Wirral Suicide & Open Verdict Audit 2016-18

Wirral Intelligence Service

September 2019

Wirral Suicide & Open Verdict Audit 2016-18

For further information please contact:
Public Health Intelligence Team
Wirral Intelligence Service
Email: intelligencerequests@wirral.gov.uk

Or visit the Wirral Intelligence Service website:
www.wirralintelligenceservice.org

Contents

Key Findings

- There were 82 cases included in this 2016-18 audit; 59 cases assigned as suicide verdicts, 17 assigned as narrative verdicts and 6 assigned as open/other verdicts
- Wirral had a slightly higher suicide rate than England overall (9.7 per 100,000 in Wirral compared to 9.6 per 100,000 in England) in 2016-18 (according to ONS data, which includes only those cases classified as suicide)
- Suicide notes were present in just over a third of Wirral cases (38%, n=31)
- Men were slightly over-represented in this audit; 77% of cases were male (n=63) and 23% were female (n=19). This is consistent with the national male/female ratio
- Average age at the time of death was 49.0 for females and 47.7 for males. The peak age band was 45-64, which is also the case nationally
- Recording of ethnicity data has improved and showed that the proportion of Wirral suicide cases who were BAME is similar to the proportion of Wirral's population who are BAME; 4.9% compared to 5.5% respectively. Numbers are too small, however, to draw any conclusions
- The most common cause of death between 2016-18 in Wirral was hanging, which, historically, has always been the most common method (both locally and nationally). When reviewing Wirral data for single years however, the most common method in 2017 was self-poisoning
- Both male and female suicide cases were most likely to be living alone (44% and 61% respectively)
- In terms of marital status, both males and females were more likely to be single (57% and 32% respectively)
- Sexuality is still poorly recorded, despite LGBT young people having a significantly higher risk of suicide (and self-harm)
- The most likely employment status for both genders was to be unemployed (40% of males and 26% of females)
- February, April and October appear to be the peak months for suicide in Wirral over the last 3 years. Locally, December does not appear to mark a particular peak in suicide and was, in fact, the month with the fewest average number of suicide cases between 2016-18
- Most cases included in this audit were known to mental health services (56% of males and 47% of females) and around one in in ten had previously been detained under the Mental Health Act (10% of males and 11% of females)
- Males appeared more likely than females to have had current or historical issues with drugs and/or current or historical issues with alcohol
- Females were more likely to have attempted suicide and have recorded instances of self-harm than males
- Physical health issues (46%), relationship issues (44%) and bereavement (18%) were the most commonly recorded antecedents in Wirral suicides between 2016-18
- Anti-depressants were the most commonly found prescribed drug at post-mortem
- Alcohol was found to be in 40% of all individuals at post-mortem
- Cocaine (16%) and cannabinoids (6%) were the most commonly found illicit substances at post-mortem

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 & Open Verdict Audit to contain data from three pooled years (in the case of this audit 2016, 2017 and 2018). 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 (possibly due to the need to collect sometimes complex evidence relating to the case).

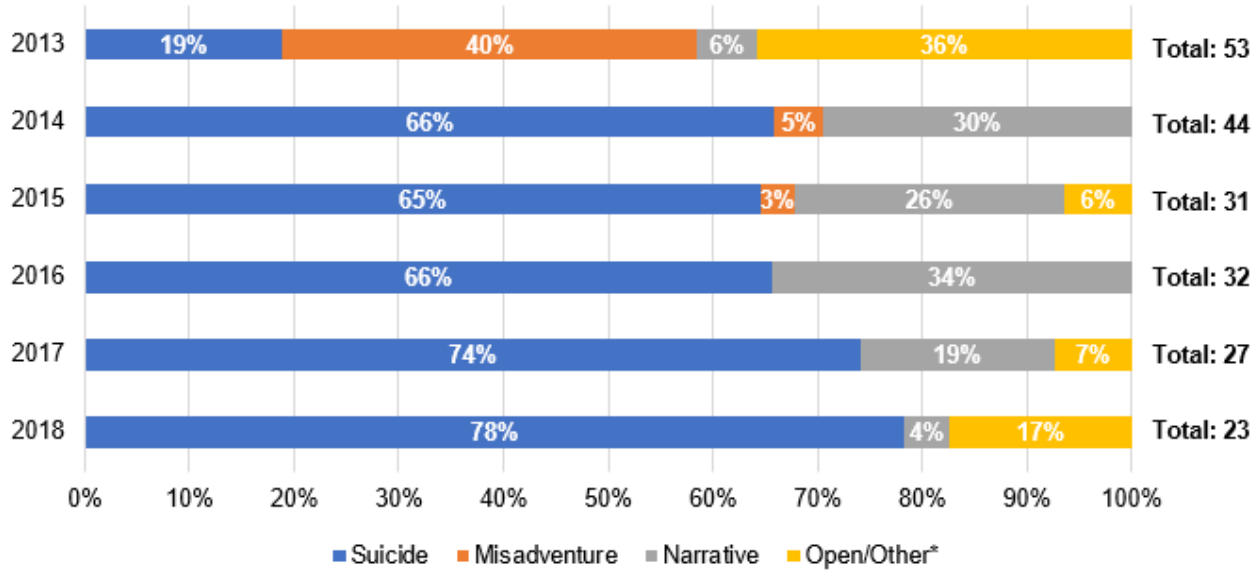
Office for National Statistics (ONS) suicide figures are also presented for the year that deaths are registered (e.g. around half of the suicides in England registered in one year will actually occur in the year before) but use the ICD-10[1] cause of death codes rather than the coroners verdict which 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 next section.

Wirral uses the standardised Cheshire and Merseyside Suicide Audit Template when collecting the data for this audit (see Appendix).

Verdicts

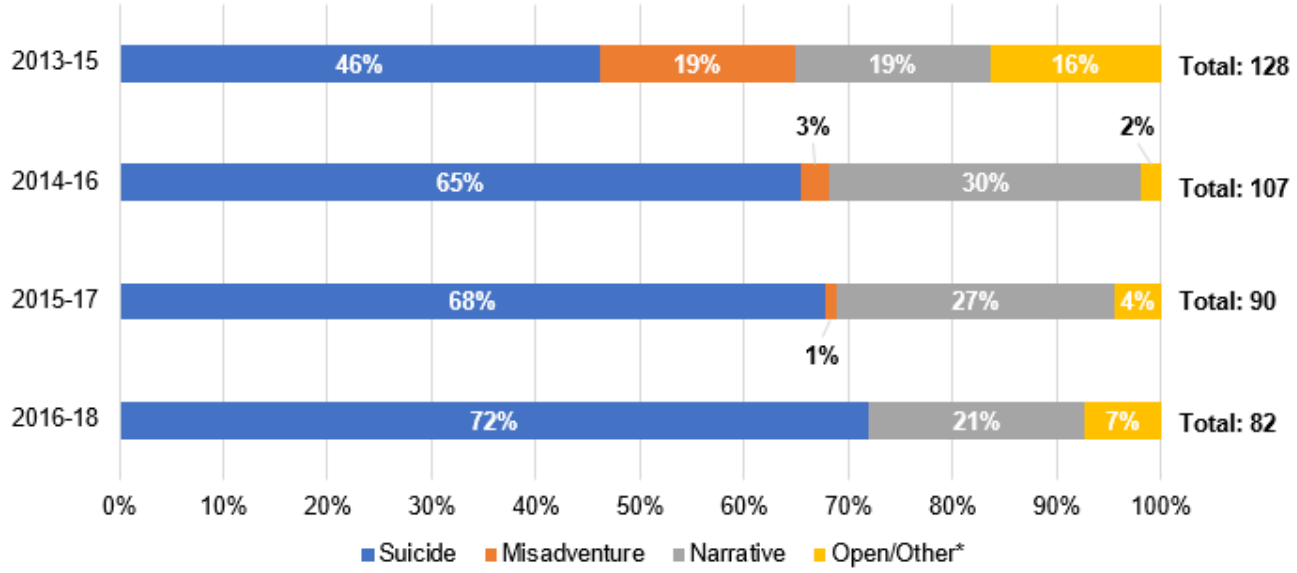
Unlike ONS suicide statistics, which are restricted to cases assigned as suicide, this audit considers cases of *potential* or *possible* suicide. It can therefore also include the verdicts of open, misadventure and narrative (see Appendix for more details on verdicts). The Coroner will only assign a suicide verdict in cases where suicidal intention is beyond reasonable doubt. Even in cases that appear to be suicide, a narrative or open verdict may still be assigned if the Coroner cannot be certain that suicide was the deceased person's clear intention.

Figure 1a: Proportion of cases included in the Wirral Suicide audits with assigned verdict, 2013 to 2018



Source: Merseyside Coroner records (data collected specifically for this audit)
***Note:** Some of the cases with verdicts as "other" include those that used self-poisoning as their method and so, in some cases, the verdict for those individuals would be 'Drug-related death'. These individuals are still included in this audit.

Figure 1b: Proportion of cases included in the Wirral Suicide audits with assigned verdict, 2013-15 to 2016-18



Source: Merseyside Coroner records (data collected specifically for this audit)
***Note:** Some of the cases with verdicts as "other" include those that used self-poisoning as there method and so, in some cases, the verdict for those individuals would be 'Drug-related death' if they were also long-term drug users.

When comparing verdicts from previous individual years, there was a significant change in categorisation after 2013. For example, in 2013, just 19% of cases were classified as suicide, compared to 36% open/other verdicts. In 2018, however, 78% of cases were assigned as suicide and 17% as open/other. Misadventure has similarly reduced from 40% of cases in 2013 to 0% since 2016. See Figures 1a and 1b.

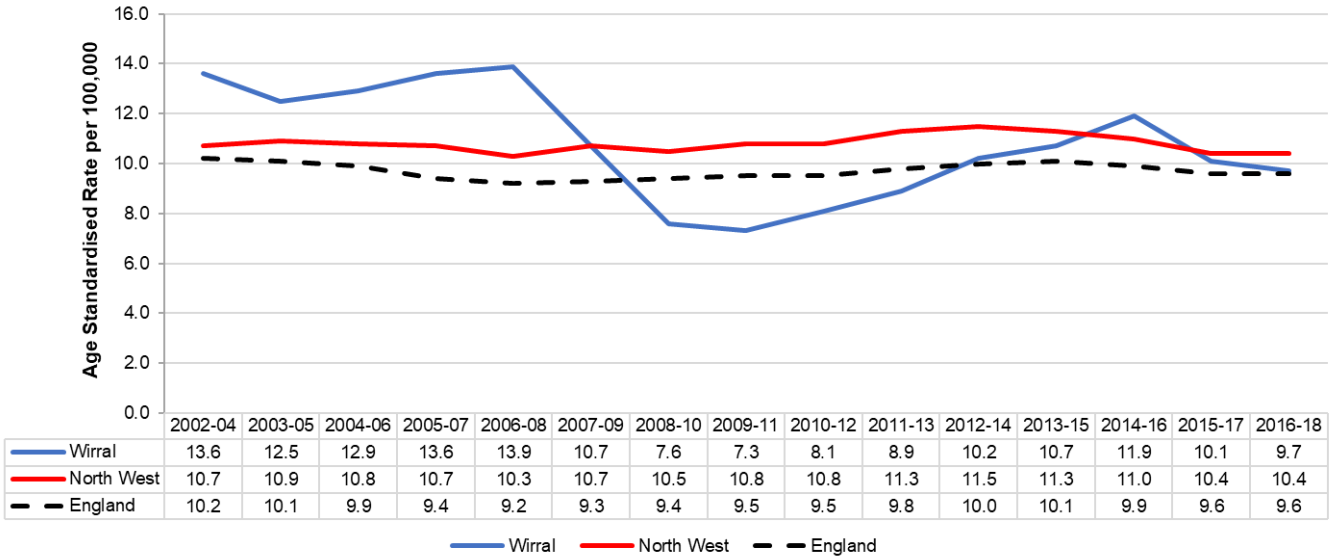
Possible contributory factors to these changes may be improvements and standardisation in the recording of information, enabling a more concise verdict to be reached; the change in jurisdiction (to the Liverpool Coroner); and/or less stigmatising attitudes towards mental health and suicide.

Trend in suicide rates

Figure 2 shows the 14-year 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 collected in this audit. It is based on national data that are restricted to ICD-10 coded causes of death.

It shows that suicide rates in Wirral have fluctuated more than England and the North West. This is typical of smaller datasets. The overall trend in Wirral, however, appears to be a downward one. This also appears to be the case nationally, albeit, with a much shallower decline than Wirral. For the past two sets of pooled years, Wirral suicide rates have been lower than the North West suicides rates. Compared to England however, Wirral's rates for 2016-18 were slightly higher (9.7 per 100,000 in Wirral compared to 9.6 per 100,000 in England). Wirral suicide rates have been consistently higher than the national rates since 2012-14.

Figure 2: Trend in suicide rate in England and Wirral, 2002-04 to 2016-18



	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
Wirral	13.6	12.5	12.9	13.6	13.9	10.7	7.6	7.3	8.1	8.9	10.2	10.7	11.9	10.1	9.7
North West	10.7	10.9	10.8	10.7	10.3	10.7	10.5	10.8	10.8	11.3	11.5	11.3	11.0	10.4	10.4
England	10.2	10.1	9.9	9.4	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1	9.9	9.6	9.6

Source: ONS, 2019
Note: This chart is based on national data which are restricted to ICD-10 coded cause of death only. More information can be found here - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

Gender

Gender is an important factor in suicide, with national and international data indicating that men are significantly more likely than women to take their own life and this has also been the case locally since recording began[2].

Despite men being more likely than women to take their own life, the recent UK Adult Psychiatric Morbidity Survey reported that women were more likely to make an attempt (5.4% of men, compared with 8.0% of women[3]). For more information about suicide attempts please see the 'History of mental health issues' section here.

Nationally, suicide cases were 75% males and 25% female in 2018 and, in previous years, Wirral has shown a very similar trend. For 2016-18, the proportion of suicides in Wirral were split 77% male whilst 23% were female – very similar to the national ratio.

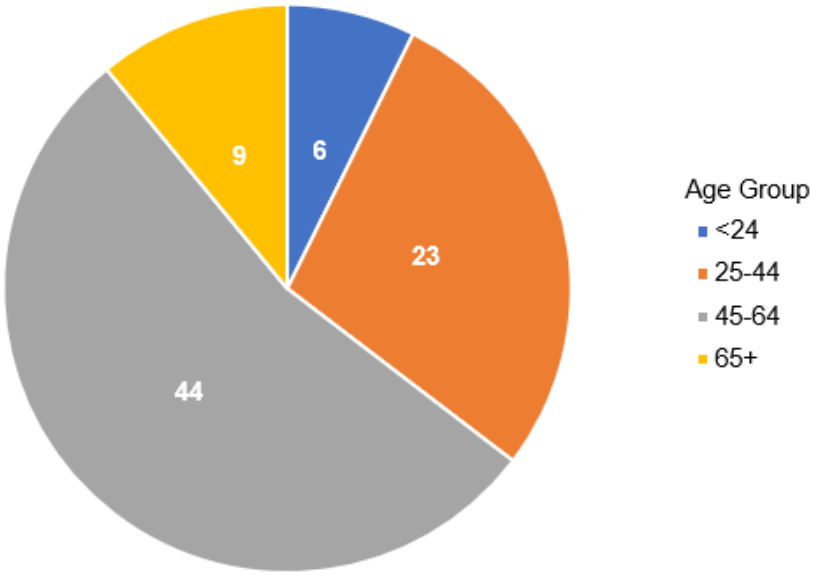
Age

Another important factor in suicide is age. Nationally, people aged between 45-64 years were most likely to take their own life (38% of all suicide cases)[4].

This was also the case in Wirral with 44 people aged between 45-64 years old (54% of all cases). Both males and females saw the highest number of suicide cases within the 45-64 age group followed by the 25-44 age group. The average age of suicide cases in this audit was 47.7 years overall; 47.2 years for men and 49.0 years for women.

As Wirral data are based on very small numbers, they are susceptible to large fluctuations; nevertheless these figure are shown in Figure 3.

Figure 3: Age breakdown of Wirral cases (2016-18)



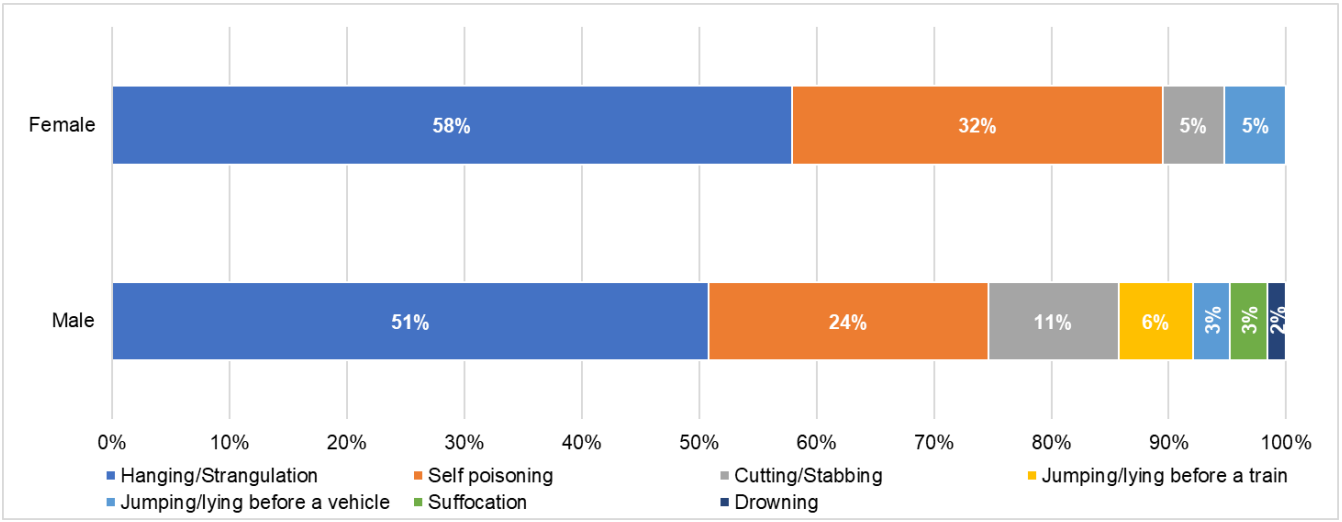
Source: Merseyside Coroner records (data collected specifically for this audit)

There were 6 cases in this audit from people aged under 24 making up 7% of all cases and a further 9 cases in this audit (11%) were aged 65+. Nationally, the rate among 10 to 24-year-old females has increased by 83% since 2012 to its highest recorded level in 2018. Males of the same age also saw a 25% increase in their rate from the previous year[5].

Method

The most common suicide method for both males and females in Wirral between 2016-18 was hanging/strangulation. Self-poisoning was the second most common method for both genders both nationally and in Wirral. Self-poisoning was also the most common method in Wirral for 2017 as a single year[6]. Males in Wirral appear to have used a greater variety of methods than females over the time period shown, although this may just be a function of a greater number of male suicides overall, see Figure 4.

Figure 4: Proportion of suicides in Wirral, by method and gender, 2016-18



Source: Merseyside Coroner records (data collected specifically for this audit)
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 specifies more detail around the methods.

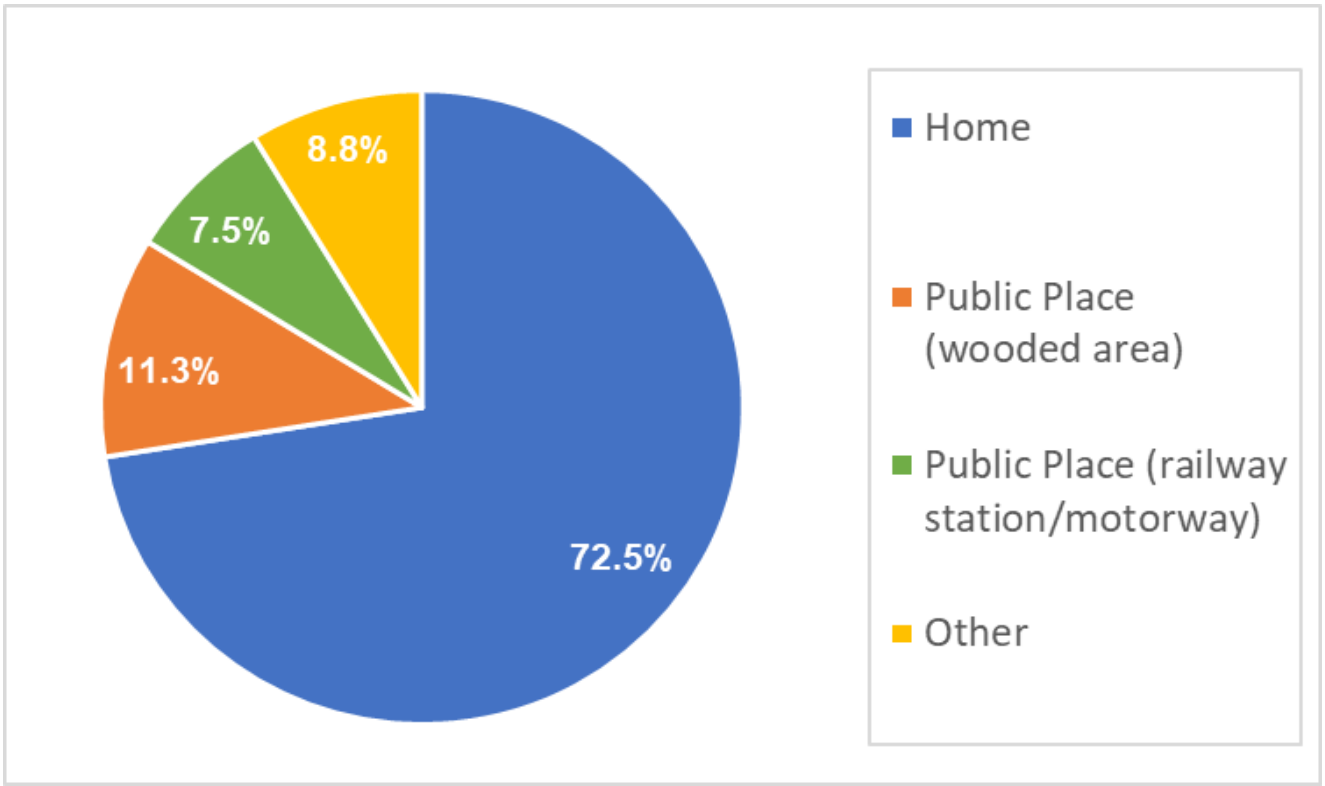
Ethnicity

Wirral is estimated to have a Black, Asian and Minority Ethnic (BAME) population of 5.5%[7], so 4.9% of suicide cases in BAME groups in 2016-18 is around what might be expected although overall figures are too small to draw firm conclusions. The ethnicity of the BAME cases has not been published for confidentiality reasons. It is not possible to compare Wirral data to a national picture, as ethnicity is not reported on national death registrations.

Location of event

As Figure 5 shows, almost 3 in 4 Wirral suicides took place in the persons own home between 2016-18. This is a consistent trend over many years in Wirral[8]. Places such as wooded public places and railway stations/motorways make up some of the remaining locations. “Other” may include locations such as being abroad or in another family members/friend’s residence.

Figure 5: Location of death of Wirral Suicide cases in 2016-18



Source: Merseyside Coroner records (data collected specifically for this audit)

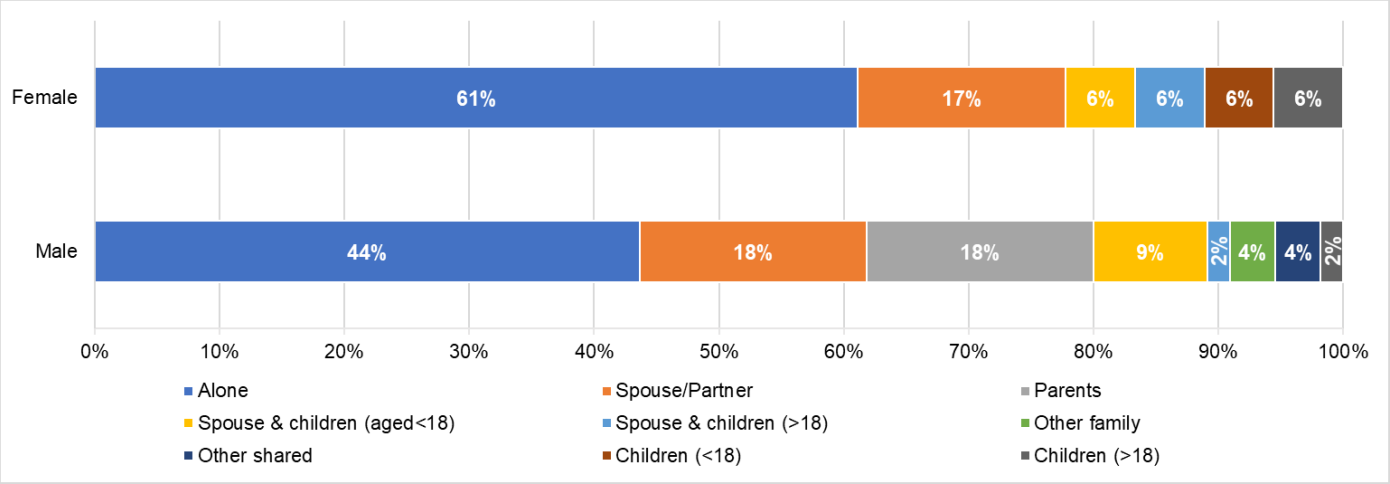
Place of birth

Place of birth may be a relevant factor for suicide because it can affect social support and mental health in general. People who are living far from their place of birth, may be more likely to lack a network of friends and family to whom they can turn in times of need. This is not just true for those born outside of the UK, but also of people born in other parts of the UK who are living far from friends and relatives. Almost three in four (72%) cases had Wirral as their place of birth. A further 13% of cases had either Chester/Cheshire or the Liverpool area as their place of birth, meaning that 15% (or almost 1 in 7) cases included in this audit were living some distance from where they were born.

Living Arrangements

Wirral data for 2016-18 appears to show that living alone was the most common living arrangement for both males and females included in this audit; this was particularly true for women. Both males and females were then next likely to live with a spouse/partner but males were also just as likely to live with their parents.

Figure 6: Living arrangements of Wirral suicide cases in 2016-18, by gender



Source: Merseyside Coroner records (data collected specifically for this audit)
Note: 9 cases overall had an unknown living situation. This is because the individuals living situation was not directly mentioned in the Coroner's report

Marital Status

Marital status is well evidenced as being related to the risk of suicide with marriage appearing to have a protective effect on individuals whereas divorced people have higher rates[9]. Table 1 shows the breakdown of suicide and related verdicts by both gender and marital status at the time of death.

Table 1: Marital status of Wirral cases of suicide and related verdicts in 2016-18, by gender

Marital Status	Male	Female	Persons
Single	57%	32%	51%
Married/Civil partnership	21%	16%	20%
Divorced	8%	21%	11%
Widowed	2%	21%	6%
Separated	11%	11%	11%
Not Known	2%	0%	1%

Source: Merseyside Coroner records (data collected specifically for this audit)

Single men accounted for the largest proportion of male suicide and related verdicts in Wirral between 2016-18 (57%). The pattern in women was less clear (mainly because numbers were much smaller), but just under one third (32%) were single, followed by equal proportions being divorced or widowed (21%). National data show that women who were divorced had higher suicide mortality rates than women who were married[9].

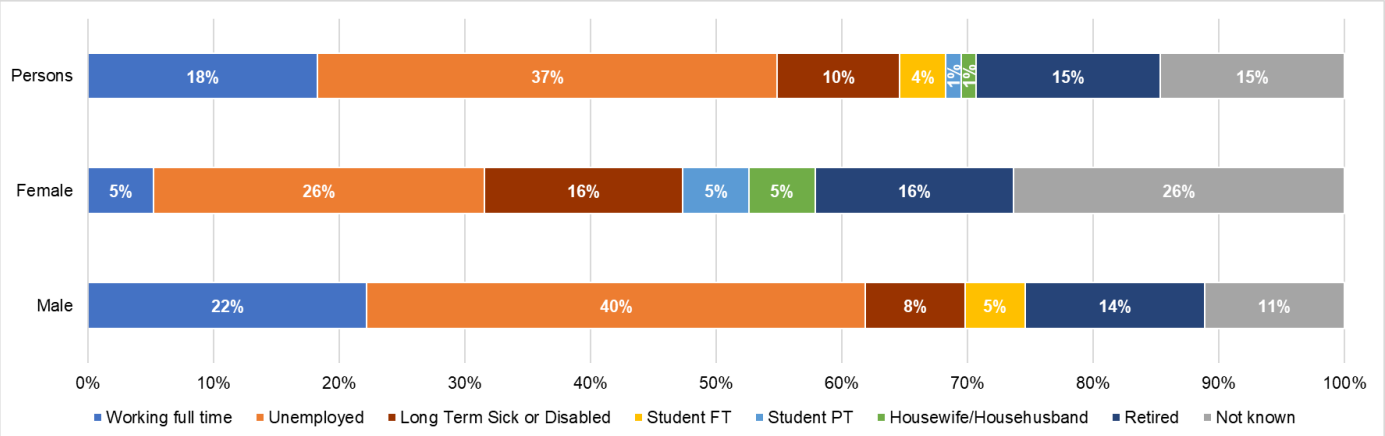
Sexuality

Data recording around sexuality is poor. It is only through anecdotal reports from family and/or friends that sexual preference is identified. Results have therefore been omitted from this audit based on limited recording and poor data (although this indicator is included on the regional Suicide Audit data collection template). This issue could perhaps be raised at various local and regional suicide forums. The RaRE Research Report (2015) has, however, estimated that young Lesbian, Gay, Bisexual & Trans (LGBT) people (those aged <26 years) are almost twice as likely to have attempted suicide at least once, compared to their heterosexual counterparts (34% versus 18%)[10].

Employment Status

Employment status is a well-evidenced risk factor for suicide, with unemployment and lower skilled roles usually associated with a higher risk of suicide[11]. The highest rates of suicide tend to be among workers with the lowest skilled jobs (for example, cleaners, low-skilled labourers), whereas the lowest rates of suicide were seen amongst those working in highly skilled occupations (for example, managers, chief executives, senior officials)[11]. It is important to note that it is not the actual occupation that puts individuals at risk, but features of that occupation such as low pay, job insecurity, lack of control over working environment and the wider socio-economic characteristics of individuals employed in a particular sector[12].

Figure 7: Suicide and related verdict cases for Wirral, 2016-18, by employment status and gender

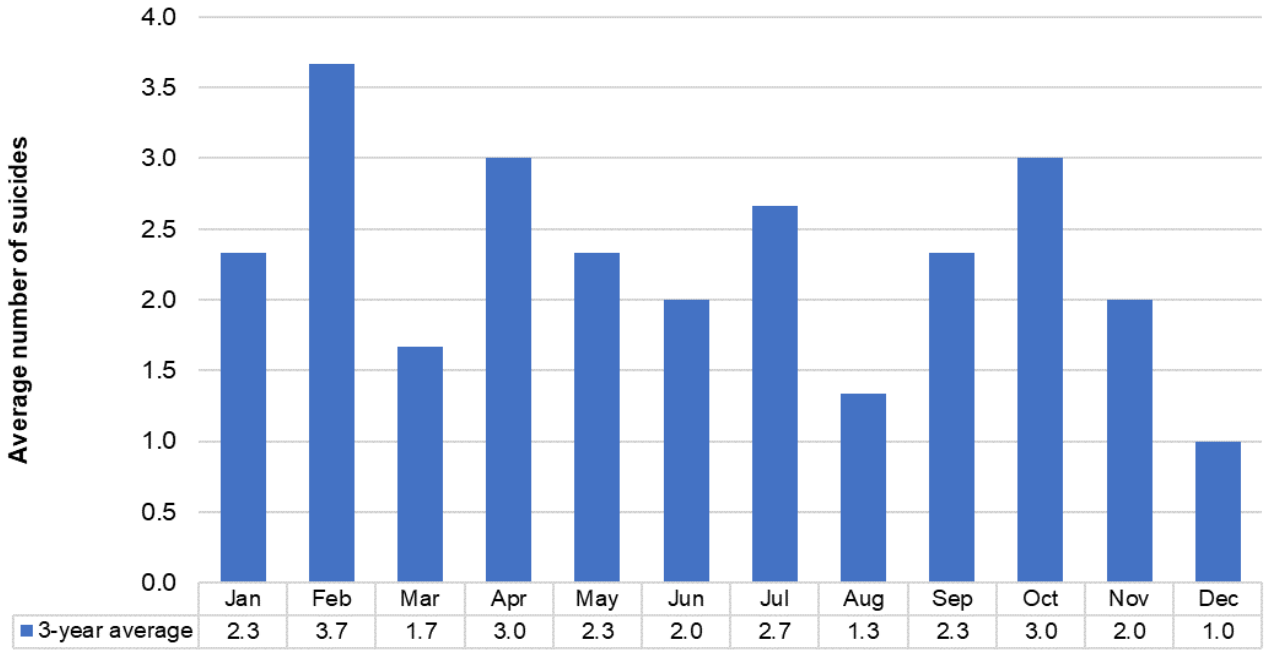


Source: Merseyside Coroner records (data collected specifically for this audit)
Note: Student FT refers to individuals who were full time students. Student PT refers to individuals who were part time students

The findings of an international study looking at World Health Organisation (WHO) data from 63 countries found unemployment elevated suicide risk[12]. Wirral data would seem to support this finding, as the employment status that made up the highest proportion both male and female suicide cases were unemployed, yet in Wirral overall, just 3.6% of the working age population are unemployed[13]. Only 5% of the female cases were in employment of any kind although, as previously stated, the small numbers of females included in this audit make for conclusions difficult to draw.

Seasonality / time of year

Figure 8: Wirral suicide audit deaths, by month of occurrence, 2016-18



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3-year average	2.3	3.7	1.7	3.0	2.3	2.0	2.7	1.3	2.3	3.0	2.0	1.0

Source: Merseyside Coroner records (data collected specifically for this audit). Date relates to when suicide occurred, not when case was examined by the Coroner (which can occasionally be some time later)

Figure 8 shows that contrary to popular expectation, December and Christmas/New Year do not mark a particular peak in suicides during the years covered by this audit. In fact, December shows the fewest average number of suicides in Wirral between 2016 and 2018. February, on the other hand, had the highest average number of suicides. Reasons for this are unclear and cannot be compared to national figures as suicide cases are not presented by month.

History of substance misuse

Substance misuse is a risk factor for suicide[14] and, as such, is recorded on the local suicide data collection template. Figures 9 and 10 show the proportion of Wirral cases, by gender, that either drug or alcohol misuse was recorded and noted by the Coroner between 2016 and 2018.

Figure 9: Proportion of suicides in which drug misuse was recorded, by male (left-hand side) and female (right-hand side), Wirral, 2016-18

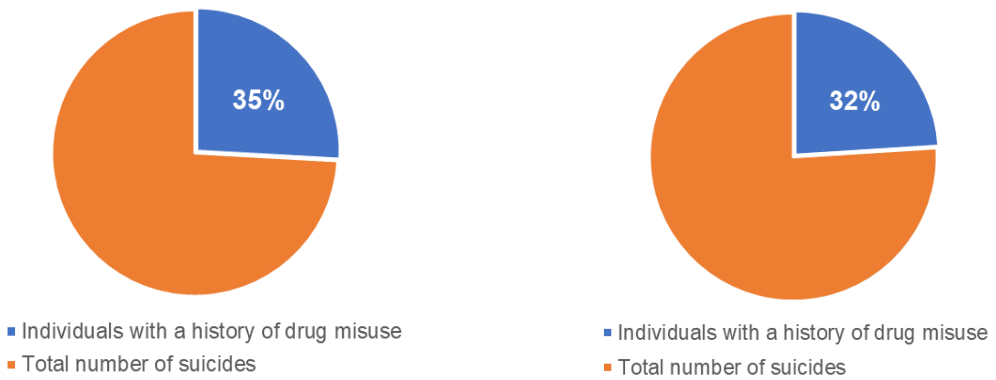


Figure 10: Proportion of suicides in which alcohol misuse was recorded, by male (left-hand side) and female (right-hand side), Wirral, 2016-18

Figures 9 and 10 show that there were an equal proportion of cases (35%) in which alcohol misuse was recorded for males as drug misuse cases. Similarly, there were an equal proportion of cases (32%) in which alcohol misuse was recorded for females as drug misuse cases. This does not mean, however, that every individual with a recorded history of substance misuse used *both* alcohol and drugs together. Many individuals only used one each.

As with all the issues noted in the Coroners records, reporting relies on accurate and/or up to date medical records, or relatives disclosing a full and frank history to the coroner. It is possible therefore, that the figures above for confirmed issues with drugs or alcohol may understate both issues. 14 of the 82 individuals (17%), however, were known to drug and alcohol services.

In over half of all cases (42 of 82 cases or 51%), individuals were noted as either having been a regular drinker of alcohol or that alcohol was present at the time of the post-mortem (detected from either blood or stomach contents). Similarly, cannabinoids (6%) and/or cocaine (16%) use were also recorded in suicide cases at post-mortem. Other non-prescribed drugs listed as a cause or contributory factor in death included methadone, amphetamines and fentanyl.

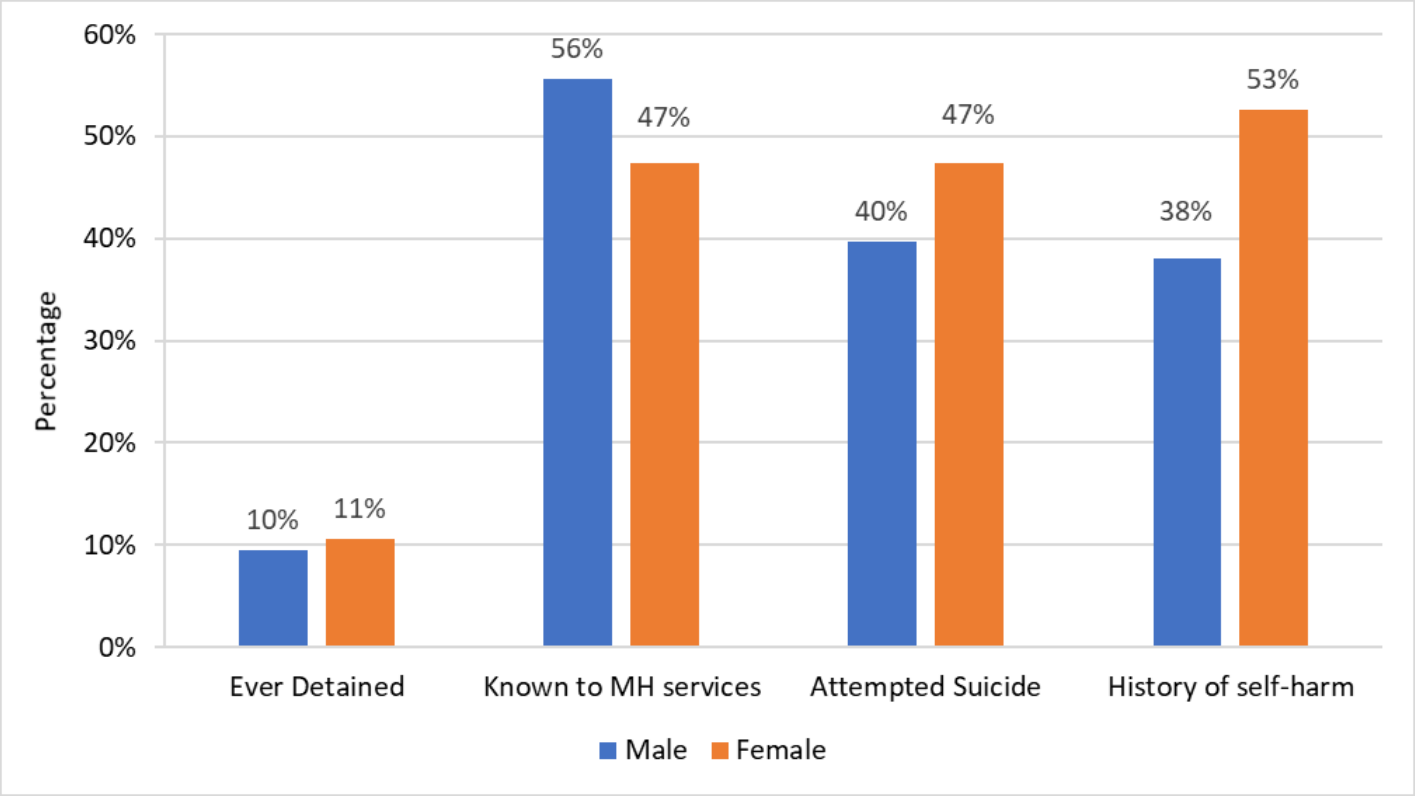
Prescribed medications

In 26 of 82 cases (or 32%), individuals had active prescriptions for mental health medications. Of these, mirtazapine (an anti-depressant) was the most commonly prescribed medication, followed by sertraline and citalopram (both anti-depressants). This figure may be lower than might be expected, given that over half of all cases were recorded as being known to mental health services.

History of mental health issues

As has been the case in previous Wirral audits, a large proportion of suicides were either currently or previously under the care of mental health services – around half in both males and females (56% and 47% respectively).

Figure 11: Proportion of individuals with a history of mental health related issues, 2016-18, by gender



Source: Merseyside Coroner records (data collected specifically for this audit)
Notes: 'Known to MH services' is every having been lifetime recipient of mental health services

As Figure 11 above also shows, almost one in ten of both females and males (11% and 10% respectively) had previously been detained under the Mental Health Act. It also shows that in Wirral between 2016-18, self-harm and previous suicide attempts were more prevalent in females than males. Self-harm is more common among young people than other age groups, particularly young women. In England, the proportion of young women who said they had self-harmed increased by 13% between 2000 and 2014[15].

Certain learning disabilities (such as Autistic Spectrum Disorders) are linked to a higher risk of suicide[16]. Between 2016 and 2018, just 2% of all cases had a record as having a learning difficulty. In these cases, the coroner report noted that the learning difficulties had increased the vulnerability of the deceased.

Other potential contributory factors

It is important to note that the information in this section, is not definitive but rather indicative from the contents of a suicide noted (if they existed) or disclosure from friends and relatives. True prevalence of these factors could be higher than Coroners are able to record.

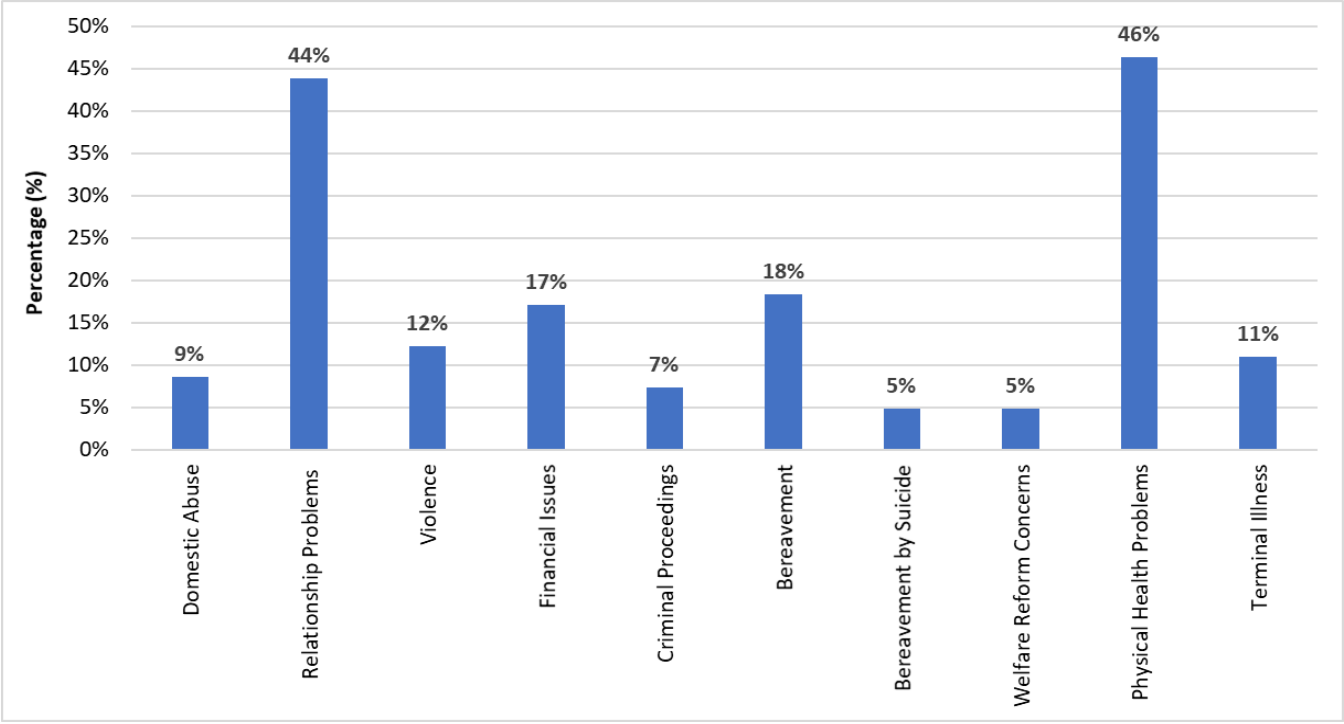
The most common factor (of those included on the Cheshire & Merseyside template) in Wirral suicide cases between 2016 and 2018 was physical health problems. This is not to suggest that these were the cause of the suicide, it is just notable that almost half (46%) had a physical health issue of some kind. In 11% of cases, the deceased person had some form of terminal illness.

Of those cases where physical health issues were noted, almost a quarter (24%) were related to excessive alcohol use or illicit drug use (e.g. alcoholic liver disease, fatty liver disease or COPD related to smoking crack or heroin).

Around 45% had relationship problems and around 1 in 5 individuals (21%) had suffered a bereavement which was noted in their records.

National figures, provided by ONS, show that male prisoners in England and Wales were 3.7 times more likely to die from suicide that men in the general population. Of these suicides, 93% were caused by hanging, strangling and suffocation. Over half of these suicides (51%) were aged between 25-39. It is important to note, however, that the increased risk of suicide may not be specifically caused by the prison environment alone, but may be influenced by the increased prevalence of substance misuse and mental health problems in the prison population[17]. In Wirral, just over 1% of cases had a history of being in prison or a youth offenders institute. In 7% of Wirral suicide cases, there were pending criminal proceedings noted in the records of the deceased.

Figure 11: Proportion of Wirral suicide cases where various potential contributory antecedents (known to be linked to suicide) were noted by the coroner



Source: Merseyside Coroner records (data collected specifically for this audit)

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Appendix

Coroners Verdicts

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, Inquest verdicts of Suicide (and Unlawful Killing) must be decided 'beyond reasonable doubt'. This is the reason that in some cases, what may appear to be an apparent suicide (e.g. a note which could be construed as a suicide note is present), is given an alternative verdict such as Narrative or Misadventure. The 'beyond reasonable doubt' requirement of a suicide verdict is that the deceased has acted in a *conscious* way; the presence of large concentrations of alcohol or drugs can therefore often mean a suicide verdict will not be assigned, because alcohol and drugs are well evidenced to affect the ability of individuals to make conscious choices.

'Short form' Inquest Verdicts

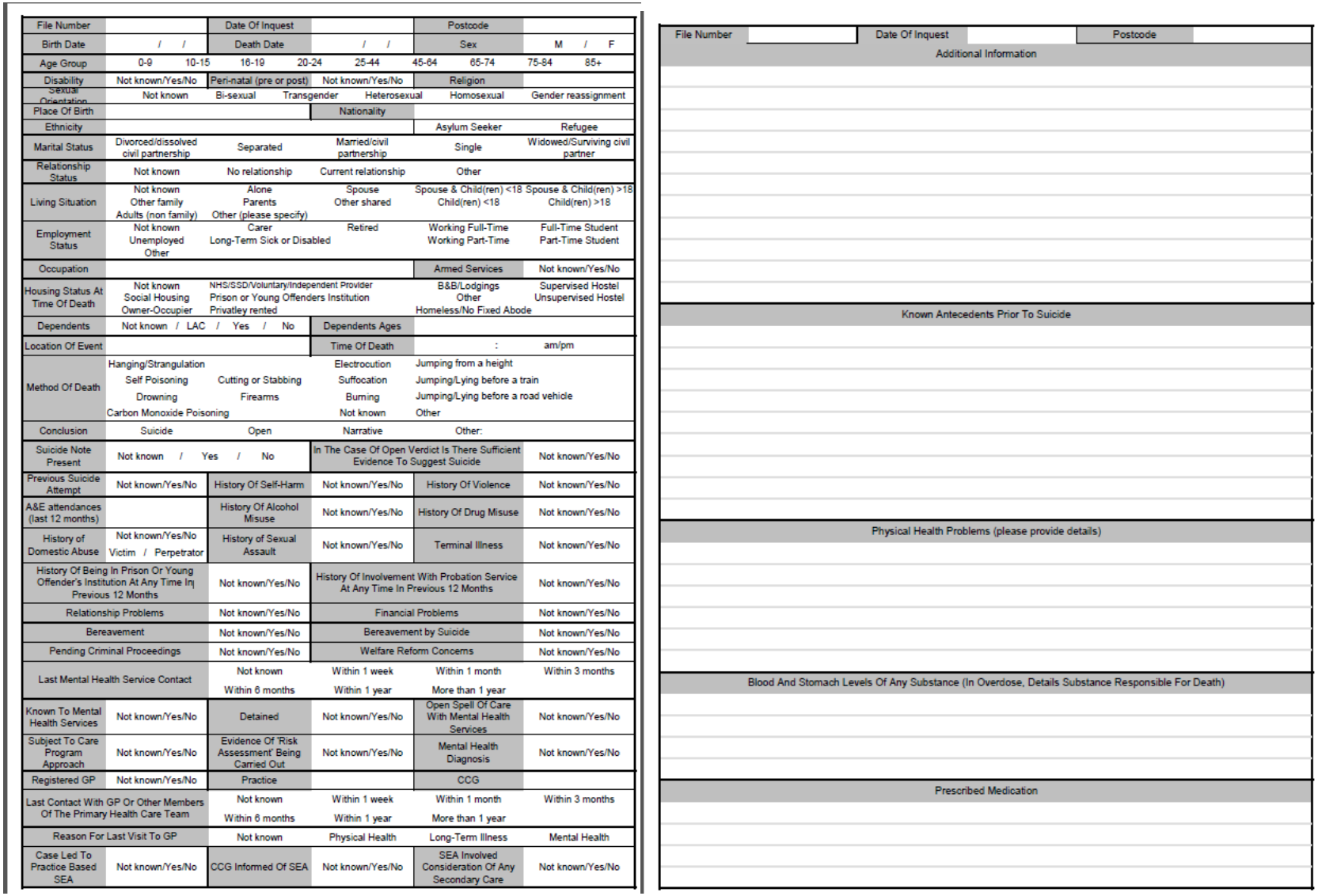
- **Suicide:** The Coroner has determined that the person has voluntarily acted to destroy his or her life in a conscious way
- **Misadventure:** Similar to Accidental Death, but implies that the deceased has taken a deliberate action that has then resulted in his or her death
- **Open verdict:** Used when there is not enough evidence to return a verdict. This is rare and generally only used as a verdict of 'last resort'

Narrative verdict

The above list is not exhaustive and the Coroner has no obligation to use short form verdicts. The Coroner can use a 'narrative verdict', which sets out the circumstances of the death in a detailed way based on the evidence that the Coroner has heard. For those attending an Inquest of a loved one, it can sometimes be more satisfying to hear the Coroner's verdict in this form, as more of a detailed conclusion of events leading to the death is provided.

Appendix

Figure xx: Cheshire & Merseyside Suicide Audit template, 2016-18



File Number		Date Of Inquest			Postcode		
Birth Date	/ /	Death Date		/ /	Sex	M / F	
Age Group	0-9	10-15	16-19	20-24	25-44	45-64	65-74	75-84	85+
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 reassignment	
Place Of Birth				Nationality			
Ethnicity					Asylum Seeker	Refugee	
Marital Status	Divorced/dissolved civil partnership	Separated		Married/civil partnership	Single	Widowed/Surviving civil partner	
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 & Child(ren) >18 Child(ren) >18	
Employment Status	Not known Unemployed Other	Carer Long-Term Sick or Disabled		Retired	Working Full-Time Working Part-Time	Full-Time Student Part-Time Student	
Occupation					Armed Services	Not known/Yes/No	
Housing Status At Time Of Death	Not known Social Housing Owner-Occupier	NHS/SSD/Voluntary/Independent Provider Prison or Young Offenders Institution Privatley rented			B&B/Lodgings Other Homeless/No Fixed Abode	Supervised Hostel Unsupervised Hostel	
Dependents	Not known / LAC / Yes / No			Dependents Ages			
Location Of Event				Time Of Death	:	am/pm	
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 vehicle 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 known/Yes/No	
Previous Suicide Attempt	Not known/Yes/No	History Of Self-Harm		Not known/Yes/No	History Of Violence	Not known/Yes/No	
A&E attendances (last 12 months)		History Of Alcohol Misuse		Not known/Yes/No	History Of Drug Misuse	Not known/Yes/No	
History of Domestic Abuse	Not known/Yes/No Victim / Perpetrator	History of Sexual Assault		Not known/Yes/No	Terminal Illness	Not known/Yes/No	
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 known/Yes/No	
Relationship Problems		Not known/Yes/No		Financial Problems		Not known/Yes/No	
Bereavement		Not known/Yes/No		Bereavement by Suicide		Not known/Yes/No	
Pending Criminal Proceedings		Not known/Yes/No		Welfare Reform Concerns		Not known/Yes/No	
Last Mental Health Service Contact		Not known Within 6 months		Within 1 week Within 1 year	Within 1 month More than 1 year	Within 3 months	
Known To Mental Health Services	Not known/Yes/No	Detained		Not known/Yes/No	Open Spell Of Care With Mental Health Services	Not known/Yes/No	
Subject To Care Program Approach	Not known/Yes/No	Evidence Of 'Risk Assessment' Being Carried Out		Not known/Yes/No	Mental Health Diagnosis	Not known/Yes/No	
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	Within 3 months	
Reason For Last Visit To GP		Not known		Physical Health	Long-Term Illness	Mental Health	
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 known/Yes/No	

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			

Contact details

For further details please contact:

- Jack Font – Apprentice Public Health Analyst – Wirral Intelligence Service at jackfont@wirral.gov.uk

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