Cambridgeshire & Peterborough

Suicide & Undetermined Injury Audit

2015

Cambridgeshire Public Health Team

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Suicide Audit 2015

Summary

1. Introduction

In 2014 there were 6,122 suicides registered in the UK[1] and it is one of the leading causes of death in young people. The impact of a suicide is devastating for those close to the individual as well the wider community and the effects can be long lasting.

Suicide rates in the UK and Republic of Ireland: 2014[1]

This audit report aims to draw together local data to give a comprehensive overview of suicides in Cambridgeshire and Peterborough in 2015. Based on recommendations from the 2014 suicide audit, this report also incorporates information gathered as part of a review of Coroner case files. This information will help guide local actions and interventions and support with the aim of preventing future suicides.

2. Background

2.1 National Context

The national suicide prevention strategy published in 2012 guided the development of the local strategy[2]. In the last year there has been further guidance from Public Health England and a confidential enquiry into suicides in young people that should be utilised to guide local practice. A summary of each of the key national documents published in 2015/16 is provided in Appendix 2, they include:

- Identifying and responding to suicide clusters and contagion: A practice resource (Public Health England, 2015)
- Preventing suicides in public places: A practice resource (Public Health England, 2015)

[1] Samaritans (2016) Suicide Statistics Report 2016.
[2] HM Government/Department of Health. (2012) Preventing suicide in England: A cross-government outcomes strategy to save lives.

- Suicide by Children and Young People in England (NCISH, 2016)[3]
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report.

2.2 National Data

A summary of the national data is presented in Appendix 2 which includes a range of data for suicide risk factors too. In general, suicide rates are higher in men than women in England (14.1 per 100,000 in males and 4.0 per 100,000 in females, 2012-14). Since 2004 there has been an increase in the England rate for males, but the rate in females has decreased. The 33-64 year old age group has the highest rate of suicides in England (13.5 per 100,000) and the method used is most commonly suffocation/strangulation (56% males, 40% females) or poison (20% males, 38% females).

2.3 Local Context

Locally suicide prevention work is coordinated by the Cambridgeshire & Peterborough Suicide Prevention Strategy Implementation Group. The group oversees the implementation of the local suicide prevention strategy (2014-2017) and corresponding action plan.

2.3.1 Coroner Case Files

The routinely collected data that the Coroner's Office compiles holds a variety of valuable information about the number of suicides and basic demographics. It was recommended in last year's audit that in addition a review of the case files for each suicide should be undertaken. This exercise, although time consuming, allows for more detailed data to be collected, which would not be possible to collate as part of routine data reporting. Furthermore it allows for the information collected routinely to be checked for accuracy.

If a suicide is suspected there is a requirement in England to have an inquest (a public hearing). The Coroner's Office gathers a range of information, which goes into the case file, prior to the inquest including statements from a range of sources that might include:

- General Practitioner including information about most recent appointments and medications.
- Personal statements from e.g. a family member.
- Statements from the police or paramedic who may have attended the suicide.
- If the individual was a patient of a mental health trust there will be a serious incident report included within the file.
- Reference to whether the individual was known to drug and alcohol services.

The Coroner will review the information and at the end of the inquest will come to a verdict which may be 'suicide', 'open' verdict or 'narrative' verdict. To conclude that a death was a

[3]Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2016. (NCISH). Manchester: University of Manchester, 2016.

suicide the Coroner must be confident that the deceased intended to end their life 'beyond reasonable doubt'[4]. An open verdict may be reached if there is insufficient evidence, or alternatively a narrative (more descriptive) conclusion[4]. Open verdicts are included with suicide verdicts in the national data and therefore the decision was made to include these cases locally also.

3. Methods

3.1 Review of Coroner Case Files

To determine the additional data that should be included as a result of reviewing the case files, templates previously used by other local authorities and the local mental health trust were reviewed. These were then cross-referenced with nationally available information on risk factors for suicide to create a list. The full list of categories of data collected is included in Appendix 1.

A template was then created to gather the data, and members of the public health team reviewed each of the case files to compile the data. During the review process, further measures that were deemed to add value were added to the list of categories. In addition, on reading each of files, the reviewer subjectively recorded the key themes that were apparent. These themes were later grouped under common headings as part of the analysis. The Cambridgeshire Public Health Intelligence Team conducted the analysis of the quantitative data and the findings are presented below.

4. Cambridgeshire & Peterborough Data 2015

Of the 70 records identified for auditing in 2015, 52 were able to be fully audited, 18 were not (as files were not available because the inquest hadn't taken place or they were still required post-inquest or the verdict had concluded death by 'misadventure' or 'accidental'). Where basic data was available for all 66 audited and non-audited files these have been included in the following analysis. It must be considered that within the 66 some cases may not have yet had an inquest, therefore this figure may change slightly. Furthermore, there may be other inquests that conclude a suicide verdict that were not included within the pre-inquest data. The number of suicides recorded for 2015 at time of writing (66) is similar to 2014 where 65 suicides were recorded.

It is important to note that the numbers reported are small and are therefore prone to variation. This analysis is a picture of suicides and unexplained deaths in 2015, with the aim of gaining insight into any clusters or themes that can help inform local suicide prevention work. To date, the data have not been compared to the general population in order to determine whether deaths are higher or lower than would be expected given the underlying population of Cambridgeshire and Peterborough. Due to the small numbers any differences

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[4]Health Talk. Bereavement due to Suicide. http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/inquest (accessed 07.07.16).

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found would be highly unlikely to be statistically significant. Where available, data from last year's audit has been included as a comparison. There was not a large scale in depth review of the Coroner case files last year, so data is not available for all variables.

The term suicide throughout this analysis refers to both suicides and unexplained deaths.

4.1 Summary of Findings

Because this data includes sensitive information and small numbers which could potentially identify individuals, a high level summary of the key findings is given below.

- The majority of suicides or unexplained deaths were by males (68%).
- In males the highest number of deaths was in under 25 year olds and 50-59 year olds.
- In females the age pattern was more mixed, with highest numbers in 30-39 year olds and 70-74 year olds.
- There were noticeably high number of 34 year olds and 28 year olds that died by suicide.
- 80% of deaths were British nationals, although it is difficult to get accurate information about nationality or ethnicity.
- The highest rate locally was in Peterborough, but Fenland and South Cambridgeshire also have high rates compared to the Cambridgeshire and Peterborough average. None of the areas were statistically significantly above that of Cambridgeshire and Peterborough as a whole though.
- There was a noticeably high number of deaths in under 30 year olds in Peterborough, which wasn't seen in 2014, and Eastern European populations were overrepresented.
- There was a higher proportion of male deaths in Fenland and Huntingdonshire and higher proportion of female deaths in Cambridge City and East Cambridgeshire.
- The cause of death in the majority of deaths was due to hanging. There was a difference in sexes for the second highest reason, with multiple injuries highest in males and poisoning highest in females. These two reasons were relatively low in the opposite sex.
- There was a peak in deaths in August 2015 (10 deaths).
- 44% of deaths occurred at home, with a further 32% being in a local town or city.
- 40% of people lived alone, over a quarter (27%) lived with a partner and a fifth lived with family. There is a difference between the sexes with no deaths in females living with their families compared to 31% of male deaths. The number of male deaths are fairly evenly distributed between those that lived alone, with their partner or their family, whereas by far the majority of female deaths were in those that lived alone.
- Living circumstances does appear to vary with age, with the majority of deaths in people in their twenties living with their families, to those in their 30's living alone to those living with partners and alone in older age bands.
- The proportions of deaths by relationship status were fairly similar for those who were married (33%) and those who were single (31%), however there were notable differences between men and women – 44% of women were divorced compared to 6% of men and 39% of men were single compared to 13% of women. There were also notable proportions of married people in both sexes (36% men and 25% women).

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- All females and 83% of males were registered with a GP practice. A couple of practices had a notably higher numbers of deaths, but there is no suggestion that the practices were at fault in any way.
- The majority of deaths were by employed people (39%), with a further 23% retired people and 21% who were unemployed at the time of death.
- Around 42% of deaths were found to have had previous or current involvement with mental health services. This cannot be compared to other estimates nationally as the definitions can vary. A third of people had previously planned or attempted suicide, including overdoses. Around 30% had been in contact with mental health services within the 6 months prior to death. Where a mental illness diagnosis was recorded in the audit records, almost three-quarters mentioned depression, as well as 29% with recorded anxiety. Just over half of people (27 out of 52) were on prescribed medication for mental illness at the time of death or around the time of death.
- Two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death.
- 11 records explicitly mentioned history of self-harm in the case files, 7 records mentioned bullying and 6 mentioned previous sexual or physical abuse.
- 19 people were found to have physical health problems, including 12 with long term conditions. Diabetes was mentioned in 6 audit files. Alcoholism was also noted in several cases.
- Alcohol misuse was noted in 9 records and 7 mentioned drugs, such as cannabis, cocaine, amphetamine and crystal meth.
- Bereavement was noted in 10 records.

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5. Themes

To add context and depth to the analysis of numerical data, a further subjective analysis of the data was undertaken. Each reviewer of the case files came to a decision about the key themes that were prominent within each case as they read through the notes. There are of course caveats with such an approach as each person's interpretation may be different, however, a strong indication can be gleaned from the Coroner's summary and the frequency in which an issue is mentioned in the statements provided.

67% of cases had at least 1 theme identified; in some cases the information in the file was too limited to identify themes. Of those that did have a consistent theme, 43% had two themes identified, with up to 5 themes in some cases (6%).

The below table shows the themes which were found in 5 or more of the cases; individuals may have displayed more than one theme. The figures may differ to indicators that were collected as part of the quantitative audit because the themes represent factors that were deemed to be significant in the particular case, rather than whether the indicator was present or not.

Table 1Themes identified in individual cases as part of the review of Coroner case files.

Theme	Number of cases the theme was identified in
Lack of social support	8
Relationship breakdown	6
Money worries/debt	6
Loneliness	5
Bereavement	5
Employment stress	5
Substance misuse	5
Physical health	5

Although not collated as a theme or an indicator, 'sleep' or 'tiredness' was mentioned in 5 cases. This may be an underestimate as this was only collected in the notes section when auditing as it was only from reviewing a few files that it became apparent that this was mentioned recurrently. Data was also collected on the use of taxis for a similar reason. This refers to cases whereby a taxi has been used to transport the individual prior to death.

6. Railway Suicides

The British Transport Police (BTP) are the national police force for the railways. They gather a range of data on suspected suicides, injurious attempts and life-saving interventions. If there are three suicides or injurious attempts recorded at a specific location/geographic area within a 12 month rolling period the issue will be escalated to the Director of Public Health. This protocol begun in September 2015 and there have currently not been any escalations to the Cambridgeshire & Peterborough Director of Public Health.

Between 2015/16 there were 275 suspected suicides on the railways in England and 1,156 life-saving interventions undertaken (may be Home Office Force, British Transport Police or a Member of the Public for example). In Cambridgeshire and Peterborough there were 5 suspected suicides in 2015/16 and 21 lifesaving interventions undertaken.

The BTP also collect data on risk factors for suicide. In Cambridgeshire and Peterborough 39 individuals were known to have a mental health history and 9 to have had a prior suicide attempt**Error! Reference source not found.**. Eleven were recorded as having drug and/or alcohol abuse as a risk factor.

7. Limitations

- Although reviewing the Coroner case files was a very informative process, the information gathered was limited by the contents of the files. For some individuals very little was known about their life, perhaps if they had newly moved to the area or were a migrant. Some of these individuals were not registered with a GP which meant that medical history was particularly lacking and a valuable insight was lost.

- Some of the indicators that it would be helpful to gather were not required as part of the Coronial process and therefore may not be requested/received. An accurate picture of ethnicity, sexuality or whether the individual had a learning disability, for example, may not be possible. The subjective analysis of themes can also only be

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based on the information in the files, therefore key relevant information may be missed.

- It is quite likely that some suicide deaths may be missed, particularly those that are drug related. It is incredibly difficult in such cases to determine whether there was intent to end life or not. Drug related deaths will not be included within the data presented here, but there is going to be a review of the Coroner case files by the Drugs and Alcohol Action Team and Cambridgeshire Public Health team that may give insight into this issue.

- The review of Coroner case files was undertaken by 4 individuals within the public health team, therefore the subjective qualitative aspect of determining themes for the cases could be influenced by this.

- The number of cases included in this report in terms of statistical analysis are relatively small and therefore comparisons with other areas and different years is not feasible. It is hoped by improving the data accuracy and quantity received on a quarterly basis from the Coroner's Office will in future years allow for patterns and trends to be identified more clearly.

8. Conclusions and Recommendations

Although it is difficult to draw firm conclusions about trends and peaks in data with a relatively small dataset, there are some key issues that this in-depth data analysis highlights about deaths by suicide and undetermined injury in Cambridgeshire and Peterborough in 2015. The following recommendations are based on the findings of this audit and should be considered as part of the local suicide prevention plan:

- Both nationally and locally in 2014 and 2015 suicides were most common in males. The age profile in 2015 shows distinct peaks in young men (under 30 years) and those in their 50s. In particular there is a concerning number of deaths in under 30s in Peterborough, particularly men, which was not seen in last year's data. In addition, Huntingdonshire and Fenland had disproportionate numbers of men that died by suicide compared to females. This information should be utilised to target local campaign work and training.

- There is an apparent overrepresentation of those that are not British, particularly apparent in those under 30 years old in Peterborough. Considerations should be made in terms of how best to reach these individuals and whether the information and work currently available is accessible to all.

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- A large proportion of those within the audit had been in contact with their GP within the prior 6 months, not always for a mental health concern. This provides an opportunity for intervention and accessing further support, training for GPs should therefore be considered. Consideration should also be given to those that are not registered with a GP, in particular this may not always be the best route for reaching young men.

- Certain GP practices also had notably higher numbers of suicide or undetermined injury deaths. There is certainly no indication or suggestion that these practices were in any way at fault, but it is important to consider postvention (after a suicide) support as a suicide can have a significant impact on the wider community and those that have been in contact with the individual.

- Peterborough, Fenland and South Cambridgeshire have the highest rates of death by suicide or undetermined injury. Wisbech specifically had notably more deaths than in other areas too. This information should steer targeted preventative work.

- There were distinct patterns in living circumstances and relationship status among women. In particular, those who lived alone or had been divorced made up a considerable proportion of deaths. This knowledge may help to identify vulnerable points in an individual's lives, awareness of which may be useful for wider health care professionals and support services.

- It is possible to see how many of the themes identified across cases could be linked – loneliness, bereavement, isolation, lack of social support and relationship breakdown for example. Alternatively, physical health and loss of independence and isolation/loneliness. The model provided in the confidential inquiry into suicides in young people (see Appendix 1) provides a potentially helpful model that would support the accumulation of vulnerabilities. This understanding of a pattern of risk factors could help identification of at risk individuals.

- Although taxi use was reported in less than 5 cases, all of these were railway suicides. British Transport Police data would suggest that there are considerably higher numbers of people that receive life-saving interventions and pre-suicidal incidents on the railways locally and therefore there are likely to be more individuals using taxis than recorded in the audit. Mental Health training for taxi drivers has been undertaken in other areas and may be potentially of benefit locally. Alternative routes to reach those who may not be in contact with services must be considered.

- Although such an intensive audit won't be undertaken every year, there are certain indicators that it would be helpful to include in a future audit; sleep problems and taxi use in particular.

- Because of the timeliness of the data, not all those originally included in the quarterly data reports will fall within the definition of suicide or unexplained death following the inquest. Therefore it is important that an annual check is built in to ensure that there is a review of the verdicts prior to producing annual data. Although at this time point the full picture would still not be fully known.

- Although a large proportion of those within the audit were in contact with mental health services, the majority of people were not. This needs to be a core consideration that steers preventative work, but also crisis work to ensure that those not in touch with mental health services know where to go for help when in crisis.

- Comparative CPFT suicide audit data will be available in Autumn 2016, this information should be compared to this report to ensure that the full picture is being captured locally. This will give more detail about those individuals who were patients of CPFT and recommendations that should be taken forward to prevent future suicides.

- It is unclear the scale of the impact of substance misuse, but clearly the data shows that some individuals have current or past substance misuse problems. It is widely acknowledged that this is likely to be an underrepresentation, with determination of intent to end life a challenge in such cases. The findings from the drug related death audit, taking place later this year, will be important to consider in relation to prevention of suicides.

- Self-harm behaviour was present in a number of cases, whether recent or past. Although most people who self-harm are not doing so with the intention of ending their life, it is a risk factor for suicide. Therefore locally it would be helpful to establish whether there is more that can be done to target this group of people, potentially through A and E or youth counselling services with suicide prevention support or resources.

- Bereavement and relationship breakdowns are clearly significant contributing factors to a number of deaths. Raising awareness of these risk factors amongst health professionals could be a helpful step in conjunction with ensuring the support services that can help are widely promoted and equipped with the skills to identify and support clients at risk.

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Appendix 1

Summaries of key national documents published in 2015/16.

Identifying and responding to suicide clusters and contagion: A practice resource (Public Health England, 2015)

This document provides a practical toolkit, including a framework for action, for identifying and responding to suicide clusters. A suicide cluster is defined as:

> "A series of three or more closely grouped deaths…which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is required."[5]

The media has a key role to play in terms of preventing suicide clusters and locally the Samaritans Guide for the media is promoted.

The toolkit provides advice in terms of identifying and responding to a cluster of suicides, the issue of which is most likely to be raised by community members. It is recommended that each area has a multi-agency suicide prevention group and that the multi-agency group should develop a community action plan for responding to suicide clusters. This work should be supported by a data group that can provide information on potential clusters.

Those bereaved by suicide should receive support, and considerations should be made for those that are vulnerable after a suicide, these individuals may be considered to have close geographic proximity, social proximity or psychological proximity (e.g. someone who feels they identify with the individual, perhaps because they are a similar age for example). The toolkit gives guidance on identifying these individuals and providing support.

Preventing suicides in public places: A practice resource (Public Health England, 2015)[6]

This toolkit provides practical guidance on preventing suicides in public places, focusing on the 'means restriction' element of the national suicide prevention strategy. There is a requirement to identify priority sites using data analysis and mapping, and then engagement of relevant stakeholders to produce an action plan.

The report also gives details of interventions to prevent suicides across 3 key areas:

1. Restrict access to the site and the means of suicide
    - Close all or part of the site
    - Install physical barriers to prevent jumping

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[5] Public Health England (2015) Identifying and responding to suicide clusters and contagion: A practice resource. https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters

[6] Public Health England (2015) Preventing suicides in public places: A practice resource. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf

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- Introduce other deterrents, for example, boundary markings or lighting

2. Increase opportunity and capacity for human intervention
    - Improve surveillance using CCTV, thermal imaging and other technologies; increase staffing or foot patrols
    - Provide suicide awareness/intervention training for staff working at or near the site; increase whole community awareness and preparedness to intervene
3. Increase opportunities for help seeking by the suicidal individual
    - Provide Samaritans signs and/or free emergency telephones
    - Provide a staffed sanctuary or signpost people to a nearby one
4. Change the public image of the site
    - Restrict media reporting of suicidal acts
    - Discourage personal memorials and floral tributes at the site
    - Introduce new amenities or activities; consider re-naming and re-marketing the location

It is suggested that the above intervention areas are considered for each site identified and that a combination of measures such as physical changes (barriers for example) and softer measures including supporting human interventions are included.

Suicide by Children and Young People in England (NCISH, 2016)[7]

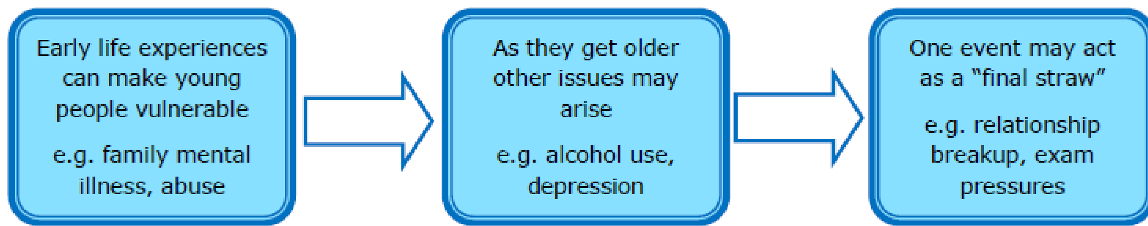
This report looks at suicides in 10-19 year olds in England, it will be followed next year by a report of those up to 25 years old. 145 suicides or probable suicides (including open verdicts) were included in the analysis. 70% of the deaths were males and the majority were in later teens. The 10 common themes identified in these cases were:

1. Family factors such as mental illness
2. Abuse and neglect
3. Bereavement and experience of suicide
4. Bullying
5. Suicide-related internet use
6. Academic pressures, especially related to exams
7. Social isolation or withdrawal
8. Physical health conditions that may have social impact
9. Alcohol and illicit drugs
10. Mental ill health, self-harm and suicidal idea.

Notably 54% had self-harmed previously, and only 27% of individuals had expressed suicidal ideation in the week before death. Almost half (43%) were not known to any service or agency and 28% had been bereaved. The analysis found that most commonly individuals would have a number of contributing issues or stresses. The document provides a model of cumulative risk that an individual

[7] Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2016. (NCISH). Manchester: University of Manchester, 2016.

may experience over time and that could potentially be used in preventative work:



The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report[8].

This report collates information on suicides across the UK from 2003-2013 looking at the number within the general population and for those who have been in contact with mental health services within the previous 12 months. The proportion of suicides by mental health service patients out of all suicides has risen from 27% in 2003 to 30% in 2013, this rise however might be caused by rising patient numbers or high risk individuals having longer contact with services. The number of suicides in male patients has particularly increased, again this may be due to rising patient numbers though.

In England, between 2003-2013 28% of suicide deaths across the population were in individuals who had been in contact with mental health services in the past 12 months. This represents an average of 1,270 patient suicides per year. There were 2,368 suicides within 3 months of discharge from in-patient care across the 10 year period. Post-discharge suicides were most frequent in the first week after leaving hospital with an average of 31 per year.

In England, between 2003-2013 there was an average of 557 deaths per year in patients (discharged from mental health services in previous 12 months) with a history of alcohol misuse (45% of the total sample). An average of 395 per year had a history of drug misuse (32% of total sample). Overall, 54% of patient suicides had a history of either drug or alcohol misuse or both.

Looking at UK wide data, around a quarter of patients who died by suicides had a major physical illness, and the figure is especially high in those aged 65 years and over (44%). The illness was often chronic and most commonly were:

- Neurological
- Endocrine
- Rheumatological/orthopaedic.

[8] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester.

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The report discusses clinical messages based on the data including[8]:

- Services should ensure that they and partner agencies address factors that add to risk in male patients - especially alcohol misuse, isolation and economic problems such as debt and unemployment.
- It is important that male patients have access to psychological as well as drug treatments within the service, that contact is not easily lost and risk is monitored, and that courses of treatment are completed.
- Crisis Resolution/Home Treatment (CR/HT) should not be used by default for patients who are at high risk or who lack other social supports.
- CR/HT should be an intensive community-based alternative to in-patient care; skills and contact time should reflect this specialised role.
- Acute admissions out of area should end - they are likely to make care planning more difficult and to add to suicide risk at the time of discharge.
- Clinicians should be aware of the potential risks from opiate-containing painkillers and should enquire about patients' access to these drugs when assessing suicide risk.
- Prescribers of these drugs should limit the duration of prescription of opiates, as they do with antidepressants, to reduce the risk of accumulating a lethal quantity. This is primarily a role for primary care but pharmacists can play a part in encouraging safe prescribing.
- Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans.
- Staff should make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.
- Physical health needs, especially long-term needs, should be reflected in mental health care plans.
- Mental health staff should regularly review care with GPs or specialist clinics.
- Sudden and unexplained deaths should always be subject to investigation and reporting by the mental health trust, and to coroner referral.
- Wards should take precautionary measures including physical health assessment as soon as practicable after admission, and avoidance where possible of high drug dosage and polypharmacy.

Opiates are the most common method of self-poisoning by mental health patients in the UK accounting for 1,215 deaths between 2003-2013. Since 2012, excluding unknowns, 36% of the opiates had been prescribed for the patient and 8% had been prescribed for someone else. Those that self-poisoned using prescribed opiates tended to be older, female, have a major physical illness and a primary diagnosis of affective disorder.

Appendix 2

Suicide prevention in Cambridgeshire and Peterborough

Summary of routinely available data 2015/16

Direction of travel key:
↑ Indicates a increse in vaule from prevoius years data
↓ Indicates a decrese in vaule from prevoius years data

Key: Compared to the England average / comparison to relevant threshold
- (light blue) Statistically significantlly better/lower
- (dark blue) Statistically significantly worse/higher
- (white) Statistically similar
- "-" Data not currently available or values not calculated and significance not assessed due to small numbers or data quality issues
- Blue highlights the highest value in the horizontal range of areas that follow

Last updated: May 2016

* Direction of travel plotted using exponential trend line against time series

**QOF data uses Midlands and East of England Commissioning Region in place of East of England

#	Domain / Indicator (short name)		Period	Summary	England	East of England	Peterborough	Cambs	Cambridge City	East Cambs	Fenland	Hunts	South Cambs
	Suicide Rates and means of suicide												
1	Directly age-standardised rate for suicide and injury undetermined (pooled), per 100,000	Male	2012-2014		14.1	12.6	13.5	12.6	13.3	9.5	18.1	10.5	12.4
		*Direction of travel	2004 → 2014		↑	↑	↓	↑	↓	↑	↑	↑	↑
		Female	2012-2014		4.0	3.8	4.2	3.6	3.8	3.8	3.4	5.0	1.7
		*Direction of travel	2004 → 2014		↓	↓	↓	↓	↓	↓	↑	↑	↓
2	Age-specific rates for suicide and injury undetermined (pooled) persons, crude rate per 100,000	Persons age 15+	2012-2014		10.6	9.6	10.7	9.7	10.1	8.1	12.8	9.4	8.6
		Persons age 15-34			8.1	7.5	9.4	9.2	8.8	7.0	13.5	9.2	8.1
		Persons age 35-64			13.5	12.2	11.9	11.3	13.1	12.3	14.9	10.3	8.4
		Persons age 65-74			7.5	6.7	7.1	5.0	4.5	0.0	6.0	3.8	8.9
		Persons age 75+			8.6	7.4	13.3	9.3	8.5	0.0	10.3	12.9	10.7
3	Years of life lost due to suicide and injury undetermined (pooled), DSR per 100,000	Persons	2012-2014		31.9	29.4	31.8	30.6	31.9	29.5	43.7	28.9	24.5
		Male			50.2	45.3	48.2	47.7	49.5	46.0	71.5	41.0	42.5
		Female			13.7	13.6	15.3	12.9	12.0	13.2	15.4	16.4	7.0
4	Proportion of suicides by method/cause of death	Male	Poison	2013	20%	-	11%	21%	0%	25%	17%	50%	9%
			Suffocation/ Strangulation		56%	-	89%	65%	100%	50%	50%	50%	82%
			Drowning		4%	-	0%	6%	0%	0%	17%	0%	9%
			Other		20%	-	0%	9%	0%	25%	17%	0%	0%
		Female	Poison	2013	38%	-	50%	45%	0%	0%	50%	60%	100%
			Suffocation/ Strangulation		40%	-	50%	45%	100%	100%	50%	20%	0%
			Drowning		6%	-	0%	9%	0%	0%	0%	20%	0%
			Other		15%	-	0%	0%	0%	0%	0%	0%	0%

Risk Factors: Mental Health

No.	Indicator	Group	Period									
5	**QOF: Mental Health Prevalence (Includes: schizophrenia, bipolar affective disorder and other psychoses)	Persons	2014/15	0.88%	0.80%	0.85%	0.76%	1.07%	0.68%	0.59%	0.65%	0.70%
6	**QOF: Depression Prevalence	Persons	2012/13	5.84%	6.01%	5.63%	5.59%	5.02%	5.56%	6.37%	6.03%	5.04%
			2013/14	6.52%	6.49%	6.20%	6.23%	5.60%	5.68%	7.37%	6.72%	5.74%
			2014/15	7.33%	7.27%	6.93%	6.98%	6.04%	6.61%	8.16%	7.68%	6.48%
		*Direction of travel	2009/10 → 2014/15	↓	↓	↓	↓	↓	↓	↓	↓	↓
7	% of adults in contact with secondary mental health services who live in stable and appropriate accommodation	Male	2014/15	58%	55%	32%	32%	-	-	-	-	-
		Female	2014/15	61%	58%	33%	35%	-	-	-	-	-
8	Child admissions for mental health, crude rate per 100,000	Persons	2011/12	91.3	63.3	68.4	73.6	-	-	-	-	-
			2012/13	87.6	77.5	77.8	82.9	-	-	-	-	-
			2013/14	87.2	71.3	54.6	68.4	-	-	-	-	-
			2014/15	87.4	78.8	68.7	76.8	-	-	-	-	-

Risk Factors: Substance Abuse

No.	Indicator	Group	Period									
9	Admitted to hospital for alcohol-specific conditions, DSR per 100,000	Persons	2014/15	364.4	269.3	431.4	311.1	442.8	264.8	350.5	282.4	277.5
		Male		502.0	358.7	601.4	415.7	635.4	356.4	460.1	375.3	365.3
		Female		235.2	185.2	268.8	209.7	251.6	179.2	243.2	192.2	194.0
10	Persons under 18 admitted to hospital for alcohol-specific conditions, crude rate per 100,000	Persons	2012/13- 2014/15	36.6	26.3	42.9	32.0	26.5	22.9	44.9	42.5	21.7
11	Admissions to hospital where the secondary diagnoses is an alcohol-attributable intentional self-poisoning, DSR per 100,000	Male	2011/12	53.0	41.2	88.2	53.2	69.0	31.9	57.3	40.8	66.1
			2012/13	49.9	37.0	73.5	27.2	21.5	19.7	44.0	35.6	17.8
			2013/14	52.0	43.6	75.4	50.9	78.5	42.9	48.4	43.9	44.6
			2014/15	45.0	38.9	40.7	66.8	45.9	37.4	47.1	39.0	47.1
		*Direction of travel	2008/9 → 2014/15	↑	↑	↓	↑	↓	↑	↑	↑	↓
		Female	2011/12	64.6	57.3	98.0	74.7	87.0	110.2	83.6	41.3	78.9
			2012/13	61.4	48.8	80.6	39.0	32.8	N	77.1	55.3	18.7
			2013/14	65.4	59.9	88.5	63.3	72.7	50.2	59.2	63.6	62.0
			2014/15	58.6	53.3	56.7	98.7	55.2	50.4	73.1	54.1	54.5
		*Direction of travel	2008/9 → 2014/15	↑	↑	↑	↑	↓	↓	↑	↑	↑
12	Claimants of benefits due to alcoholism, crude rate per 100,000	Persons	2015	136.8	83.2	101.3	67.7	108.9	58.1	69.8	56.7	43.5
13	Adults in treatment at specialist drug misuse services, crude rate per 1,000	Persons	2013/14	5.0	3.6	7.7	3.3	N	N	N	N	N
14	Prevalence of opiate and/or crack use, crude rate per 1,000	Persons	2011/12	8.4	5.8	10.5	4.3	7.2	3.7	6.5	3.5	1.4
15	Hospital admissions due to substance misuse (15-24 years), DSR per 100,000	Persons aged 15-24	2012/13 - 2014/15	88.8	68.7	108.6	76.0	-	-	-	-	-
16	% of people entering prison with substance dependence issues who are previously not known to community treatment	Persons	2012/13	47%	46%	37%	49%	-	-	-	-	-

Risk Factors: Self-Harm

17	Hospital stays for self-harm, DSR per 100,000	Persons	2014/15	191.4	173.8	300.7	221.5	252.7	238.5	236.2	184.0	228.4
18	Hospital admissions as a result of self-harm (10-24 years), DSR per 100,000	Persons	2012/13	346.3	291.2	620.5	396.2	-	-	-	-	-
			2013/14	412.1	378.3	678.8	524.4	-	-	-	-	-
			2014/15	398.8	354.7	611.2	477.6	-	-	-	-	-

Risk Factors: Employment and Social Isolation

19	Long term unemployment (16-64 years), crude rate 1,000	Persons	2015	4.6	2.9	3.5	1.2	1.5	1.0	2.0	0.9	0.8
20	% point gap in the employment rate between those with a long-term health condition and the overall employment rate	Persons	2013/14	8.7	6.8	7.2	5.7	5.8	3.4	15.3	-0.4	6.6
21	% point gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Male	2014/15	72.6	76.3	76.0	81.5	-	-	-	-	-
		Female	2014/15	59.3	62.2	61.1	69.7	-	-	-	-	-
22	Percentage of adult social care users who have as much social contact as they would like	Persons	2014/15	44.8	43.6	42.0	43.9	-	-	-	-	-
23	% of households occupied by a single person aged 65 or over	Persons	2011	5.2%	5.3%	4.5%	4.9%	-	-	-	-	-

Other Factors

24	% of population who have reported good or very good health	Male	2011	84.6%	-	83.6%	87.1%	86.6%	87.4%	82.9%	87.6%	89.4%
		Female		84.2%	-	82.2%	86.7%	86.7%	87.1%	82.5%	87.1%	88.7%
25	% of population with long-term activity-limiting illness	Male	2011	14.1%	-	14.5%	11.9%	12.2%	11.5%	15.2%	11.6%	10.2%
		Female		14.6%	-	15.6%	12.7%	12.7%	12.1%	15.8%	12.4%	11.2%
26	% of population with long-term day-to-day activity-limiting illness	Male	2011	6.5%	-	6.5%	4.8%	5.1%	4.6%	6.8%	4.7%	3.7%
		Female		6.4%	-	6.8%	5.0%	5.0%	4.7%	7.0%	4.9%	4.1%
27	Statutory homelessness, crude rate per 1,000 households	Persons	2014/15	2.4	2.7	4.4	2.3	3.0	1.5	2.1	3.0	1.4
28	Deprivation score (IMD 2015)	-	2015	21.8	-	27.7	13.4	13.8	12.1	25.4	11.8	8.1
29	Children in the youth justice system, crude rate per 1,000	Persons age 10-18	2013/14	7.0	6.6	6.8	6.4	-	-	-	-	-
30	Domestic abuse incidents, crude rate per 1,000	Persons age 16+	2014/15	20.4	18.0	16.8	16.8	-	-	-	-	-
31	% of adults whose current marital status is separated or divorced	Persons	2011	11.6%	11.8%	13.6%	10.8%	8.4%	11.1%	13.0%	12.0%	9.9%
32	Median registration delay (in days) between date of death and registration of death (pooled)	Persons	2011-2013	145	-	357	151	151	153	163	151	154

Appendix 3

Information collected/verified as part of the review of the Coroner Case Files:

- Age
- Gender
- Nationality
- Ethnicity
- Sexuality
- Living Circumstances
- Home location
- Death location
- Relationship Status
- Recent relationship break down (in past year)
- GP Practice
- Employment status
- Occupation
- Military veteran
- Reason for unemployment
- Previous/existing mental health team involved (and when last contact was)
- Previous planned or attempted suicide
- Last contact with primary care
- Last contact with A&E – mental health related
- Diagnosis of mental illness (state illness)
- Diagnosis of depression
- Prescribed medication for mental illness at time of death/around time of death
- History of self-harm
- History of bullying
- Other illness/long term condition (recent diagnosis?)
- Substance misuse at time of death or in the past
- Any familial history of suicide
- Recent bereavement (relationship and when)
- Involvement with criminal justice system
- Learning Disability
- History of abuse from others [physical/sexual]
- Taxi involvement (in terms of taking an individual to a location prior to death)
- Whether there is a GP statement
- Whether there is a Cambridgeshire and Peterborough Foundation Trust Serious Incident
- Whether there was is a personal witness statement(s)

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