deaths by suicide in Berkshire is similar to the national profile with more males ending their lives than people of other genders. The latest audit included males, females and transgendered individuals.

From 2014/15 to 2017/18, Berkshire's male suicide rate was 11.6 per 100,000 population, which was significantly higher than the female rate of 3.2 per 100,000 population. In Berkshire, most deaths by suicide occurred amongst men aged 40 to 49. However the difference between rates for this and for other age groups was not statistically significant.

National evidence demonstrates that those living in the lowest socio-economic status i.e. in the most deprived areas, are 10 times more at risk of suicide than those of the highest socio-economic status living in the most affluent area. The latest audit data for Berkshire, however, shows no statistically significant difference between suicide rates in areas of relative deprivation in Berkshire.

The majority of people included in the latest audit were either in full-time work (24%),

unemployed (20%) or retired (18%).

80% of all of those who were employed had a job title recorded and 43% of these worked in a skilled trade.

6% of all people included were recorded as being in education at the time of death.

Section 2: information relating to death

26% of all deaths were pronounced more than 24 hours after suspected time of death and these cases were excluded from the analysis of season and month of death. Over the different audit time periods, there does not appear to be a significant difference in suicide rates between different seasons or months.

'Own home' was where the majority of deaths occurred for suicides across all Berkshire local authorities.

Hanging/strangulation has consistently been the main method used across audit time periods.

Section 3: personal and social factors

67% of all cases considered had relationship issues recorded in the inquest file. Of all those with a relationship issue recorded, 78% were with an intimate partner/spouse or ex-partner/spouse.

19% of all cases had financial issues recorded.

15% of all cases showed the person who died had been recorded as being involved with the Police or a court prior to death.

75% of individuals included in the audit were registered with a GP, and 61% of these had one or more physical health condition.

63% of all individuals had one or more mental health diagnosis, of which, 35% had depression diagnosed, 27% had anxiety/phobia/panic disorder/OCD diagnosed and 25% had personality disorder diagnosed. Individual people may feature more than one in this breakdown where they had more than one diagnosis.

20% of all people whose case was reviewed had work related stress recorded on the inquest notes..

6% of all people included were known to have been bereaved by suicide.

21% of all deaths considered involved people whos had a history of self-harm, which was lower than the 51% rate reported nationally

Section 4: contact with services

10% of all individuals were known to substance misuse services in their lifetime. 20% had a documented history of alcohol misuse and 17% had documented history of drug misuse.

51% of those who died and were registered with a GP saw their GP within 1 month prior to the date of death. This is a little higher than the rate of 45% noted in national audit data.

36% of all deaths occurred to people known to mental health services, compared to a rate of 33% nationally.

31% of individuals had been in contact with mental health services in the 12 months prior to their death, compared to 30% nationally.

Thames Valley Police: Real-time surveillance system

The latest audit gave us an opportunity to review the accuracy of the real-time surveillance system. In 2016 and 2017, 91% of cases were recorded on Thames Valley Police (TVP)'s system and included in the latest audit. The real-time surveillance system is not expected to pick up 100% of cases as not all cases involve the Police e.g. people who die following a hospital admission. Other Police surveillance systems have reported picking up as few as 79% of cases.

Recommendations

In addition to the following All-Party Parliamentary Group recommendations relating to suicide audits, general recommendations are made here in light of the latest Berkshire audit, as well as more specific recommendations which address the findings detailed in the various sections of the audit.

The themes of the audit fall into four categories:

A. Data
B. Communication
C. Governance and Assurance
D. Training

which in turn link to the six priorities of the Berkshire Suicide Prevention Strategy 2017-20:

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health in specific groups
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring

Delivery of the Berkshire Suicide Prevention Strategy is overseen by a Public Health Consultant lead, who chairs a Berkshire-wide group, supported by six locality groups.

Recommendation	**Category and priority area**	**Lead**
1. Update Joint Strategic Needs Assessments in light of the latest suicide audit.	A (vi)	Locality groups
2. Data collection: determine whether it is realistic to collect the following information which is not routinely collected for a coroner's inquest, but which may relate to increased risk of suicide. a. Sexual orientation The latest Berkshire audit was unable to explore this area as this data is not collected as part of the coroner's inquest. It was agreed by the audit team that sexual orientation of the deceased cannot be determined from marital status. It should be noted that even if the coroner's team did collect this data, it would be a member of their family/friend who would state the deceased's sexual orientation, which may be inaccurate. b. Migration It was not possible to collect migration status of the deceased on a consistent basis as this data is not collected as part of the coroner's inquest.	A(i)	Berkshire-wide group

c. Ethnicity It was not possible to collect ethnicity of the deceased on a consistent basis ethnicity as this data is not collected as part of the coroner's inquest. d. Responsibility for dependents It was not possible to collect information on a consistent basis as to whether the deceased had dependent children or caring responsibilities for an adult as this data is not collected as part of the coroner's inquest.		
3. The Berkshire Coroner's team occasionally collects information about the deceased's place of work. General Data Protection Regulations (GDPR) must be complied with, but - either through this source or through records held by other agencies – this information could be used to provide support to others who are affected or bereaved by the suicide. If the Coroner's team requests the name of the deceased's employer and of the employer of any staff involved in discovering the suicide, this could enable Public Health teams to reach more people bereaved/affected by suicide, e,g. by sharing "Help Is at Hand" with Human Resources departments and the chief officers of relevant organisations.	B(iv)	Berkshire-wide team
4. Explore the opportunities around the Internet of Things to prevent suicides via the Smart Cities Cluster Project in Thames Valley, which can include physical environments and use of social media, e.g.. posts which may flag as suicidal ideation.	B(i)	PH Consultant lead
5. Review opportunities to support those bereaved by suicide or affected by suspected suicide, e.g. by ensuring the 'Help is at hand' booklet is available from funeral directors, chapels of rest and community settings such as registry offices, libraries, primary care venues, community centres, places of worship (temples, Gurdwara's, Mosques, churches), bereavement support organisations, and counsellors.	B(iv)	Locality groups
6. Consider ways to target support on people experiencing relationship breakdowns by mapping relevant local services and contact points.	B(i)	Locality groups
7. Identify key partners and appropriate resources to support suicide prevention whilst communicating with individuals in financial difficulty.	B(i)	Berkshire-wide group
8. Noting that most suicides in the audit occurred amongst males aged 40-59, review the effectiveness of suicide prevention/support targeting this group, e.g.	B(i)	Berkshire-wide group

CALMzone.		
9. Liaise with Network Rail and the British Transport Police about their suicide response and audit plans to ensure these are properly supported and addressed within the Berkshire Suicide Prevention Strategy. This will include keeping a watching brief with Crossrail coming in, scheduled December 2019 (Reading).	C(iii)	Berkshire-wide group
10. Liaise with the Environment Agency and the Canals and Rivers Trust about their suicide response and audit plans to ensure these are properly supported and addressed within the Berkshire Suicide Prevention Strategy.	C(iii)	Berkshire-wide group
11. Review access to support for work-related stress (e.g. from occupational health or human resources teams) within key employer organisations, and what support could improve promotion and targeting, e.g. raising awareness of suicide risk for those in demanding jobs, at risk of being fired, faced with gross misconduct allegations or experiencing relationship difficulties at work. Consider how Time to Change resources could support improvements.	C(ii)	Locality groups
12. Use the Health Education England review of suicide and self-harm training to identify training needs within key organisations, and liaise with partners to support meeting those needs. a. Training for JobCentre staff around suicide risk and unemployment, and ensuring support for those out of work includes access to suicide prevention support as appropriate. b. Raising awareness of suicide risk and support available amongst staff in industries where there are higher levels of suicide. c. Raising awareness of suicide risk and support available amongst housing/rent collection and fraud investigation teams in local authorities. d. Raising awareness of the potential impact on staff who encounter suicide in a professional capacity, e.g. police, rail, ambulance, Accident & Emergency, and mental health provider services e. Improving understanding of bereavement by suicide for staff who may be involved in supporting family and friends to make changes after a suicide, e.g. dealing with house clearance or sale.	D(i)	Berkshire-wide group and locality groups

Introduction

Report Context

Previous suicide audits have been completed for Berkshire, the first of which covered 2007-2009. Unfortunately, the raw data from previous audits was not transferred between organisations when the Public Health teams transitioned from the NHS into local authorities. However, the previous audit reports are available.

In 2014 the Berkshire Public Health teams completed an audit covering all suicide, open and narrative verdicts in Berkshire with a final inquest date from 1st April 2012 – 31st March 2014. The information from this audit was used to inform Suicide Prevention work in Berkshire, including the Berkshire Suicide Prevention Strategy (2017-2020).

In 2015 the All-Party Parliamentary Group on Suicide and Self-harm Prevention recommended local authorities conduct suicide audits, recognising the importance of local intelligence in order to successfully implement the national suicide prevention strategy.

The latest audit covers a four year period, reviewing data from final inquests dating from 1st April 2014 to 31st March 2018. Data collection for the audit has been developed to align with national evidence, incorporating more data than ever before, so developing a depth of knowledge which can be built upon in future audits. This report sets out the findings from the most recent audit, and includes comparative data from previous audits, where possible. This intelligence should be used to inform the Berkshire Suicide Prevention Strategy (2017-2020) and local suicide prevention action plans.

It is important to note that there is a lag time between date of death and date of final inquest, which may be from 6 months to 3 years.

Percentages quoted in this report relate to people who died by suicide where an inquest then took place between the specified dates, as the total population. The percentages do not necessarily extrapolate to wider populations. The figures given only relate to the characteristics of and actions taken by those who took their life, and do not necessarily reflect the wider population view or reaction to particular situations or services. Numbers less than 5 have been suppressed to prevent identifying individuals disclosure.

Locally, age-standardised suicide rates per 100,000 population have continued to be lower than the South East and England rates. Table 1 shows this data at a local authority level and gives a comparison to England's rates.

Table 1. Age-standardised rate per 100,000 population (3 year average) by LA

Area	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bracknell Forest	5.2	6.6	9.4	7.8	9.7	6.5	8.1	7.9
Reading	10.9	8.8	7.4	7.7	9.3	9.8	11.0	9.9
Slough	7.7	8.4	8.6	10.8	10.7	10.8	8.8	9.6
West Berkshire	7.3	8.9	8.9	9.2	10.0	8.6	7.0	6.7
RBWM	6.9	5.8	7.1	7.7	7.9	6.8	7.1	9.2
Wokingham	7.9	7.9	6.5	6.0	5.3	5.4	6.0	7.3
South East	9.1	9.3	9.5	9.3	9.9	10.1	10.2	9.8
England	9.3	9.4	9.5	9.5	9.8	10.0	10.1	9.9

Key to Comparator

Similar to England	Significantly lower than England	Significantly higher than England

Source: Public Health England (2018), Suicide Prevention Profile

Methodology

There is currently no agreed methodology for conducting a suicide audit. For comparability purposes with previous Berkshire audits, coroner's inquest files were reviewed. Where available, the review included data from other services such as primary and secondary care. For full details of the methodology applied, see Appendix A.

The auditing team used examples of good practice and sought to maintain consistency with previous audits. The previous audit tool (Excel) used to collect the audit data was used to shape the initial structure of the latest audit tool. The structure of the updated audit tool can be split into 4 sections;

Section 1: Demographics and characteristics
Section 2: Information relating to death
Section 3: Personal and social factors
Section 4: Contact with services

The updated audit tool was independently piloted by each auditor with two real cases to ensure a) it was fit for purpose b) to ensure inter-rater reliability for test-retesting (degree of agreement among auditors). After each auditor independently reviewed the 2 cases and completed data collection, both auditors then compared and discuss data collected to ensure consistent recording. The updated tool is held by the Berkshire Public Health Shared Service.

Criteria

Previous Berkshire audits are likely to have used different inclusion/exclusion criteria, therefore comparisons across different audit periods should be viewed with caution.

It should be noted that coroner's verdicts of the nature used for this audit are given only to people aged 10 and over.

In the latest audit, the inclusion/exclusion criteria were:

Table 2. Inclusion/exclusion criteria for the 2014/15-20/1718 suicide audit

Inclusion	Exclusion
All cases of suicide or likely suicide (open/narrative verdict) in Berkshire filed after a final inquest date from 1st April 2014 – 31st March 2018	Incident leading to death occurred outside the county but person was admitted to hospital within the county prior to death
Deceased died in Berkshire	Cases where it is felt that the open/narrative verdict was not likely to be self-inflicted i.e. accidental death or misadventure
Incident leading to death occurred in Berkshire	

Section 1: Demographics and characteristics

In the latest audit, 241 cases met the audit criteria. Overall, 87% were suicide verdicts, 7% were open verdicts and 6% were narrative verdicts. 97.5% of these cases had a final verdict between 6-12 months after date of death. 2.5% of cases came to a final verdict within 2-3 years after date of death, the absolute numbers being small. In these rare circumstances multiple agencies were often involved - for example British Transport Police, Broadmoor Hospital, Thames Valley Police, Independent Police Complaints Commission, NHS Trusts.

94% of cases concerned Berkshire residents, of which fewer than 5% had no fixed abode or were homeless in Berkshire. and 5% lived outside of Berkshire. Table 3 shows the number of cases included in previous Berkshire suicide audits. The count between 2007 to 2011 is not known due to loss of data during the transfer of teams ring from the NHS to local authorities. It is believed that the audits conducted for 2007-2011 collected and analysed data by calendar year. The 2012/13-2013/14 audit collected and analysed data by financial year. The latest audit also collected and analysed data by financial year. The count and annual rates, as shown in Table 3, are thought to illustrate fluctuations rather than a real difference.

Table 3. Number and rate of deaths per 100,000 population by Suicide Audit year

Year	Number of deaths	Population (aged 10+)	Directly standardised rate per 100,000 population*	
			Rate	Confidence intervals (95%)
2012/13 – 2013/14	120	762,249	7.7	6.6 - 9.4
2014/15 – 2015/16	109	771,167	7.1	5.9 - 8.5
2016/17 – 2017/18	132	771,167	8.6	7.2 - 10.1

*Rates include out of area residents

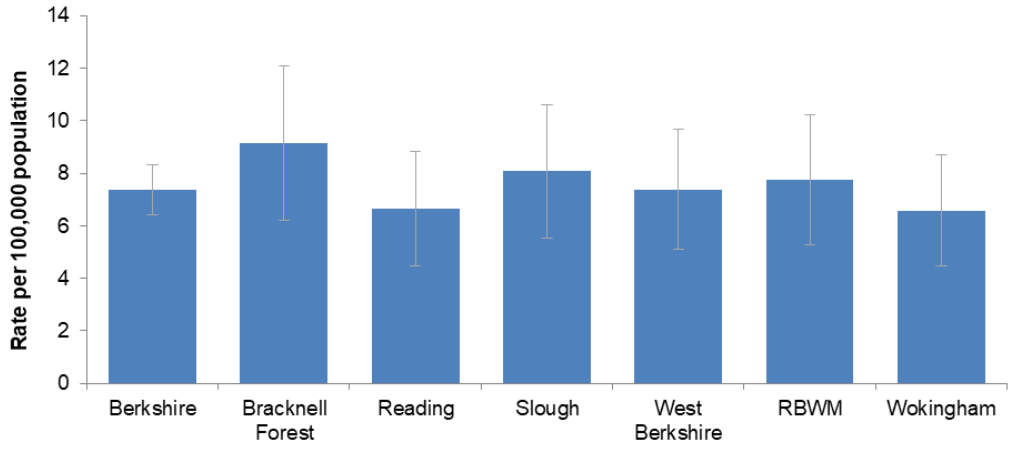
It is worth noting that the Berkshire Suicide Prevention Strategy (2017-2020) set an ambition of reducing suicide by 25% by 2020. In terms of numbers, this would mean a reduction in the number of cases meeting the suicide audit criteria from 132 (2016-18) to 99 (2018-2020). It is also worth noting the increase in population size and accounting for this when assessing success against this ambition.

Table 4 shows the number and rate of deaths captured in the Suicide Audits from 2014/15 to 2017/18. These have been presented by local authority area. While Bracknell Forest has the highest rate at 9.1 per 100,000 population, this is not significantly different to the rate for the other local authorities or the overall Berkshire rate of 7.4 per 1,000 population. Broadmoor Hospital is located within Bracknell Forest and there were fewer than 5 suicides here between 2014/15 to 2017/18.

Table 4. Number and rate of deaths per 100,000 population (2014/15 to 2017/18)

Area	Number of deaths	Population (aged 10+)	Directly standardised rate per 100,000 population	
			Rate	Confidence intervals (95%)
Bracknell Forest	37	103,237	9.1	6.2-12.1
Reading	36	139,383	6.7	4.5-8.8
Slough	39	121,281	8.1	5.5-10.6
West Berkshire	40	136,984	7.3	5.1-9.7
RBWM	38	130,054	7.8	5.3-10.2
Wokingham	37	140,228	6.6	4.5-8.7
Berkshire	227	771,167	7.4	6.4-8.3
Out of Area	14	-		

Figure 1: Directly standardised rate of deaths in Berkshire local authorities (2014/15 to 2017/18)



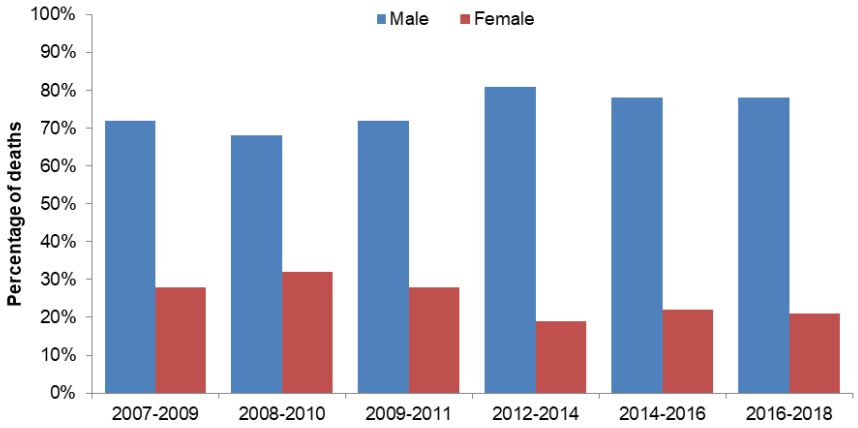
Place of birth

79% of all cases concerned people who were born in the UK and 7% were born in Poland. All other places of birth accounted for under 5 cases. It should also be noted that 29% of those who died in Berkshire were born in Berkshire.

Gender

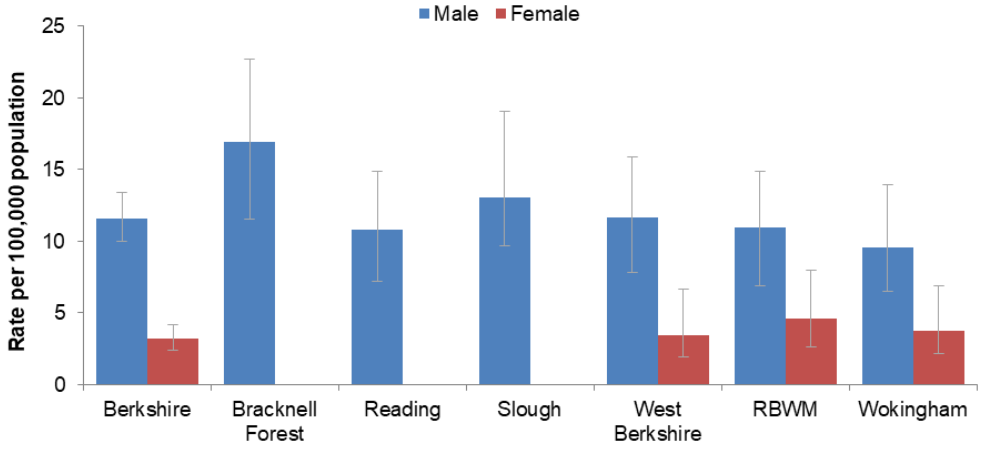
Figure 2 presents information for previous audits and indicates that more males in Berkshire ended their lives than did people identifying as other genders. This is consistent with the national figures, as 75% of suicides in England were completed by men in 2014-2016 (Public Health England 2018). Transgender was recorded for the first time in the latest audit. In this report gender differences are calculated, however, transgender is not included in the gender breakdown as numbers are low and the data could therefore be misleading.

Figure 2. Percentage of deaths by gender and audit time period



From 2014/15 to 2017/18, Berkshire's male suicide rate was 11.6 per 100,000 population, which was significantly higher than the female rate of 3.2 per 100,000 population. Figure 3 provides this detail at a local authority area. Data cannot be shown for females in Bracknell Forest, Reading and Slough, as the number of deaths in this time period was fewer than 10 and can therefore not be standardised.

Figure 3. Directly standardised rate of deaths by gender and place of residence in Berkshire (2014/15-2017/18)



Public Health England (2016) states that pregnant women and those who have given birth within 12 months are at higher risk of suicide. Of the females included in this audit, none were recorded as having a child within 12 months prior to death or were known to be pregnant at time of death. However, pregnancy is not routinely tested in post-mortems. Recent termination of pregnancy was noted in fewer than 5 of the female cases.

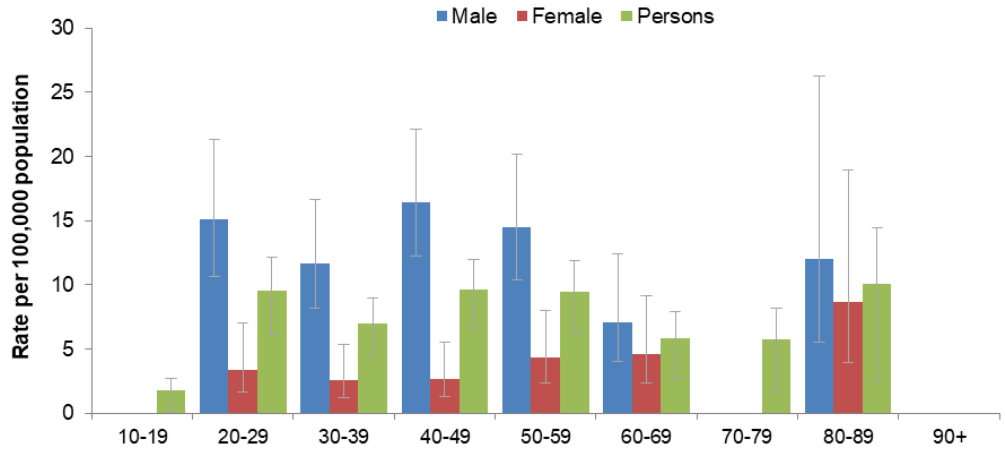
Age

In 2016, the highest suicide rates in England were amongst men aged 40 to 49 at 21.7 per 100,000 population. Local audit data also shows that men aged 40 to 49 had the highest rate of suicides in Berkshire compared to other age groups. It is important to note, however,

that this is not significantly different to the rate for other male age groups between 20 and 69 and 80 to 89.

Figure 4 shows the age-specific suicide rates by gender for Berkshire residents between 2014/15 to 2017/18. All deaths concerned people aged 17 and over. Data has been suppressed for age-groups where there were fewer than 5 deaths.

Figure 4. Age-specific rate of deaths by age and gender for Berkshire residents (2014/15-2017/18)



When data is broken down by local authority, there is no significant difference in age-specific suicide rates compared to the overall Berkshire picture

Children

It is thought that having children is a protective factor against suicide. Data relating to (not) having children was not routinely available, however. In 40% of cases reviewed, it was not clear whether the person who died did or did not have children, therefore the figures are not given.

Marital status

All of the Berkshire Suicide Audits have reported being single as the marital status with the highest proportion of suicides. In the 2014-15 to 2017-18 audits, this status was broken down further to being 'single with no partner evident' and being 'single with a partner'. In these audits, those recorded as being 'single with no partner evident' had the highest proportion of suicides. The proportion of deaths from married people has remained fairly consistent at between 23-30% of the total number. Table 4 provides a breakdown of deaths by marital status for each of the audits.

Table 4. Overview of marital status at time of death across audit years; Percentage

Marital status at time of death	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Co-habiting	<5%	<5%	<5%	10%	<5%	<5%
Divorced	14%	13%	13%	8%	10%	18%
Married	23%	29%	30%	29%	24%	29%
Separated	10%	7%	7%	<5%	<5%	<5%
Single	45%	39%	39%	40%	58%	41%
Single no partner evident	-	-	-	-	48%	33%
Single with partner	-	-	-	-	10%	8%

Widowed	<5%	6%	7%	<5%	<5%	10%
Unknown	<5%	<5%	<5%	6%	-	-

When marital status is broken down by gender, both men and women had 'single with no partner evident' as the status with the highest proportion of suicides. There were no significant differences between genders and the proportion of suicides from different marital statuses.

Housing status at time of death

This data is not routinely collected and as a result there was insufficient data to present any findings. The housing status for the majority of cases was unknown for 2014-2016 and 2016-2018 (56% and 55%, respectively), as shown in Table 5.

Table 5. Overview of housing status at time of death across audit years

Housing status at time of death	**Percentage**					
	2007 - 2009	**2008 - 2010**	**2009 - 2011**	**2012/13 - 2013/14**	**2014/15 – 2015/16**	**2016/17 – 2017/18**
Owner/Occupier	46%	46%	52%	Insufficient data: 35% did not have housing status recorded	Insufficient data: 56% did not have housing status recorded	Insufficient data: 55% did not have housing status recorded
Privately Renting	41%	33%	25%			
Council House/ Housing Association	5%	9%	11%			
Supervised Hostel	<5%	<5%	<5%			
Unsupervised Hostel	<5%	<5%	<5%			
Other	<5%	<5%	<5%			
Unknown	<5%	<5%	<5%			

Living circumstances at time of death

In most cases, living circumstances were determined at time of death. People living alone have consistently had the highest proportion of suicides recorded, followed by those living with a spouse/partner. Other living circumstances include being homeless or being an inpatient.

Table 6. Overview of living circumstances at time of death across audit years

Housing status at time of death	**Percentage**					
	2007 - 2009	**2008 - 2010**	**2009 - 2011**	**2012/13 - 2013/14**	**2014/15 - 2015/16**	**2016/17 - 2017/18**
Alone	41%	43%	49%	34%	26%	30%
With spouse/partner	17%	25%	28%	26%	22%	25%
With parents	15%	14%	11%	11%	18%	17%
Other	10%	7%	<5%	10%	19%	14%
With spouse/partner and children	9%	8%	6%	7%	10%	8%
Unknown	7%	<5%	<5	13%	5%	6%

Deprivation

National evidence suggests suicide is a significant inequality issue, with marked differences in suicide rates according to people's social and economic backgrounds. PHE (2016) suggests people in the lowest socio-economic group and living in the most deprived

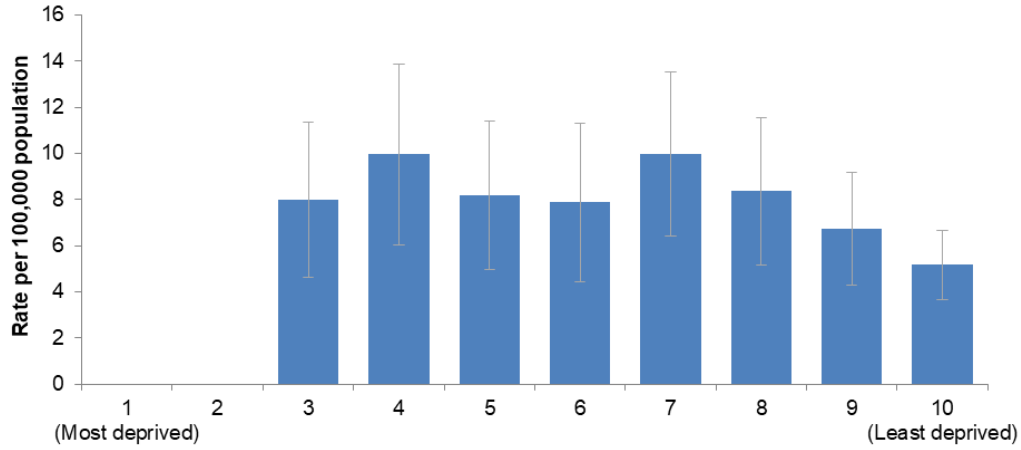
geographic areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

Berkshire is a relatively affluent area with 43% of the population living in the 20% least deprived areas in England. However, there are some areas within Berkshire that are more deprived, particularly within Slough and Reading. In 2016, over 20,000 people aged 10 and over in Berkshire were living in the 20% most deprived areas in England. The latest audit data shows that there was no statistically significant difference in suicide rates between areas of deprivation in Berkshire, as illustrated in Table 7 and Figure 5.

Table 7. Number and rate of deaths per 100,000 population by deprivation decile in Berkshire (2014/15 to 2017/18)

Deprivation decile	Number of deaths	Population (aged 10+)	Directly standardised rate per 100,000 population	
			Rate	Confidence intervals (95%)
1 (Most deprived)	0	2,281	0.0	
2	<5	18,137	Suppressed	
3	22	58,156	10.0	4.7-11.3
4	25	61,440	8.2	6.0-13.9
5	25	82,933	7.9	5.0-11.4
6	20	64,531	10.0	4.4-11.3
7	30	77,266	8.4	6.4-13.5
8	26	76,870	6.7	5.1-11.6
9	29	107,656	5.2	4.3-9.2
10 (Least deprived	46	221,897	8.0	3.7-6.7

Figure 5. Directly standardised rate of deaths by deprivation decile in Berkshire (2014/15-2017/18)



There is also no statistically significant difference between the rate of deaths and deprivation at a local authority level in Berkshire.

Employment status at time of death

Public Health England (2016) states that unemployment is a risk factor for suicide. In Berkshire unemployment is low, although there has been some fluctuation. Data from this audit shows a mixed picture. The majority of cases in the latest audit concerned people either in full-time work, unemployed or retired, as shown in Table 8. This is similar to

previous Berkshire audits, which do not reflect the pattern described by PHE. The “other” category includes self-employment, caring for family and those employed but not working e.g. on sick leave or zero hours contracts. It is important to note that employment status was not known for 20% of cases included in the latest audit and these figures are based on a relatively small numbers.

Evidence from Public Health England (2016) shows that low job security has been linked to a rise in suicide risk, and that certain occupational groups, including doctors, nurses, farmers, veterinary and agricultural workers are at higher risk of suicide. It is difficult to determine whether the Berkshire picture reflects the national picture in this regard as data is not available on what proportion of the Berkshire population is working as doctors, nurses, farmers, veterinary and agricultural workers. Similarly, job security is not known as this is not routinely collected.

Table 8. Overview of employment status at time of death across audit years

Employment status at time of death	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Full-time	46%	51%	55%	36%	23%	25%
Housewife/house husband	<5%	<5%	<5%	<5%	0%	<5%
Long-term illness/ disability benefits	<5%	<5%	<5%	<5%	<5%	<5%
Other	-	-	-	-	7%	5%
Part-time	5%	<5%	<5%	<5%	<5%	<5%
Retired	18%	17%	17%	11%	17%	18%
Student	6%	6%	<5%	<5%	<5%	<5%
Unemployed	13%	11%	14%	38%	27%	15%
Unknown	8%	5%	<5%	12%	20%	205

Occupation at time of death

In the latest audits (2014/15-2017/18), 80% of employed people had a job title recorded at the time of death. These have been categorised by occupation, according to Office of National Statistics coding, and are shown in Table 9.

Table 9. Occupation at time of death (2014/15-2017/18)

Occupation	Number of deaths	Percentage of deaths for employed people
Skilled Trade	58	43%
Professional	31	13%
Managerial	16	7%
Administration	11	5%
Househusband/wife	<5	<5%
Unskilled Trade	<5	<5%
Private income / other affluent	<5	<5%
Job title not recorded	14	10%

When broken down by sector, the following occupational groups appeared to be over-represented in suicides across Berkshire:

- Property and construction
- Food/catering industry
- Public services and administration
- Large private sector employers

Although not routinely available, name of employer was recorded where possible. 20% of cases in the latest audit mentioned the organisation the deceased worked for prior to death.

Benefits

Data relating to benefits was not routinely available for the latest audits. 14 people (6%) were recorded as receiving benefits. Due to low numbers, further data cannot be presented here.

Education at time of death

Although data was not routinely collected, 14 people (6%) were recorded as being in education at time of death in the latest audits. Two educational establishments had more than one death over the 4 year period. Neither of these establishments is in Berkshire.

Carers

Caring status at time of death was not routinely collected. However, 10 people (4%) were recorded as being a carer for a partner or family member prior to death.

Section 2: Information relating to death

Season/month of death

The following table shows the season in which all included deaths were pronounced. It should be noted that in 26% of all cases in 2014/15-2017/18 the pronouncement of death was likely to have been more than 24 hours after the suspected time of death, which may skew the statistics for season. Over time, there appears to be a fairly even spread across all seasons. Winter had a slightly higher proportion for 2016/17-2017/18 compared to previous years, but this is likely to be due to natural fluctuation. There is no statistically significant difference in cases by month.

Table 10. Overview of season of death across audit years

Season	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Winter (Dec-Feb)	24%	23%	27%	28%	28%	34%
Spring (Mar-May)	29%	30%	27%	31%	26%	23%
Summer (Jun-Aug)	25%	21%	21%	21%	27%	22%
Autumn (Sept-Nov)	21%	26%	28%	18%	20%	21%

Place of death; Local authority

When analysing by place of residence and place of death, over 80% of cases ended their life in the local authority where they lived from 2014/15 to 2017/18.

Place of death; Location

The majority of deaths occurred at the person's own home or someone else's home across all audits. The latest audit separated own home and someone else's home into different categories and the majority happened at own home. The other locations where deaths took place appear to have remained fairly stable when looking at previous audits. 'Other' locations included car parks, hotels, woodland, fields and hospital.

Table 11. Overview of location of death across audit years

Location	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Own / someone else's home	62%	64%	66%	71%	-	-
Own home	-	-	-	-	62%	67%
Someone else's home	-	-	-	-	<5%	<5%
Other	28%	18%	17%	13%	18%	17%
Rail	6%	9%	9%	<5%	11%	8%
River or waterway	<5%	9%	8%	6%	6%	<5%
Road	-	-	-	-	<5%	<5%
Unknown	-	-	-	6%	-	-

The latest audit shows no gender difference for locations of death. There were no female river deaths, however given small numbers this is not a true gender difference. The audit also does not show any significant difference for locations of death by local authority. There are a number of postcodes where more than one person ended their life in this time period

and these will be shared with the Public Health Consultant lead.

Method used

Based on previous audit data and national data, hanging/strangulation is the most commonly used method (Public Health England 2016). There appears to be an increase in self-poisoning nationally, however this may be due to a change in categorisation of methods, this is not the case locally. Self-poisoning in the latest audit includes alcohol poisoning, carbon monoxide poisoning, helium poisoning and overdose. Methods categorised as 'other' include suffocation without gas/strangulation and firearms. A breakdown by method for each audit period is shown in Table 12.

Table 12. Overview of method used across audit years

Method used	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Cutting/stabbing	-	-	-	-	<5%	8%
Drowning	<5%	7%	7%	6%	5%	<5%
Hanging/ Strangulation	54%	47%	48%	49%	54%	47%
Jumping/ laying before a train	6%	9%	9%	<5%	10%	8%
Jumping from a height	11%	11%	8%	<5%	<5%	<5%
Other	7%	12%	14%	38%	6%	12%
Self-Poisoning	18%	14%	14%	<5%	18%	20%
Unknown	-	-	-	<5%	-	-

Table 13 provides further analysis of method by gender and indicates that a higher proportion of men used the method of hanging/strangulation than did women (55% and 35% respectively). By contrast, a higher proportion of women used self-poisioning methods than did men (35% compared to 15%). compared to 18 (35%) of women. It is important to note the small numbers here. However, these figures do reflect the national pattern (Public Health England 2016). Previous audits did not break method down by gender, so it cannot be determined whether these have changed over time.

Table 13. Method used by gender (2014/15-2017/18)

Method used	Male		Female	
	Number of deaths	Percentage of deaths	Number of deaths	Percentage of deaths
Cutting/stabbing	12	6%	<5	Suppressed
Drowning	6	3%	<5	Suppressed
Hanging/strangulation	103	55%	18	35%
Jumping/laying before a train	15	8%	6	12%
Jumping from a height	7	4%	<5	Suppressed
Self-poisoning	28	15%	18	35%
Other	17	9%	5	10%

Self-poisoning

20% of deaths in the latest audit (2014/15 to 2017/18) used self-poisoning as the method to end their life. The majority of those who self-poisoned used prescribed drugs, followed by non-prescribed drugs and a combination of prescribed and non-prescribed drugs. The most common prescribed drugs used were analgesics and antidepressants.

Evidence suggests restriction to lethal means has strengthened suicide prevention, especially with regard to the control of analgesics. 9% of all cases had analgesics in their system in the latest audit.This data was not previously collected hence comparisons cannot be made and it is unknown whether use of analgesics has reduced locally.

Toxicology: Alcohol and drugs

The previous audit (2012/13 – 2013/14) identified whether alcohol and/or prescribed drugs were in the person's system at time of death. The latest audit (2014/15 – 2017/18) also identified whether non-prescribed drugs were in the person's system at time of death.

Tables 14 to 16 show that in between 10-12% of cases there was no record of the level of alcohol or drugs detected at the time of death. In both audit periods, 54% of cases did not have any alcohol detected and 43-47% did not have any prescribed drugs detected. In the most recent audit, 73% of cases did not have non-prescribed drugs detected.

Table 14. Level of alcohol detected

Alcohol level	2012/13-2013/14	2014/15-2017/18	
	Percentage of deaths	Number of deaths	Percentage of deaths
At fatal level	0%	7	29%
At intoxicating level	23%	40	17%
At non-intoxicating level	13%	39	16%
No alcohol detected	54%	129	54%
Not known	10%	26	11%

Table 15. Level of prescribed drugs detected

Prescribed drugs level	2012/13-2013/14	2014/15-2017/18	
	Percentage of deaths	Number of deaths	Percentage of deaths
At fatal level	14%	30	12%
At intoxicating level	8%	<5	Suppressed
At therapeutic level	20%	67	28%
None detected	43%	113	47%
Not known	16%	c.30	12%

Table 16. Level of non-prescribed drugs detected

Non-prescribed drugs level	2012/13-2013/14	2014/15-2017/18	
		Number of deaths	Percentage of deaths
At fatal level	Not available	16	7%
At intoxicating level		20	8%
None detected		176	73%
Not known		29	12%

In the latest audit, around 40% of cases had prescribed drugs detected in their system at the time of death, The following drugs were implicated from highest to lowest - antidepressants, benzodiazepines, codeine/tramadol, opiates, antipsychotics, anticonvulsants, pregabalin/gabapentin, antihistamines, sleeping pills. Of those with prescribed drugs in their system, the majority had antidepressants in their system at time of death.

In 15% of all cases, non-prescribed drugs were detected in the person's system at time of death. The following drugs were implicated from highest to lowest - crack/cocaine, paracetamol, opiates, amphetamines, cannabis, codeine/tramadol, antihistamine, ecstasy,

antidepressants, barbiturate, ketamine.

Notes

Table 17 shows the percentage of cases in which the person who died left a note prior to death and indicates that in the majority of cases people did not leave a note. The latest audit also found no gender difference between those that leave notes.

Table 17. Note left at time of death across audit years; Percentage

Note left	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Yes	29%	32%	40%	36%	39%	41%
No	71%	68%	60%	54%	61%	59%
Unknown	0	0	0	10%	0	0

Section 3: Personal and social factors

Personal and social factors are thought to be associated with suicide risk, including relationship issues, bereavement by suicide and depression (Public Health England 2016).

Relationship issues

Although this is a subjective measure, the data gives an indication of relationships issues the deceased had prior to death. In approximately half of all cases, the person who died by suicide had experienced relationship issues according to the data collected in the latest audit, as shown in Table 18. This shows an increase in relationship issues prior to death over the audit time periods. However, this may be because inquest files now collect more data around relationship issues rather than an actual increase. In the latest audit, 73% of all males and 60% of all females had relationship issues.

Table 18. Relationship issue(s) prior to death across audit years

Relationship issue(s)	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 -2013/14	2014/15-2015/16	2016/17-2017/18
Total	14%	6%	<5%	29%	40%	48%

Of the 116 cases with relationship issues recorded in the latest audit period, over three-quarters had relationship issues with an intimate partner/spouse or ex-partner/spouse. Issues such as discussing separation, recent relationship break-up, going through divorce/separation, access to children and affairs were recorded as relationship issues. 17% of those who experienced relationship issues had problems with parent(s) and fewer than 5 people had issues with their children or authority figures recorded, as shown in table 19.

Table 19. Type of relationship issue(s) prior to death (2014/15-2017/18)

Relationship issue(s) by category	Number of deaths	Percentage of deaths
Child(ren)	<5	Suppressed
Intimate; (ex)partner/spouse	90	78%
Parent(s)	20	17%
Authority figure	<5	Suppressed

Financial issues

Financial issues are also a subjective measure. However, the data is useful in building knowledge around a person's circumstances around time of death. Table 20 shows that the number of people recorded as experiencing financial issues – which appears to fluctuate over the audit time-periods. This may be due to changes in recording at inquests.

Table 20. Financial issue(s) prior to death across audit years

Financial issues	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 -2013/14	2014/15-2015/16	2016/17-2017/18
Total	9%	6%	<5%	24%	27%	13%

In the 2014/15-2017/18 audit, the majority of people with financial issues prior to death had 'other debts', such as student loan, loans and credit cards. Other reasons for financial issues included utility bills/rent, work related issues (business accounts, sick pay stopped), drug debt, gambling, bankruptcy and being the victim of a scam.

Police or court action

15% of people were involved with police/court prior to death over the latest audit period (2014/15 -2017/18). Over 90% of these were male and reasons for involvement with police/court included multiple offences/cautions, thefts, restraining orders, domestic violence, county/high court letters, sexual offences/grooming, being under surveillance and pursuing a court case. The proportion of cases in which people were recorded as being involved with police or count prior to death was higher than in previous audit periods, which recorded this factor in fewer than 5% of cases. However, the absolute numbers are small.

Abuse, violence and neglect

The latest audit included new data on history of abuse or violence prior to death, as there is evidence to suggest this is a risk factor. Of all cases in the latest audit, in 14% the person who died was recorded as being a victim, and/or perpetrator of abuse or violence. 17% of all females and 13% of all males had a history of abuse/violence prior to death. In fewer than 5% of cases, there was a history of neglect recorded over the 4 year period.

It should be noted that data relating to abuse, violence and neglect is not routinely collected and therefore this may underestimate the actual number of cases in which this was a factor.

Physical health

Figures from the latest audit showed that 75% of all the individuals concerned were registered with a GP. Based on GP records for these cases, 61% had one or more physical health conditions recorded with a higher proportion of females than males having a physical health condition recorded.

The most common recorded conditions were musculoskeletal, cardiovascular and neurological. The most common disease clusters were chronic pain (excluding back pain), chronic airways disease, hypertension and chronic neurological disorder.

Mental health

In 63% of all cases in the latest audit, the person had one or more mental health diagnoses recorded. Of those with a mental health diagnosis, 39% had 1 diagnosis, 49% had 2 diagnoses and 11% had 3 or more diagnoses. Table 21 shows the types of mental health conditions recorded. Individuals will have been double-counted in this table where they had more than one diagnosis.

Table 21. Percentage of cases with mental health diagnoses by cluster (2014/15-2017/18)

Mental health cluster	Percentage of deaths
Depression (all)	35%
Anxiety / phobia / panic disorder / OCD (all)	27%
Personality disorder (all)	25%
Adjustment disorder / reaction (all)	24%
Bipolar affective disorder (all)	20%
Schizophrenia / other delusional disorders (all)	8%
Eating disorder (all)	<5%
Head injury (all)	<5%

Data was collected about the number of cases where the individual had diagnosed depression and was prescribed anti-depressants. However, the numbers are too small to publish. For more information relating to antidepressants see Mind.

Learning and physical disability

Data relating to whether the deceased had learning disabilities or physical disabilites was not routinely collected. Based on the information gathered in the latest audit, in fewer than 5% of all cases a learning and/or physical disability was recorded.

Work related stress

Work related stress was recorded as affecting the person who died in around 20% of cases in the latest audit. These issues included job demands (performance, probation, increased responsibility), being fired / disciplined/ suspended / gross misconduct, relationships at work/bullying, being signed-off, post-traumatic stress disorder and redundancy. It is also worth noting that in some cases there was a recording of being stressed with finding work after university. These local findings may mirror Public Health England's (2016) evidence that there is an association between suicide and factors such as working conditions, low job control and high job demands.

Public Health England (2016) states that work related stressors and suicide appear to be particularly pronounced in manual labour jobs. It is difficult to determine whether or not local data supports the evidence as data is not available on the proportion of people working in manual labour jobs.

Bereavement by suicide

Public Health England (2016) evidence also suggests that those bereaved by suicide have an increased risk of suicide. In the latest Berkshire audit, 6% of all cases included a record that the person who died was known to have been bereaved by suicide. The majority of these had been bereaved more than 12 months prior to death. Data was not sufficient to determine whether those who died by suicide found the previous individual who died by suicide. It is logical to believe those who find the deceased or someone who has attempted to end their life will be psychologically affected. However, the risk of suicide to the person who finds the body is not known.

History of self-harm

Not all episodes of self-harm will be documented, as this is dependent on whether the individual sought help from an agency such as their GP, psychiatrist, mental health team, Accident & Emergency (A&E) department, or the South Central Ambulance Service (SCAS), and also the individual's disclosure of self-harm.

Public Health England (2016) states that the strongest identified predictor of suicide is previous episodes of self-harm, and evidence suggests that around 50% of people who die by suicide have a history of self-harm. In many cases an episode of self-harm occurs shortly before death.In the latest Berkshire audit, there was a recorded history of self-harm in 21%, of all cases, which is lower than the national rate evidence suggests. Of those that had a recorded history of self-harm, 85% self-harmed within 12 months prior to date of death.

It should be noted that the proportion of the population aged 10 and over who self-harm is unknown.

History of attempted suicide

Again, it is reasonable to believe that not all attempts will be documented, as not all of those who have attempted suicide may disclose this. Data from the latest audit showed that 32% of those that who ended their life had a previous suicide attempt recorded in their lifetime.

Section 4: Contact with services

Contact with substance misuse services

10% of individuals whose cases were included in the latest audit were recorded as having involvement with substance misuse services. Fewer than 10 people were current service users.

History of alcohol and drug misuse

20% of people included in the latest audit had a history of alcohol misuse recorded and 17% had a history of drug misuse indicated. Fewer than 5% had documented abstinence of alcohol or drugs prior to death.

History of probation, prison, youth offending institute and remand

Evidence from Public Health England (2016) suggests that suicide risk is at its highest at transition points in the criminal justice system, such as moving into, within or out of the system. Risk among recently released prisoners is at its highest within the first 28 days after release.

In 7% of cases in the latest audit, there was an indicated history with the criminal justice system. Fewer than 5% of all cases had a history of probation within 12 months prior to death. Of those with a history of prison, youth offending institute or remand, it was not known how long people had been released for and therefore comparisons cannot be made to national figures.

Contact with GP

Information about GP registration was not available for 20% of cases in the latest audit. 75% of individuals included had a known GP registration and fewer than 5% were known to not be registered with a GP. According to Public Health England (2016), the majority of people who die by suicide are in contact with their GP within 12 months prior to death, with 45% seeing their GP in the month before their death. In the latest audit, 83% of people who were registered with a GP had visited their GP Practice within 12 months prior to death, with 51% visiting within 1 month prior to death. This detail is shown in Table 22.

Table 22. Contact with GP prior to death (2014/15-2017/18)

Contact with GP	Number of deaths	Percentage of all deaths	Percentage of cases known to be registered to a GP
Contact with GP unknown	52	22%	-
Not registered with GP	9	4%	-
Last week	36	15%	20%
Last month	56	23%	31%
Last 3 months	29	12%	16%
Last 12 months	29	12%	16%
Over 1 year ago	30	12%	17%

The latest audit indicated that 63% of women had contact their GP in the month prior to their death, compared to 31% of men. Additional detail cannot be provided at a gender-level due to the relatively small numbers in the audit and the number of cases without a GP contact recorded.

Of those that went to their GP Practice in the 12 months prior to death, the main reason recorded for attendance was physical health (51%), followed by mental health (42%) and physical and mental health (7%). There was no gender difference in reason for visiting GP.

Public Health England (2016) states that suicide risk rises with the number of GP consultations. The latest audit shows that around 50% of people registered with a GP saw their GP either once or not at all in the 12 months prior to death, while 20% went 5 or more times in the 12 months prior to death. The local audit does not appear to reflect the national evidence. However, this data is limited to the GP practice documentation provided for the inquest.

Contact with mental health services

Public Health England (2016) state that 1 in 3 people who die by suicide are known to mental health services. In the latest Berkshire audit, 36% of all individuals were known to mental health services. Of those with a diagnosis, 45% were in ongoing secondary care and 26% had a history of input from secondary care. 35% were under care of their GP only. Nationally, 30% of all suicides are completed by people who had contact with mental health services in the past 12 months (Public Health England 2016). In the latest Berkshire audit, 31% of all individuals had contact with mental health services within 12 months prior to death, which was similar to the national figure.

The latest audit recorded data about the step down care people received from mental health services. The majority of the 87 people known to mental health services had received a step down in their care over 1 year prior to death.

Contact with A&E or Hospital

70% of the cases included in the latest audit had a known status recorded for their previous contact with A&E and hospital in the year prior to their death. 61 (29%) of these individuals had attended A&E or been admitted to hospital in that timeframe, including 19 peope who died in A&E or hospital as a result of their suicide attempt.
Reasons were recorded for the latest attendance or admission, excluding those who died in A&E or hospital. These included mental health, overdose, ongoing treatment after surgery, self-harm and pain related reasons.

Contact with other services

The latest audit found that 6% of people had a record of contact with Social Services. Fewer than 5% had a known contact with a voluntary sector service, accommodation service, faith or community service, or had been in touch with occupational health in the 12 months prior to death. No cases were recorded as being involved with employment services within 12 months prior to death.

It is important to note that the involvement with other services is not routinely collected information as part of a coroner's inquest, so this will not be completely accurate picture of contact with other services.

Real-time surveillance

Real-time surveillance is a system that enables suicide prevention leads to consider and agree if intervention is required after a death occurs where the circumstances suggest suicide in advance of the coroner's verdict. This system provides an opportunity for timely support to people who have been bereaved or affected by a suspected suicide. Real-time surveillance can be done by the Police or Coroners.

Thames Valley Police (TVP) have been collecting real-time surveillance data around suspected suicides since 2016 across Berkshire, Buckinghamshire, Oxfordshire and Milton Keynes. The latest audit provided an opportunity to review the surveillance system.

It should be noted that it is not expected that 100% of cases included in a suicide audit would be collected within a real-time surveillance system operated by the police. This is because not all suspected suicides are attended by Police e.g. people who go to hospital before death, or deaths on railway (investigated by British Transport Police). Another suicide surveillance system implemented by a Police force in the UK has reported picking up 79% of cases.

In the first year of real-time surveillance, TVP noted 52% of all 2016 deaths that met the audit criteria. The figure increased for 2017 to 91% of deaths which met the audit criteria. This increase is promising for the benefits of operating a real-time surveillance system in Berkshire, reflecting TVP's and Berkshire Coroner's contribution to real-time surveillance data accuracy.

Table 22. Crude measure of accuracy of TVP's real-time surveillance system

Year	Total collected by TVP & included in audit	% of cases included in audit and collected by TVP
2016	37	52
2017	63	91

References

Public Health England (2018); Suicide Prevention Profile
https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Public Health England (2016); Local Suicide Prevention Planning: A Practical Resource
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

Appendix A: Methodology

There is currently no agreed methodology for conducting a suicide audit. For comparability purposes coroner's inquest files were reviewed, as had been done for previous audits.Where available this included data from other services such as primary and secondary care.

Data source and access

Inquest files were accessed at the Berkshire coroner's office in Reading. Dates were scheduled in advance to access the inquest files. All inquest files were paper-based - these will be digitalised from 2018. Files were manually selected by the coroner's team from their archives beforehand. Inquest files typically included the 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 any suicide note; photos of the scene (usually in a separate envelope); 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.

To ensure all relevant case files were reviewed as part of the audit, the audit lead liaised with the Child Death Overview Panel lead.

Audit team

It was agreed that the audit should be conducted by a team. The audit team comprised the lead auditor and one other auditor at any time during the data collection process. In total there was one lead auditor and three additional auditors who collected the data.

Criteria

Previous Berkshire audits are likely to have used different inclusion/exclusion criteria, therefore when comparing audit data over different item periods should be viewed with caution. It should be noted that coroner's verdicts of the nature selected for inclusion in this audit are given to people aged 10 and over only.

In the latest audit the inclusion/exclusion criteria were:

Inclusion/exclusion criteria for the 2014/15-2017/18 suicide audit

Inclusion	Exclusion
All cases of suicide or likely suicide (open/narrative verdict) in Berkshire filed after a final inquest date from 1st April 2014 – 31st March 2018	Incident leading to death occurred outside the county but person was admitted to hospital within the county prior to death
Deceased died in Berkshire	Cases where it is felt that the open/narrative verdict was not likely to be self-inflicted i.e. accidental death or misadventure
Incident leading to death occurred in	

Berkshire	

All open and narrative verdicts were screened against the audit criteria as to ensure all likely self-inflicted deaths were included in the audit.

Audit tool

The previous audit tool (Excel) used to collect data was used to shape the initial structure of the latest audit tool. The audit lead then used examples of good practice to enhance the audit tool. Where possible, drop-down cells were used to restrict data entry, free-text options were also used where relevant. 128 cells of data were recorded over 4 sections per inquest file. Each cell was filled even if "N/A" to ensure data collection was complete.

Structure of the updated audit tool;
Section 1: Demographics and characteristics
Section 2: Information relating to death
Section 3: Personal and social factors
Section 4: Contact with services

The updated audit tool was independently piloted by each auditor with two real cases to ensure a) it was fit for purpose b) to ensure inter-rater reliability for test-retesting (degree of agreement among auditors). After each auditor independently reviewed the 2 cases and completed data collection both auditors compared and discuss the data collected to ensure consistent recording. Thereafter, each auditor reviewed inquest files individually, logging data as they went. Each auditor's audit tool was password protected. Discussion was encouraged and complicated cases were considered by both auditors. All inquest files remained on the secure premises at Berkshire Coroner's at all times. The updated tool is held by the Berkshire Public Health Shared Service.

Practicalities

- Each inquest file took between 30 minutes and 1 hour to review. A time should be set for each auditor to complete in this time so as to ensure the individual does not get involved with the narrative of the file.
- Coroner's office allowed use of the Coroner's court to review inquest files on days the court was not in use.

In each session we:
- Checked in before starting / checked out at the end of the day
- Looked out for one another i.e. non-verbal cues while auditing
- Discussed anything that bothered the auditor
- Took breaks at any time
- Knew we could stop auditing if we did not want to continue
- Knew if there was anything that bothered us about a case we would let the other auditor review the file e.g. knew the deceased / family, died in the area where the auditor lives, born same year as auditor etc.
- Were reminded that supervision is available through the auditor's employer via the counselling service. This should be made available before, during and after conducting the audit. You cannot underestimate how this might affect someone in their working and personal life.