Wirral Suicide Audit 2021-23

Public Health Intelligence Team

June 2025

The information contained within this document may be upsetting or cause distress.

Finding Help

You can contact Samaritans for free on 116 123 (UK and Republic of Ireland; this number will not appear on your phone bill), email jo@samaritans.org, or visit the Samaritans website to find details of the nearest branch. Alternatively, you can contact other sources of support, including those listed on the NHS help for suicidal thoughts web page. Support is available 24 hours a day, every day of the year.

Wirral Suicide Audit 2021-23

Public Health Intelligence

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Contents

Key Findings

- There were **78 cases** included in this 2021-23 audit; 74 of which were assigned as suicide verdicts (95%); the remaining 4 cases (5%) were assigned 'narrative' verdicts.
- Wirral had a slightly **higher suicide rate** than England overall with **11.9 per 100,000** in Wirral compared to **10.7 per 100,000** in England in 2021-23 (according to ONS data, which includes only those cases classified as suicide).
- Men were over-represented in this audit; **73%** of cases were male and **27%** were female. This is consistent with the national male/female ratio (3:1).
- Average age at the time of death was **49 years**; the peak age group was **45-64 years**.
- Hanging was the most frequently recorded method of suicide in Wirral between 2021 and 2023 (59%), consistent with historical trends both locally and nationally.
- Ethnicity recording continued to improve with only **6%** of cases having no ethnicity noted. Cases identified as having a White ethnicity accounted for **88%** of suicides.
- **70.5%** of cases occurred at their **home** address.
- Of the 78 cases, **70%** were either born in Wirral, Cheshire or Merseyside (those born in Wirral accounted for **56%** of suicides).
- Information on sexuality remains limited, with no reference recorded in 67% of cases.**45%** of suicides had a marital status of **'single'**.
- **31 cases showed alcohol** in blood and stomach contents which accounts for **nearly 40%** of all suicides in the Wirral.
- **67%** of females and **44%** of males were **known to mental health services** at some point in their lives.
- **40%** of suicide cases had previously attempted suicide.
- Females were more likely than males to have a history of suicide attempts (57% vs. 33%) and self-harm (57% vs. 23%).
- The **3 most commonly prescribed medications** (in all cases of suicide) were mirtazapine, sertraline and diazepam, as was the case in the 2020-22 suicide audit.

Introduction

Suicide cases for single calendar years have decreased in recent years making it difficult to establish any conclusions about trends. It has therefore been decided for the Wirral Suicide Audit to use data from three pooled years (in the case of this audit years 2021, 2022 and 2023 were included). The date of death may not necessarily have been during those years however, as some cases take time for an official verdict to be reached (due to complex evidence needing to be collected relating to some cases).

Office for National Statistics (ONS) suicide figures are also presented for the year that deaths are registered (around half of the suicides in England registered in one year will actually occur in the year before) but use the ICD-10[1] cause of death codes rather than the coroners verdict which are presented in this audit. This discrepancy can explain differences between the figures that are presented in this audit for Wirral and the national figures produced by ONS for Wirral – along with the fact that this audit also includes cases of potential or possible suicide (see Verdicts section below).

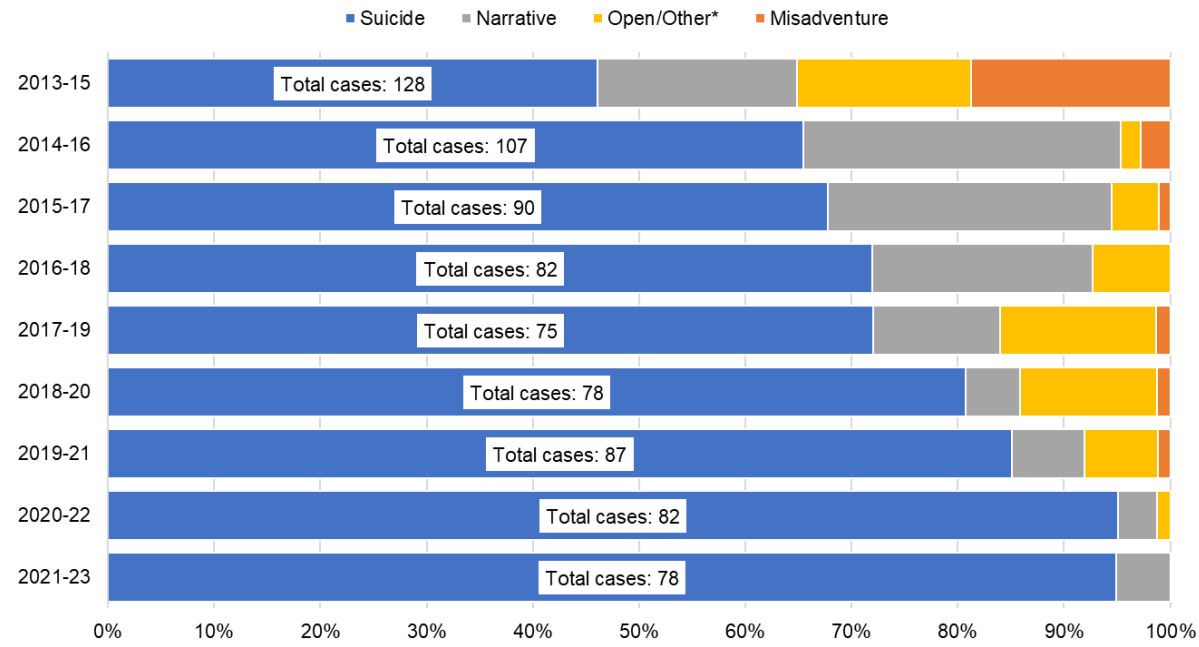
Wirral uses the standardised Cheshire and Merseyside Suicide Audit Template when collecting the data for this audit (see Appendix One). Unless otherwise indicated, all data used in this report is sourced from this template, completed using the Merseyside Coroner records. It should be noted that this template was recently updated, however changes in recording will only be seen for suicide cases from 2023 onwards.

Cases

Verdicts

Unlike ONS suicide statistics, which include only confirmed suicides, this audit also considers cases where there is evidence suggesting the deceased intended to end their life. In July 2018, the standard of proof required by coroners to classify a death as suicide changed from the criminal standard of “beyond all reasonable doubt” to the civil standard of “on the balance of probabilities.” However, when intent cannot be clearly established, coroners may assign alternative verdicts. As a result, this audit includes other classifications such as ‘open,’ ‘misadventure,’ ‘accidental death,’ ‘drug-related death,’ and ‘narrative.’ See Appendix Two for more details on the evidence threshold changes of 2018.

Figure 1: Cases by assigned verdicts (% and total) 2013-15 to 2021-23



Note: Cases with verdicts such as "other" include Accidental and Drug Related Death (i.e. the method was self-poisoning)

As **Figure 1** shows, there has been a notable change in categorisation from 2013 onwards. In 2013-15, just under half (46%) of cases were classified as suicide. By 2021-23 however, 95% of cases were assigned as suicide by the coroner.

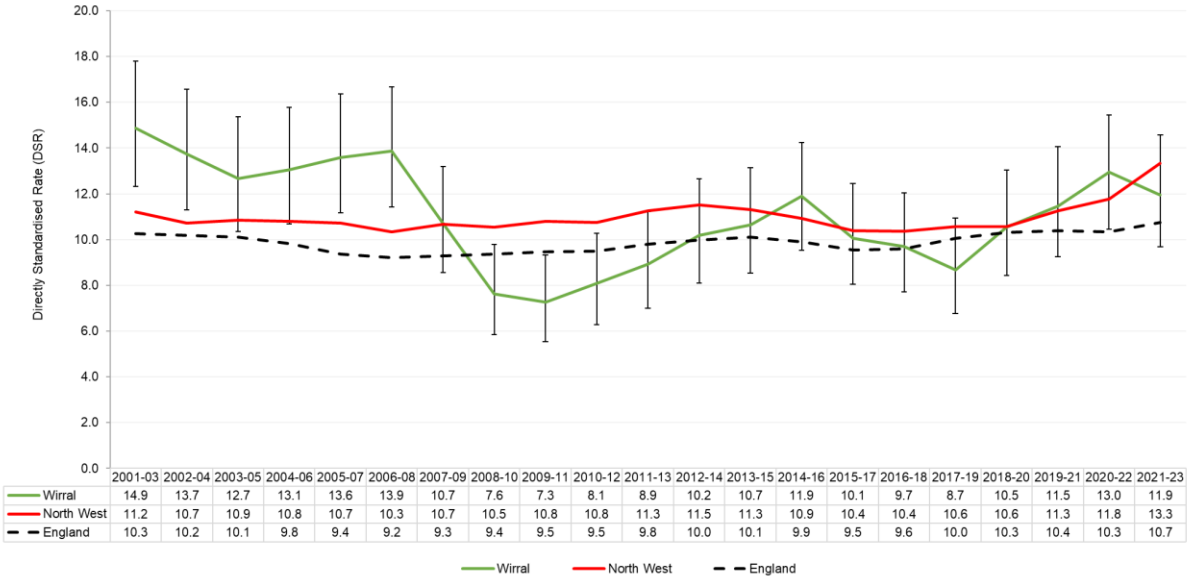
Possible contributory factors to this change may be improvements and standardisation in the recording of information enabling a more concise verdict to be reached; the change in jurisdiction (to the Liverpool Coroner); fewer stigmatising attitudes towards mental health and suicide, and the change in 2018 discussed above regarding the threshold for considering suicide.

Trend in suicide rates

Figure 2 shows the trend in suicide rates locally, regionally and nationally using ONS data. It should be noted that the information in **Figure 2** is NOT based on numbers/data collected in this audit. It is based on national data that is restricted to ICD-10 coded causes of death.

Figure 2 shows that suicide rates in Wirral have fluctuated more than England and the North West, which is typical of smaller datasets. Nationally and regionally, the trend in suicide appears grossly static with only slight changes to the regional and national rates (both slight increases compared to 2020-22) for the latest period 2021-23. Over the same period, Wirral has shown a decrease in suicide rate (11.9 per 100,000) and is lower than the North West (13.3 per 100,000), but higher than England (10.7 per 100,000).

Figure 2: Trend in suicide rate for Wirral, North West and England, 2001-03 to 2021-23



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20	2019-21	2020-22	2021-23
Wirral	14.9	13.7	12.7	13.1	13.6	13.9	10.7	7.6	7.3	8.1	8.9	10.2	10.7	11.9	10.1	9.7	8.7	10.5	11.5	13.0	11.9
North West	11.2	10.7	10.9	10.8	10.7	10.3	10.7	10.5	10.8	10.8	11.3	11.5	11.3	10.9	10.4	10.4	10.6	10.6	11.3	11.8	13.3
England	10.3	10.2	10.1	9.8	9.4	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1	9.9	9.5	9.6	10.0	10.3	10.4	10.3	10.7

Source: Public Health Outcomes Framework, OHID (2025)
Note:

i) This chart is based on national data which is restricted to suicide-related ICD-10 cause of death codes only. More information around coding and Directly Standardised Rates (DSRs) can be found here - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

ii) A confidence interval (black vertical lines shown in Figure 2) is a range of values that are used to quantify the imprecision in the estimate of a particular indicator. A wider confidence interval shows that the indicator value presented is likely to be a less precise estimate of the true underlying value. A 95% confidence interval shows that we can be 95% certain the true value lies in between the range shown by the upper and lower bound of the confidence interval. Where the lower bound of Wirral's confidence interval is higher than the England value, Wirral's value is statistically significantly higher for that time period. Where the upper bound of Wirral's confidence interval is lower than the England value, Wirral's value is statistically significantly lower for that time period. Where there is overlap between (i.e. when England's value crosses the upper and lower bounds of Wirral's confidence interval), there is no statistically significant difference between Wirral and England.

Gender

National and international data indicates that men are significantly more likely than women to die by suicide and this has been the case locally since recording began[2].

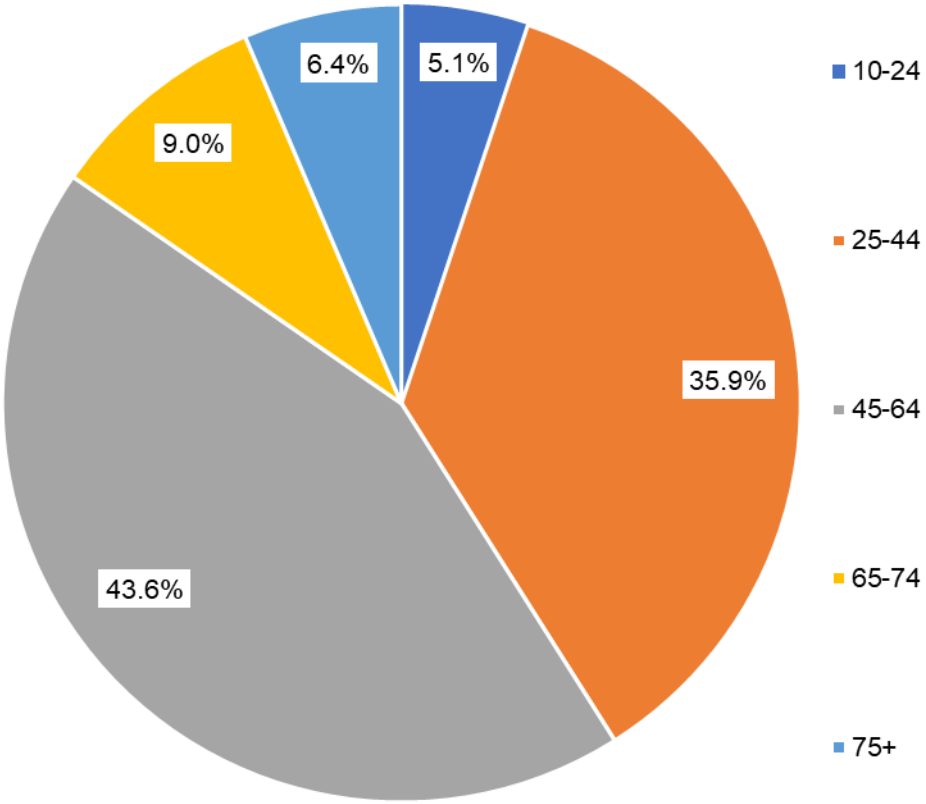
Although men are more likely to die by suicide than women, the UK Adult Psychiatric Morbidity Survey reported that women were more likely to make a suicide attempt (8.0% of women compared with 5.4% of men[3]). For more information about suicide attempts, please see the 'History of mental health issues' section.

Nationally, previous trends have shown that 75% of suicide cases were by males with females accounting for 25% of cases. For 2021-23 the proportion of suicides in Wirral were split 73% male to 27% female, which is in line with the national ratio.

Age

Nationally, people aged between 45-64 years were most likely to die by suicide[2]. In Wirral in 2021-23, the largest proportion of cases were also aged 45-64 which comprised 43.6% of total cases, in keeping with national data.

Figure 3: Age breakdown of Wirral suicide cases in 2021-23 (proportions)



Females saw the highest number of suicide cases within the 25-44 age group (42.9% of female cases), while in males it was those aged 45-64 years (45.6% of male cases). The average age of suicide cases in this audit was 49 years.

To note, there were less than 5 suicide cases included in this audit among people aged 10-24. There were 5 cases among people aged 75+.

Method

The most common suicide method for both males and females in Wirral between 2021-23 was hanging/strangulation (59% of all cases). Self-poisoning was the second most common method for both genders, and this was true in both Wirral and nationally[2].

As noted in the previous audits, males in Wirral appear to have used a greater variety of methods than females over the time period shown, although this may simply be a function of a greater number of male suicides – see **Table 1**.

Data obtained for those who used self-poisoning as their method of suicide (that also included documented cause of death), was available for the period of 2021-22 only and not for 2023, therefore this analysis was made using the available data only and comprised of 12 cases.

Opiate derived medications were prescribed in 50% of cases of self-poisoning (6 cases), often in the form of codeine (co-codamol/dihydrocodeine) or tramadol. 3 cases had medications that had not been currently prescribed to them found in blood/stomach contents, indicating an element of drug abuse. In 7 cases there was a combination of medications (2 or more) that the coroner noted had contributed to a person's death.

Table 1: Proportion of suicides in Wirral, by method and gender, 2021-23

Method	Females	Males	Persons
Hanging/Strangulation	62%	58%	59%
Self poisoning	33%	16%	21%
Cutting or stabbing	<5%	12%	9%
Drowning	5%	5%	5%
Carbon Monoxide poisoning	<5%	<5%	<5%
Firearms	<5%	<5%	<5%
Jumping from height	<5%	<5%	<5%
Jumping/lying before a train	<5%	<5%	<5%

Note: ONS use a different categorisation of suicide methods compared to the Cheshire and Merseyside Suicide Audit Template. ONS only use 5 broad categories: 'drowning', 'fall and fracture', 'poisoning', 'hanging, suffocation and strangulation' and 'other' whereas the Cheshire and Merseyside Suicide Audit Template contains a greater number of methods.

Ethnicity

This audit categorised ethnicity by one of 5 high-level ethnic groups – Asian, Black, Mixed, Other, Unknown and White. 88% of suicides on the Wirral were from a White ethnicity as **Table 2** shows.

According to ONS Census 2021[4] for Wirral, White was the largest ethnic group accounting for 95.2% of people, with Asian (2.3%), Mixed (1.5%), Other (0.6%) and Black (0.4%) ethnicities following. The ethnic diversity in the Wirral varies slightly from England as a whole[5], where White ethnicities account for 82% of the population, Asian 9%, Black 4%, Mixed 3% and Other 2%.

When comparing the ethnic diversity across the Wirral with the 2021-23 suicide data, it appears White ethnicities are underrepresented (88%), however this may simply be a function of a smaller data set.

The recording of ethnicity data continues to improve year on year within Coroner records. For the cycle 2021-23, only 6% of cases had an unknown ethnicity, compared to 9% in 2020-22 and 12% in 2019-21.

Table 2: Suicide cases by Ethnic group in Wirral, 2021-2023

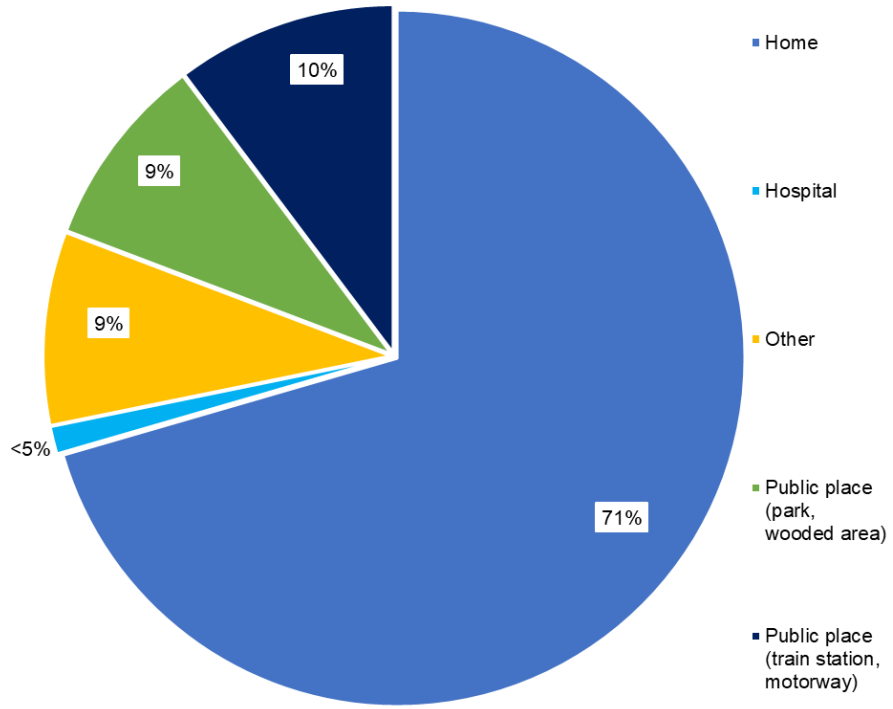
Ethnicity	Percentage
White	88%
Unknown	6%
Asian	<5%
Black	<5%
Mixed	<5%
Other	<5%

Location of event

As **Figure 4** shows, the most likely place for someone to take their own life was in their own home with 70.5% of the cases occurring there. This trend has remained consistent over many years in Wirral and is a comparable to the 2020-22 audit (72%). The second most likely place was in a public place (train station, motorway) accounting for 1 in 10 (10.3%) of the cases.

Other documented locations included public places (wooded area, park), hospital and 'other' which may include locations such as being abroad, in a hotel, or where records have not been clear about the specific location.

Figure 4: Location of death of Wirral suicide cases in 2021-23



Note: Cases with 'hospital' as the place of death are generally those who have been conveyed from a place they were discovered, but who were unable to be resuscitated in hospital for example.

Place of birth

Place of birth may be an important factor for suicide. Living away from your birthplace may increase a person's feelings of isolation[6] and result in a lack of social support in times of need. This could have a negative impact upon a person's mental health and wellbeing, and can be true both for those who were born outside of the UK, or those who were born within UK and have moved to other areas of the country.

The majority (56%) of cases had Wirral as their place birth. A further 14% of cases had Cheshire or Merseyside as their place of birth. This comprises a total of 70% who are from the local area. Of the remaining 30% of cases, those born within the rest of UK had the next largest proportion with 19%. This was an increase from the previous audit cycle (11%).

Table 3: Place of birth of Wirral suicide cases in 2021-23 by number and proportion

Place of birth	Number	%
Wirral	44	56%
Rest of UK	15	19%
Cheshire & Merseyside (excl. Wirral)	11	14%
Europe	<5	5%
Rest of world	<5	<5%
Unknown	<5	<5%
Total	**78**	**100%**

Living arrangements

Wirral data for 2021-23 shows that overall, the majority of suicides were from people living alone accounting for 32%. There was however a difference when looking at gender, with the majority of male suicides being in those who were living alone (33%) whereas the most common living arrangement for female suicides were found in those living with a spouse or partner (38%). This is similar to 2020-22 data.

Table 4: Living arrangements of Wirral suicide cases in 2021-23

Living situation	Female	Male	Persons
Alone	29%	33%	32%
Spouse/partner	38%	19%	24%
Unknown	10%	19%	17%
Parents	5%	12%	10%
Other adults (non family)	<5%	7%	5%
Children (<18)	10%	<5%	<5%
Other family	<5%	<5%	<5%
Spouse & children (aged<18)	<5%	<5%	<5%
Children (>18)	5%	<5%	<5%
Other shared	<5%	<5%	<5%
Spouse & children (>18)	5%	<5%	<5%

Note: Cases are classified as unknown when the individuals' living situation is not explicitly mentioned in the coroner report

A sizeable percentage of total cases (16.7%) had unknown living arrangements with 19.3% of males and 9.5% of females, respectively.

Sexuality

The LGBT in Britain Health report[7] found that over half of Lesbian, Gay, Bisexual and Trans (LGBT) people said they'd experienced depression in the previous year with 1 in 8 reporting that they had attempted to take their own life during this period. It should be noted however, that sexual orientation does not cause the increased risk of suicide, but rather experiences such as homophobia, discrimination and social isolation impact a person's wellbeing which in turn can affect an individual's mental health.

The audit shows that data recording around sexuality remains poor but has shown some improvement compared to previous years. This may be explained by the way this information is typically collected – it is often obtained through anecdotal reports from close family and/or friends. Detailed results have therefore been omitted from this audit due to limited data however almost 67% of Wirral cases for 2021-23 had no reference to sexual orientation (despite this indicator being included on the regional Suicide Audit data collection template).

Marital status

ONS evidence for England and Wales indicates that both men and women who are married are less likely to take their own life (suggesting that marriage perhaps offers an element of protection), whereas those that are divorced are much more likely to die by suicide[8]. This contrasts to local Wirral data shown in **Table 5** that suggests being single is the most common marital status in those who have died by suicide for both males and females. This is the case both for the current audit cycle 2021-23 and also for 2020-22.

Table 5: Marial status of Wirral suicide cases, by gender in 2021-23

Marital Status	Female	Male	Persons
Co-habiting	48%	44%	45%
Married/Civil Partnership	19%	25%	23%
Not known	14%	19%	18%
Separated/ Divorced	10%	5%	6%
Single	10%	<5%	<5%
Widowed	<5%	<5%	<5%
In a relationship: Not cohabiting	<5%	<5%	<5%

The next most common status was to be married or in civil partnership, again this was true of both males and females (23% of cases overall). This is a change from the previous audit (2020-22) where the second most common status was to be separated or divorced.

Employment status

Employment status is an evidenced risk factor for suicide with lower skilled roles and unemployment carrying the greatest risk[9]. Nationally, ONS Data shows that males in England working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average, and the risk of suicide among low-skilled male labourers (particularly in construction roles) was three times higher than the national average. In comparison, the lowest risk of suicide in males was found among corporate managers and directors which was 72% lower than the national average[10].

For females nationally, no main occupation group showed a statistically significant higher average risk of suicide. Only on looking at more individual groups do trends emerge. Elementary trade occupations showed the greatest risk (as with males) at nearly twice the national average, but the total number of suicides is low compared to groups of occupations where women are more likely to work. In occupations where there were at least 50 suicides, deaths among those working in culture, media and sport showed a 69% higher risk of suicide compared to the national average[10].

Locally in the Wirral, as shown in **Table 6**, almost 1 in 4 suicides were from those who were unemployed, but actually the largest number of cases (25.6%) were from those who's employment status was unknown; 33.3% of female cases had an unknown employment status which is a slight reduction from 2020-22 suicide data (40% of female cases had an unknown employment status).

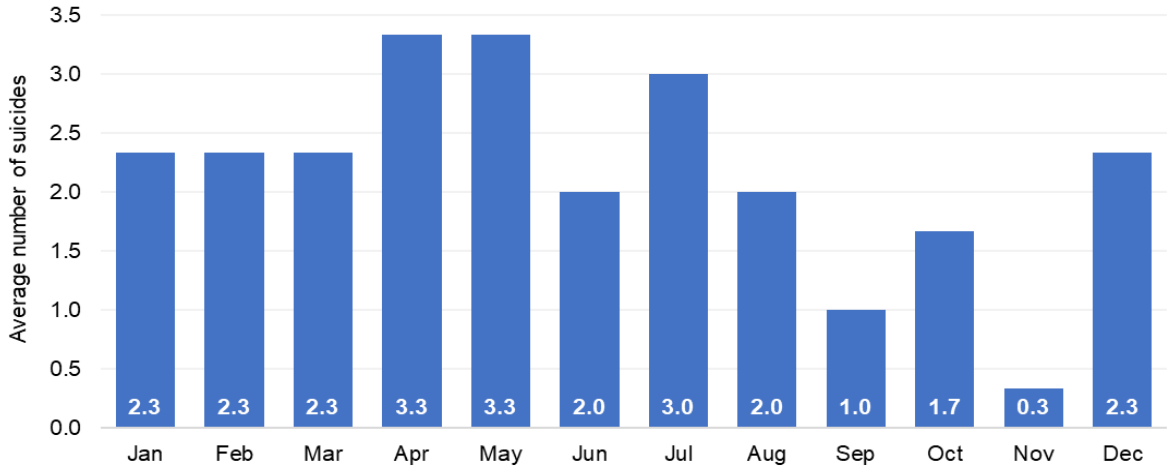
Table 6: Suicide cases in Wirral by employment status and gender 2021-2023

Employment Status	Female	Male	Grand Total
Unemployed	19.0%	24.6%	23.1%
Working full-time/part-time	23.8%	22.8%	23.1%
Retired	9.5%	19.3%	16.7%
Long term sick or disabled	9.5%	7.0%	7.7%
Housewife/househusband	<5%	<5%	<5%
Self-employed	<5%	<5%	<5%
Not known	33.3%	22.8%	25.6%

Seasonality/time of year

Figure 5 shows that both April and May had the highest average rate of suicides at 3.3 cases per month and November and September having the lowest average rate of suicides with 0.3 and 1.0 cases respectively.

Figure 5: Average number of Wirral suicide cases by month of occurrence, 2021-23

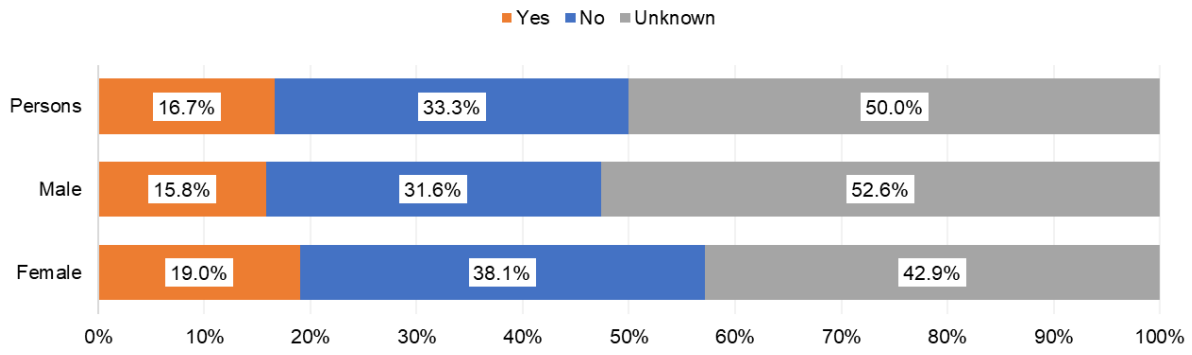


History of drug misuse

As **Figure 6** shows, 16.7% of suicide cases occurred in people where prior drug misuse was recorded which can include both prescription, illicit drugs or legal drugs (typically alcohol). This is a reduction compared to the previous audit cycle (23% in 2020-2022), and there appears to be a modest improvement in the percentage of 'unknown' cases (50%) compared to last year's cycle (54.9%). The substantial proportion of 'unknowns' may under-represent the actual number of people with prior drug misuse.

When reviewing all cases, the most common substances found both in blood and stomach contents were alcohol (in 31 cases - see below), caffeine and cannabis (12 cases respectively). Cocaine, sertraline and nicotine were the next most common substances (9 cases each).

Figure 6: percentage of suicides where prior drug misuse was recorded, by gender 2021-23

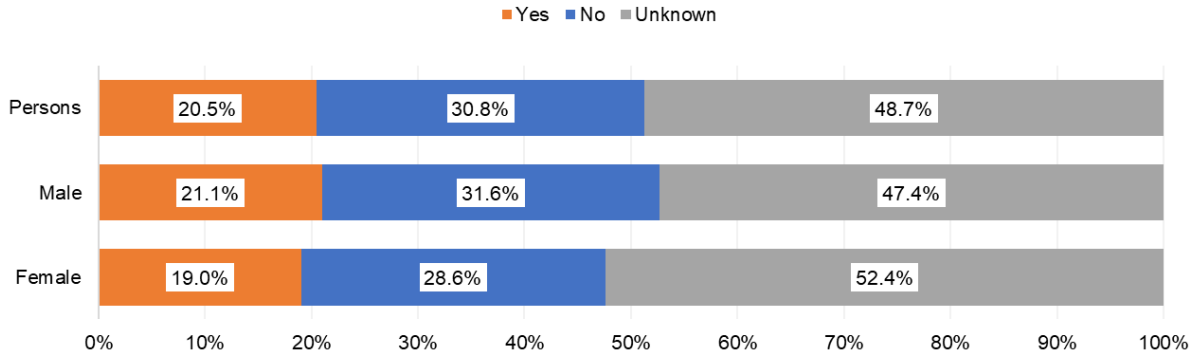


History of alcohol misuse

Slightly more cases showed a background of alcohol misuse than drug misuse, 20.5% of cases versus 16.7% respectively. There is very little difference when looking at prior alcohol misuse when comparing cases between males (21.1%) and females (19%). As mentioned above, 31 cases showed alcohol in blood and stomach contents which accounts for nearly 40% of all suicides in the Wirral. Important to note is that while alcohol was found in a large number of cases, it may not have actually caused the death, but may have contributed to it.

The reporting of drug and alcohol issues relies on accurate/up to date medical records, or relatives disclosing a full history to the coroner, which has its own associated challenges. Therefore, it may be that alcohol/drug misuse is under-reported and therefore the data may understate these concerns.

Figure 7: Percentage of suicides where prior alcohol misuse was recorded, by gender, Wirral 2021-202

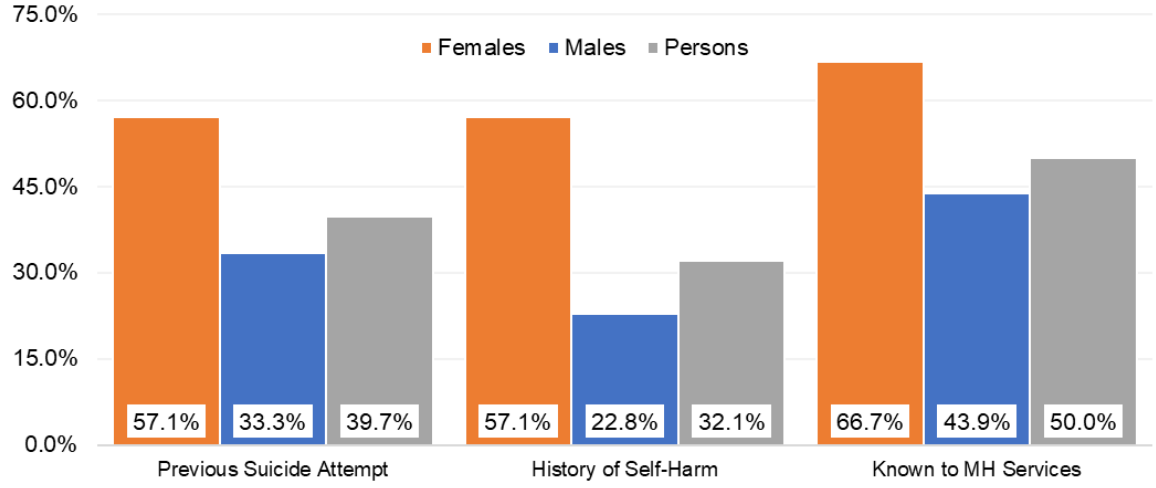


History of mental health issues

In keeping with previous Wirral suicide audits, a large proportion of suicide cases were known to mental health (MH) services. 67% of female cases and 44% male cases were known to MH services at some point.

As **Figure 8** shows, females were more likely than men to have undertaken a previous suicide attempt and were also more likely to have a history of self-harm. This is also reflected in the number of emergency hospital admissions in the Wirral for intentional self-harm over the period of 2021-2023. Data from the Department of Health and Social Care, shows females having a statistically significantly higher rate of admissions for this complaint compared to males[11].

Figure 8: Percentage of cases with a history of mental health related issues, by gender 2021-2023



Prescribed medications

When analysing all suicide deaths, the two medications prescribed most commonly were mirtazapine (20 cases) and sertraline (found in 13).

Sertraline is a selective serotonin reuptake inhibitor (SSRI) licenced as per the British National Formulary (BNF) for depressive illness, obsessive-compulsive disorder, panic disorder and post-traumatic stress disorder[12]. Mirtazapine is a tetracyclic antidepressant and works to increase central noradrenergic and serotonergic neurotransmission and is licenced for major depression[13]. Both therefore are commonly prescribed in those with Mental Health concerns.

Diazepam (a form of benzodiazepine) was the next most commonly prescribed medication found in 10 cases and is often used for its anxiolytic effects[14]. These 3 medications (mirtazapine, sertraline and diazepam) were also found to be the 3 most commonly prescribed medications in the previous audit cycle (2020-22).

Important to note however is that mirtazapine was only found in the blood/stomach contents in 4 cases, sertraline in 9 cases, and diazepam in 7 cases. This perhaps indicates that despite being prescribed, the medications were not being taken as intended.

Other potential contributory factors

Given the data recording issues discussed within this audit, it is important to note that the following section is not definitive but rather indicative of issues raised when a suicide has been notified, or from disclosure from friends and relatives of the deceased. The true prevalence of these issues could be higher than the coroner is able to record.

The most common potential contributory factors for suicide were physical health problems; nearly 35% of cases had at least 1 physical health problem, with 28% of cases having a chronic or terminal illness.

Suicides where relationship problems were noted accounted for nearly 1 in 5 cases and those with financial difficulties accounted for 10%.

A recent addition to the Wirral 2021-23 Suicide Audit is the inclusion of 'Online Harms'[15] to reflect the growing concern in this area.

Table 7: Percentage of Wirral suicide cases showing various potential contributary antecedents, 2021-2023

Potential Risk Factor	%
Physical Health Problems	26.9%
Chronic/Terminal Illness	19.2%
Relationship problems	19.2%
Bereavement	14.1%
History of Domestic Abuse	14.1%
Financial problems	10.3%
History of Violence	9.0%
Pending Criminal Proceedings	7.7%
History of Sexual Assault	5.1%
History of Online Harms	<5%
History of Prison or Youth Offenders Institution	<5%

References

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2. Suicides in England and Wales - Office for National Statistics
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6. Suicidal thoughts and behaviours and social isolation: A narrative review of the literature - ScienceDirect
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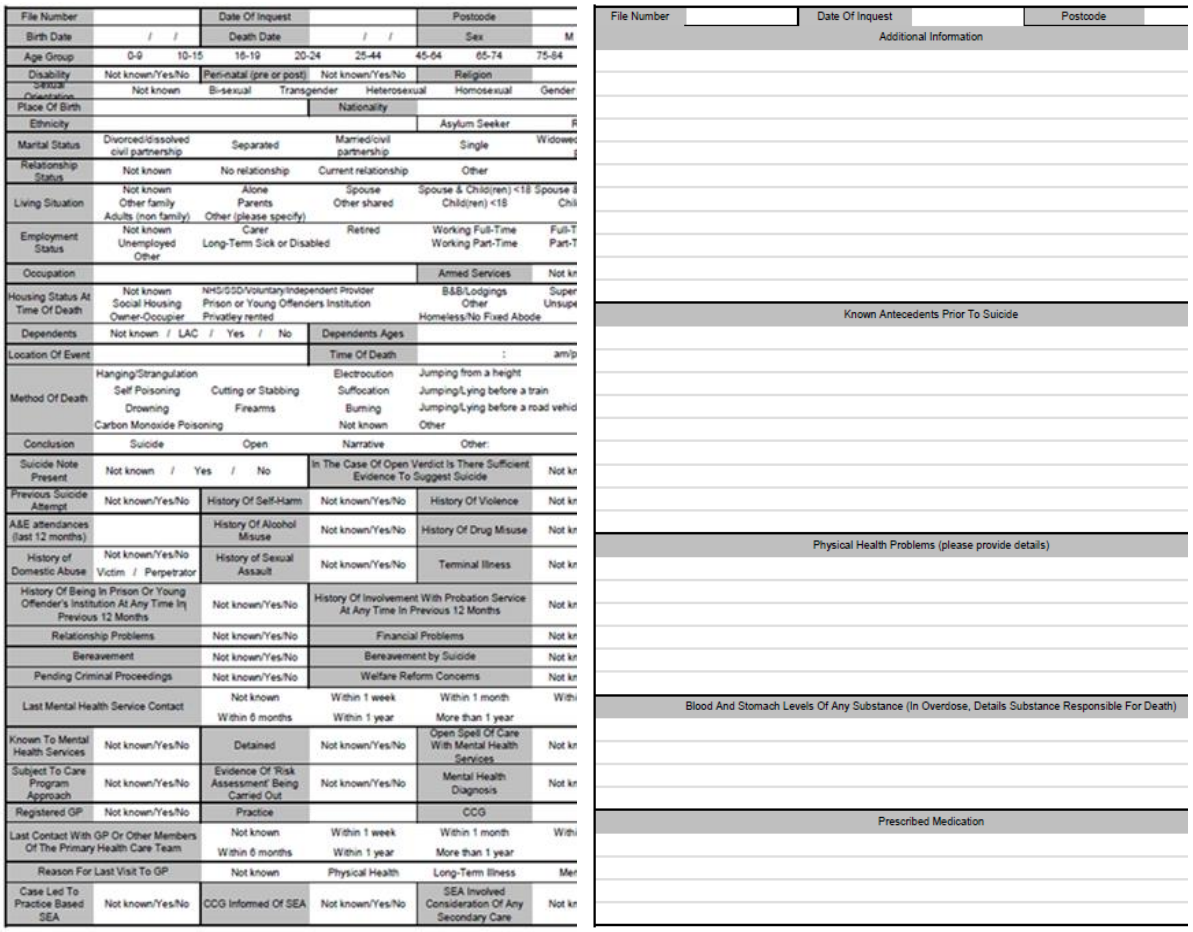
8. Who is most at risk of suicide? - Office for National Statistics
9. The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviours and Interventions to Mitigate Their Impact: A Review - PMC
10. Suicide by occupation, England - Office for National Statistics
11. Emergency Hospital Admissions for Intentional Self-Harm, Wirral
12. Sertraline | Drugs | BNF | NICE
13. Mirtazapine | Drugs | BNF | NICE
14. Diazepam | Drugs | BNF | NICE
15. Understanding and reporting online harms on your online platform - GOV.UK

Appendix

Appendix One

Cheshire & Merseyside Suicide Audit template



File Number		Date Of Inquest		Postcode	
Birth Date	/ /	Death Date	/ /	Sex	M
Age Group	0-9 10-15	16-19	20-24	25-44	45-64 65-74 75-84
Disability	Not known/Yes/No	Peri-natal (pre or post)	Not known/Yes/No	Religion	
Sexual Orientation	Not known	Bi-sexual	Transgender	Heterosexual	Homosexual Gender
Place Of Birth			Nationality		
Ethnicity				Asylum Seeker	R
Marital Status	Divorced/dissolved civil partnership	Separated		Married/civil partnership	Single Widowed
Relationship Status	Not known	No relationship	Current relationship	Other	
Living Situation	Not known Other family Adults (non family)	Alone Parents Other (please specify)	Spouse Other shared	Spouse & Child(ren) <18 Child(ren) <18	Spouse I Chil
Employment Status	Not known Unemployed Other	Carer Long-Term Sick or Disabled	Retired	Working Full-Time Working Part-Time	Full-T Part-T
Occupation				Armed Services	Not kr
Housing Status At Time Of Death	Not known Social Housing Owner-Occupier	NHS/GSD/Voluntary/Independent Provider Prison or Young Offenders Institution Privatley rented		B&B/Lodgings Other Homeless/No Fixed Abode	Super Unsupe
Dependents	Not known / LAC / Yes / No		Dependents Ages		
Location Of Event			Time Of Death	:	am/p
Method Of Death	Hanging/Strangulation Self Poisoning Drowning Carbon Monoxide Poisoning	Cutting or Stabbing Firearms	Electrocution Suffocation Burning Not known	Jumping from a height Jumping/Lying before a train Jumping/Lying before a road vehic Other	
Conclusion	Suicide	Open	Narrative	Other:	
Suicide Note Present	Not known / Yes / No		In The Case Of Open Verdict Is There Sufficient Evidence To Suggest Suicide		Not kr
Previous Suicide Attempt	Not known/Yes/No	History Of Self-Harm	Not known/Yes/No	History Of Violence	Not kr
A&E attendances (last 12 months)		History Of Alcohol Misuse	Not known/Yes/No	History Of Drug Misuse	Not kr
History of Domestic Abuse	Not known/Yes/No Victim / Perpetrator	History of Sexual Assault	Not known/Yes/No	Terminal Illness	Not kr
History Of Being In Prison Or Young Offender's Institution At Any Time In Previous 12 Months		Not known/Yes/No	History Of Involvement With Probation Service At Any Time In Previous 12 Months		Not kr
Relationship Problems		Not known/Yes/No	Financial Problems		Not kr
Bereavement		Not known/Yes/No	Bereavement by Suicide		Not kr
Pending Criminal Proceedings		Not known/Yes/No	Welfare Reform Concerns		Not kr
Last Mental Health Service Contact		Not known Within 6 months	Within 1 week Within 1 year	Within 1 month More than 1 year	Withi
Known To Mental Health Services	Not known/Yes/No	Detained	Not known/Yes/No	Open Spell Of Care With Mental Health Services	Not kr
Subject To Care Program Approach	Not known/Yes/No	Evidence Of 'Risk Assessment' Being Carried Out	Not known/Yes/No	Mental Health Diagnosis	Not kr
Registered GP	Not known/Yes/No	Practice		CCG	
Last Contact With GP Or Other Members Of The Primary Health Care Team		Not known Within 6 months	Within 1 week Within 1 year	Within 1 month More than 1 year	Withi
Reason For Last Visit To GP		Not known	Physical Health	Long-Term Illness	Mer
Case Led To Practice Based SEA	Not known/Yes/No	CCG Informed Of SEA	Not known/Yes/No	SEA Involved Consideration Of Any Secondary Care	Not kr

File Number		Date Of Inquest		Postcode	
Additional Information					
Known Antecedents Prior To Suicide					
Physical Health Problems (please provide details)					
Blood And Stomach Levels Of Any Substance (In Overdose, Details Substance Responsible For Death)					
Prescribed Medication					

Note: The Wirral Public Health Information Team now collects the information used to complete this audit electronically, but the range of fields remains the same as that shown in the paper version of the template (shown above). It is important to note that Coroners records do not always include all the variables shown in the template; variables are omitted where completeness is poor, for quality reasons. This template has recently been updated but will only take effect when auditing cases from 2023 onwards.

Appendix Two

Coroners Verdicts Pre-2018

Most inquest verdicts must be decided on the balance of probability (in other words 'it is more likely than not' that the death of a person happened in a particular way). However, prior to 2018, inquest verdicts of suicide (and unlawful killing) were decided based on being 'beyond reasonable doubt.'

This is the reason in some cases that may have appeared to be an apparent suicide (e.g. a note which could be construed as a suicide note, was present), alternative verdicts such as Narrative or Misadventure were given.

The ‘beyond reasonable doubt’ requirement of a suicide verdict meant that a coroner believed that the deceased had acted in a *conscious* way; the presence of large concentrations of alcohol or drugs therefore often meant a suicide verdict would not be assigned, because alcohol and drugs are well evidenced to affect the ability of individuals to make conscious choices.

Coroners Verdicts Post-2018

On 26th July 2018, as a result of a case in the High Court, the standard of proof – the evidence threshold – used by coroners to determine whether a death was caused by suicide was changed from the criminal standard of “beyond reasonable doubt”, to the civil standard of “on the balance of probabilities”.

The “standard of proof” refers to the level of evidence needed by coroners when determining whether a death was caused by suicide. This legal change appears not to have resulted in any significant change in the reported suicide rate in England and Wales.

‘Short form’ Inquest Verdicts

- **Suicide:** The coroner has determined that the person has voluntarily acted to end his or her life in a conscious way.
- **Misadventure:** implies that the deceased has taken a deliberate action that has then resulted in his or her death, i.e., an intended act but with unintended consequence; like Accidental death.
- **Open verdict:** Used when there is not enough evidence to return a verdict. This is rare and only used as a verdict of ‘last resort.’

Narrative verdict

The coroner is not obliged to use short form verdicts and can use ‘narrative verdicts’ which set out the circumstances of the death in a detailed way, based on the evidence heard. For those attending an inquest of a loved one, it can sometimes be helpful to hear the coroner’s verdict in this form, as more of a detailed conclusion of events leading to the death is provided.