Wirral Suicide Audit 2020-22

Public Health Intelligence Team

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WIRRAL

Wirral Suicide Audit 2020-22
Public Health Intelligence

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Key Findings

- There were **82 cases** included in this 2020-22 audit; 74 of which were assigned as suicide verdicts (95%); the remaining 4 cases (5%) were assigned other verdicts (e.g. open, narrative).
- Wirral had a slightly **higher suicide rate** than England overall (**13.0 per 100,000** in Wirral compared to **10.3 per 100,000** in England) in 2020-22 (according to ONS data, which includes only those cases classified as suicide).
- Men were over-represented in this audit; **77%** of cases were male and **23%** were female. This is consistent with the national male/female ratio (75:25).
- Average age at the time of death was **48 years**; the peak age group was **40-59 years**.
- The most common cause of death between 2020-22 in Wirral was hanging (**61%**), which, has historically been the most common method used (both locally and nationally).
- Ethnicity recording improved with only 9% of cases having no ethnicity noted. The split of cases between White British and those who are ethnically diverse is consistent with population proportions (around **92% and 8%** respectively).
- Of the 82 cases, **35%** involved people who were born outside of Wirral, with around **8%** born outside of the UK.
- Sexuality is still poorly recorded, despite LGBT young people having a significantly higher risk of suicide (and self-harm); **74%** of Wirral cases had no mention of sexuality.
- Being unemployed due to being long term sick or disabled and unemployed (when considered together) was the most common employment situation of cases in Wirral.
- Over half of cases were recorded as being known to mental health services (**60%**); around **1 in 7 (or 15%)** had previously been detained under the Mental Health Act.
- Females were more likely to have previously attempted suicide than males (**60%** versus **40%** of males) and have recorded instances of self-harm than males (**65%** versus **40%** of males).

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 2020, 2021 and 2022). 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 the need to collect complex evidence relating to some cases).

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.

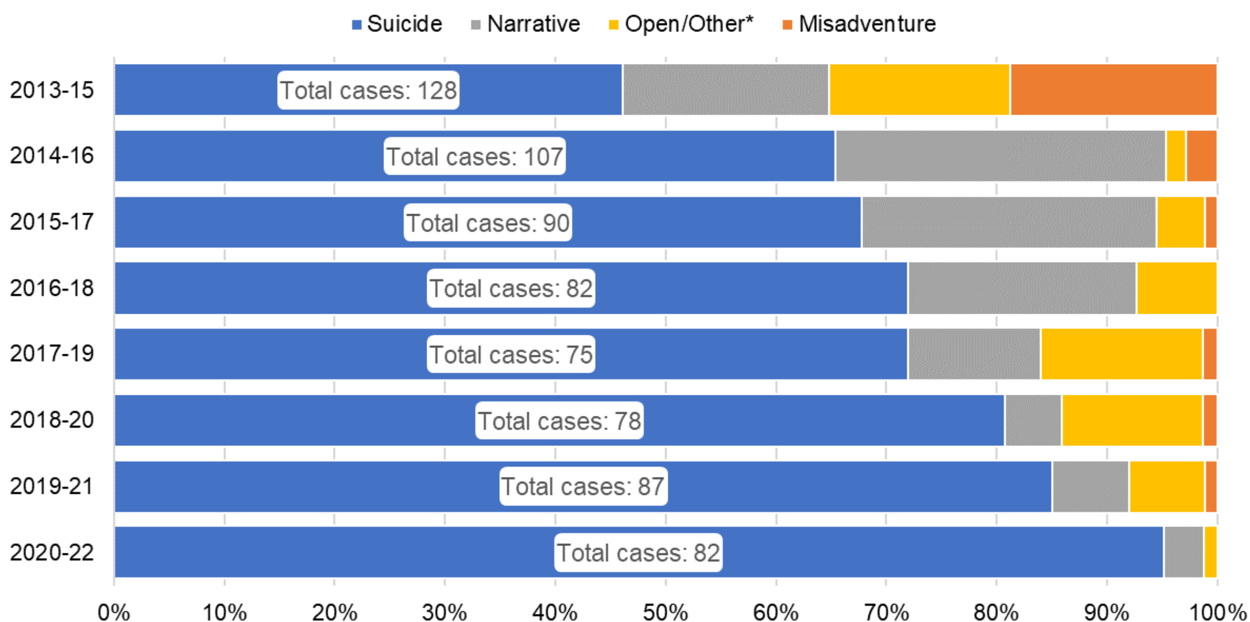
Wirral uses a standardised Cheshire and Merseyside Suicide Audit Template when collecting the data for this audit (see Appendix One). Unless otherwise indicated, all data used in this report is sourced from this template completed using the Merseyside Coroner records. It should be noted that this template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

Cases

Verdicts

Unlike ONS suicide statistics, which are restricted to cases assigned as suicide, this audit considers cases of potential or possible suicide where there appears to have been intent on behalf of the deceased person to end their life. Since 2018, Coroners assign suicide verdicts in cases where suicidal intention is a ‘reasonable probability’, however, sometimes cases that appear to be suicide, may still be assigned other verdicts if the coroner cannot be certain of intention. It is for this reason that other verdicts as categorised before 2018, such as open, misadventure, accidental death, drug related death and narrative are sometimes included in this audit – see Appendix Two for more details on the evidence threshold changes of 2018.

Figure 1: Cases by assigned verdicts (% and total) 2013-15 to 2020-22



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 significant change in categorisation from 2013 onwards. In 2013-15, just under half (46%) of cases were classified as suicide; by 2019-21 however, 95% of cases were assigned as suicide.

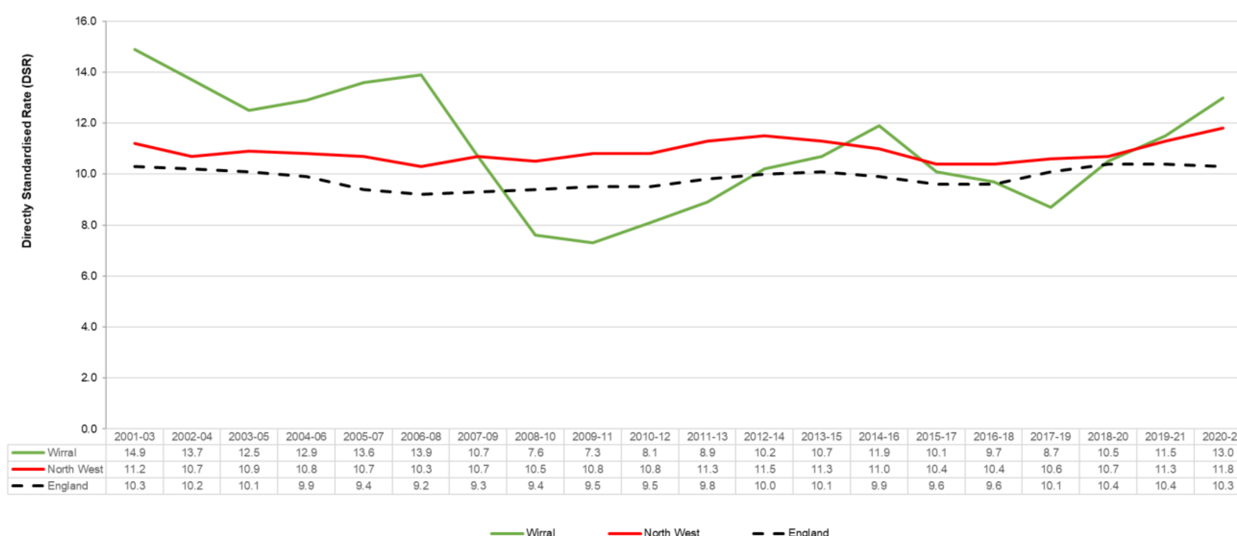
Possible contributory factors to this change may be improvements and standardisation in the recording of information enabling a more concise verdict to be reached; the change in jurisdiction (to the Liverpool Coroner); less stigmatising attitudes towards mental health and suicide and the change in 2018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

Trend in suicide rates

Figure 2 shows the trend in suicide rates locally, regionally, and nationally using ONS data[2]. 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.

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 static, with only slight changes to the regional (increase) and national (decrease) rates for the latest period (2020-22). Over the same period, Wirral (13.0 per 100,000) has shown an increase and remains higher than England and the North West.

Figure 2: Trend in suicide rate in Wirral, North West and England, 2001-03 to 2020-22



	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
Wirral	14.9	13.7	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	8.7	10.5	11.5	13.0
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	11.0	10.4	10.4	10.6	10.7	11.3	11.8
England	10.3	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	10.1	10.4	10.4	10.3

Source: Public Health Outcomes Framework, OHID (2022)
Note: 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

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].

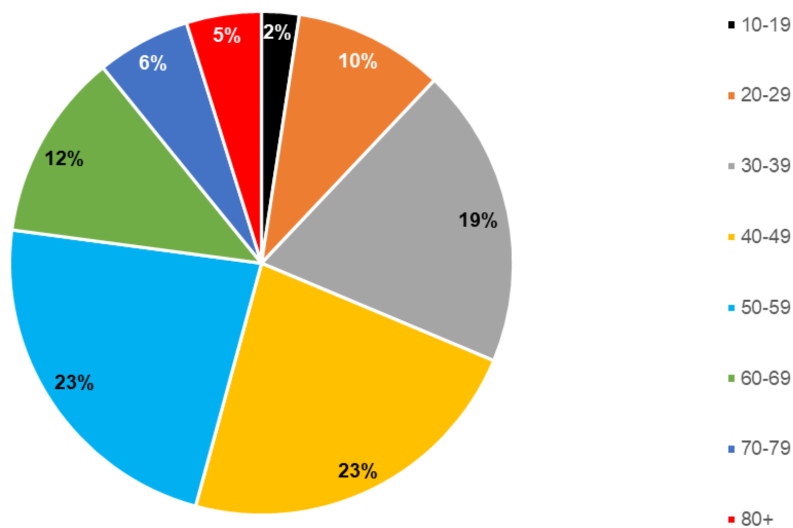
Despite men being more likely than women to take their own life, the most recent UK Adult Psychiatric Morbidity Survey reported that women were more likely to make a suicide attempt (5.4% of men, compared with 8.0% of women[3]). For more information about suicide attempts please see the 'History of mental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

Nationally, 75% of suicide cases were by males with females accounting for 25% of cases – this has been the trend in previous years. For 2020-22 the proportion of suicides in Wirral were split 77% male to 23% female, which is in line with the national ratio.

Age

Another key factor in suicide is age. Nationally, people aged between 40-59 years were most likely to take their own life (40% of all suicide cases)[2]. In Wirral in 2020-22, those aged 40-59 comprised 46% of all suicide cases. Nationally the largest proportion of suicides, in a single 10-year age band, was seen in those aged 50-59 years (20%), whereas in Wirral both cohorts, 40-49 years and 50-59 years, comprised 23% of suicides – see **Figure 3**.

Figure 3: Age breakdown of Wirral suicide cases in 2020-22 (proportions)



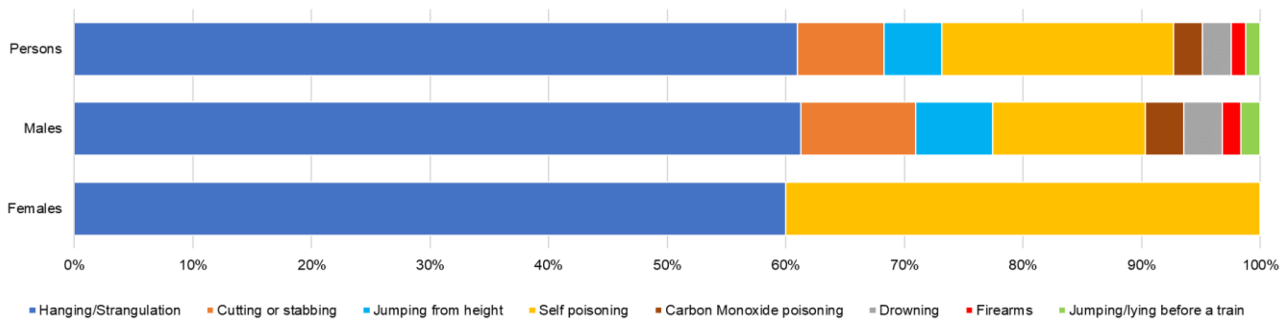
Females saw the highest number of suicide cases within the 40-49 age group, while in males it was those aged 50-59 years: 30% and 24% respectively. The average age of suicide cases in this audit was 48 years.

Method

The most common suicide method for both males and females in Wirral between 2020-22 was hanging/strangulation (61% of all cases). Self-poisoning was the second most common method for all genders, and this was true in both Wirral and nationally.

Males in Wirral appear to have used a greater variety of methods than females over the period shown (true in previous time periods also), 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, 2020-22



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

The 2020-22 audit shows that 8% of suicide cases were ethnically diverse with the majority of individuals in these cases being categorised as White Other (i.e. White people born outside of the UK). This mimics 8%[5] of Wirral's population being ethnically diverse, with the largest ethnicity within this being White Other.

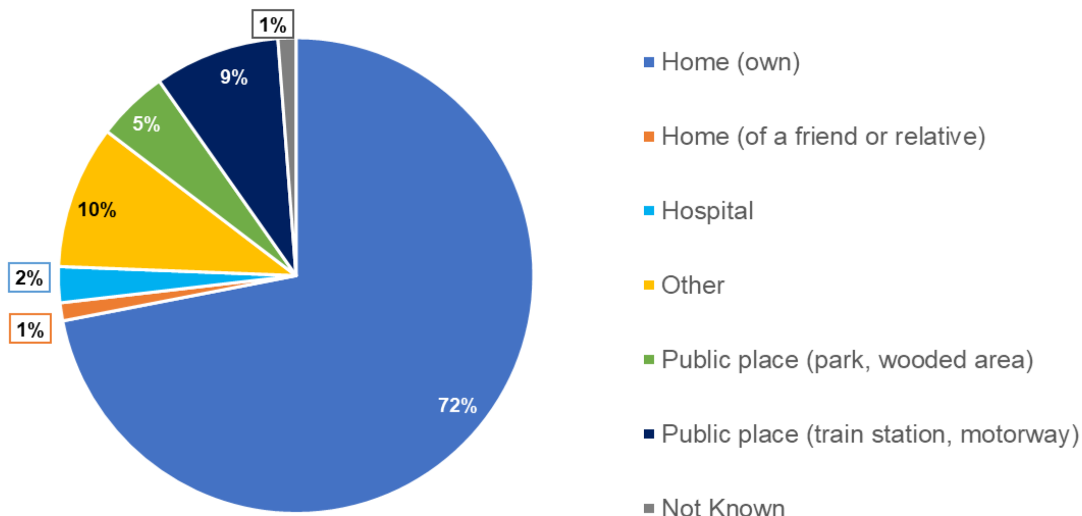
The recording of ethnicity data within Coroner records continues to improve, with only 9% of cases being of an unknown ethnicity compared to 12% in the Suicide Audit 2019-21[4].

Location of event

As **Figure 5** shows, for period 2020-22, the most likely place people took their own life was in or around their own home and this was reflected in close to three in every four cases (or 72%). This is a consistent trend over many years in Wirral but has increased slightly from previous periods[6].

Places such as wooded public places, railway stations/ motorways and hospitals or other care settings make up some of the remaining locations. "Other" may include locations such as being abroad, in a hotel or where records have not been clear about the specific location.

Figure 5: Location of death of Wirral Suicide cases in 2020-22



Note: Cases with 'hospital' as their 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 a relevant factor for suicide as living away from your birthplace can mean moving away from family and friends. This could impact social support, feelings of isolation and therefore impede mental health and wellbeing in general, all of which can increase the risk of suicide[6]. 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 two-thirds of cases (65%) had Wirral as their place of birth – see **Table 1**. A further 16% of cases had the Cheshire or Merseyside area as their place of birth, meaning that 19% of (or just under one in five) cases included in this audit were living some distance from where they were born.

Table 1: Place of birth of Wirral suicide cases in 2020-22 number and proportion

Place of birth	Number	%
Wirral	54	65%
Cheshire & Merseyside (excl. Wirral)	12	16%
Rest of UK	9	11%
Europe	<5	5%
Rest of world	<5	<5%
Unknown	<5	<5%
Total	**82**	**100%**

Living Arrangements

Wirral suicide cases during 2020-22 show that living alone was the most common living arrangement; this is true for both females and males – see **Table 2**).

Females were then next likely to live with a spouse/partner, whereas males were next likely to live with their parents (excluding cases were living arrangements were unknown). Female cases included in this audit appear more likely than males to live with dependents under 18 years old.

Table 2: Living arrangements (%), by gender, Wirral, 2020-22

Living situation	Female	Male	Persons
Alone	30.0%	38.7%	36.6%
Spouse/partner	40.0%	9.7%	17.1%
Parents	0.0%	12.9%	9.8%
Other family	5.0%	4.8%	4.9%
Other adults (non family)	0.0%	4.8%	3.7%
Spouse & children (aged<18)	0.0%	4.8%	3.7%
Children (<18)	10.0%	1.6%	3.7%
Spouse & children (>18)	5.0%	0.0%	1.2%
Children (>18)	5.0%	0.0%	1.2%
Other shared	0.0%	1.6%	1.2%
Unknown	5.0%	21.0%	17.1%

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

Sexuality

The LGBT in Britain – Health Report[7] found that over half of Lesbian, Gay, Bisexual & Trans (LGBT) people said they'd experienced depression in the previous year, with one in eight reporting that they had attempted to take their own life during this period. It should be noted that this sexual orientation does not cause the increased risk but rather experiences such as homophobia, discrimination and social isolation impacting mental wellbeing.

Data recording around sexuality remains poor, this is mainly due to information only being ascertained via anecdotal reports from family and/or friends. Detailed results have therefore been omitted from this audit based on 74% of cases for 2020-22 having no reference to sexual orientation. It should be noted that this indicator is included on the regional audit template – see Appendix 1).

Marital Status

Marital status can have both an adverse and positive impact in terms an individual attempting suicide. In that separation/divorce can have a negative effect compared to marriage, which can have a protective effect[8]. **Table 3** shows the breakdown of suicide and related verdicts by both gender and marital status at the time of death.

Table 3: Marital status of Wirral cases of suicide and related verdicts in 2020-22, by gender

Marital Status	Female	Male	Persons
Co-Habiting	5%	0%	<5%
Married/Civil Partnership	25%	21%	22%
Not known	0%	5%	<5%
Separated/divorced	20%	24%	23%
Single	45%	45%	45%
Widowed	5%	5%	5%
Total	**100%**	**100%**	**100%**

Note: Figures may not sum due to rounding

Males and females who were single accounted for the largest proportion of suicide and related verdicts in Wirral between 2020-22 (45%). The next most common status was to be separated or divorced, again this was true of both males and females (23% of cases overall), closely followed by Married/Civil Partnership (22% of cases overall).

Employment Status

Employment status is an evidenced risk factor for suicide, with unemployment and lower skilled roles usually associated with a higher risk of suicide[9,10].

In Wirral, between 2-3% of the working age population are unemployed (as at May 2024[6]), however, 20% of suicide cases in 2020-22 were recorded as being unemployed individuals. Data shows that this was not the most common employment status in suicide cases for 2020-22 as **Table 4** shows. Both female and male cases were most likely to be working (20% and 27% respectively and 26% overall).

It should be noted, however, that around 44% of cases were not working for various reasons, including retirement and long-term sickness/disability. Looking at grouped cohort emphasises that proportionately, the risk of suicide is much higher for those who are now working.

Table 4: Cases in Wirral, by employment status and gender, 2020-22

Employment Status	Females	Males	Persons
Homemaker	5.0%	0.0%	1.2%
Long Term Sick or Disabled	5.0%	6.5%	6.1%
Not known	40.0%	22.6%	26.8%
Retired	15.0%	17.7%	17.1%
Self-employed	0.0%	1.6%	1.2%
Unemployed	15.0%	21.0%	19.5%
Working full time	20.0%	27.4%	25.6%
Working part time	0.0%	3.2%	2.4%

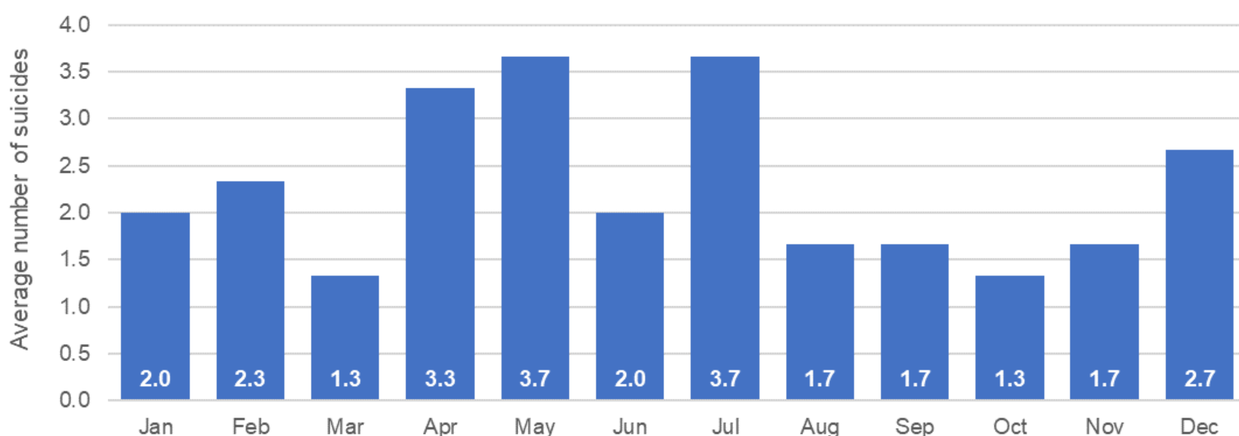
Note: Student FT refers to individuals who were full time students. Student PT refers to individuals who were part time students.

Between 2020-22 in England, the highest number of suicides in males tended to be among routine & manual jobs (for example, electricians, construction workers or goods drivers). For females, the most common occupation sector recorded was in the care sector (care workers, nurses or other health professionals) for the same period[9]. It is important to note that it is not the actual occupation that puts individuals at risk, but features of that occupation such as lone working, job insecurity or lack of control over working environment. However, the period 2020-22 encompasses the COVID-19 pandemic and subsequent restrictions, which may have further impacted the aforementioned employment sectors in different ways; namely increased pressure of being key workers, especially in the care sector, or by being unable to work during the peak of the pandemic, for example construction work was halted in the initial lockdown in Spring 2020. It should also be note that differences in numbers of deaths may merely reflect the underlying population structure as opposed to differences in risk.

Seasonality / time of year

Figure 6 shows that March and October had the lowest average number of suicide cases between 2020-22. The months of May and July had the highest average number at 3.7 cases per month.

Figure 6: Average number of Wirral suicide audit cases, by month of occurrence, 2020-22

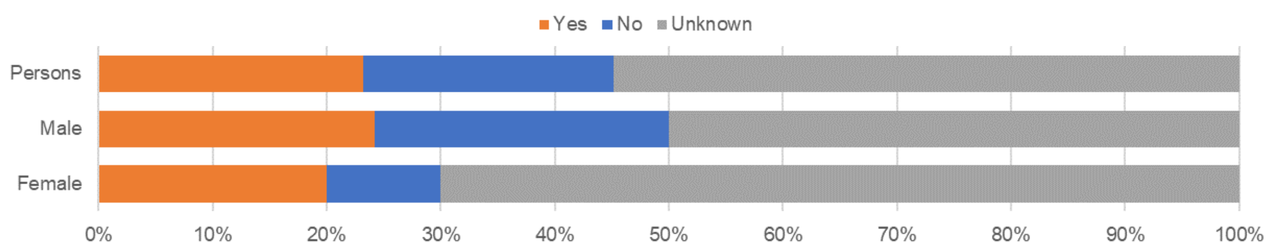


Note: Date relates to when the death occurred, not the date of the coroner concluded the case

History of drug misuse

Drug misuse is a risk factor for suicide[14] and, as such, is recorded on the local suicide data collection template. **Figure 7** shows the proportion of Wirral cases, by gender, where drug misuse (illicit or prescribed) was recorded in the case records. As **Figure 7** shows, just over one in three cases included in this audit, had a history of drug misuse noted in the case records. It should be noted however, that there are a large proportion of unknowns (around 55% of cases), so this may be an under-representation of the true picture.

Figure 7: Suicides (%) where prior drug misuse was recorded, by gender, Wirral, 2020-22

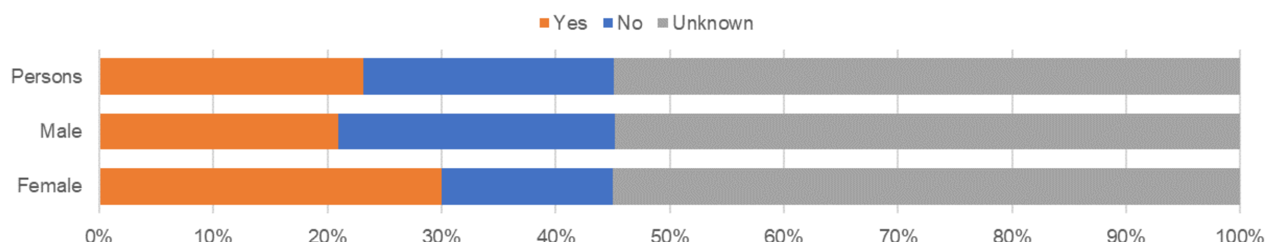


The most common illicit or non-prescribed drugs detected at post-mortem were cannabis (15%) and cocaine (11% of cases). There were also a number of prescription drugs detected, such as sertraline, diazepam and morphine – these were not always prescribed to the deceased.

History of alcohol misuse

Figure 8 shows that similarly to drug misuse, there appears to be around one in three cases included in this audit who have a noted history of alcohol misuse, with little difference between males and females.

Figure 8: Suicides (%) where prior alcohol misuse was recorded, by gender, Wirral, 2020-22

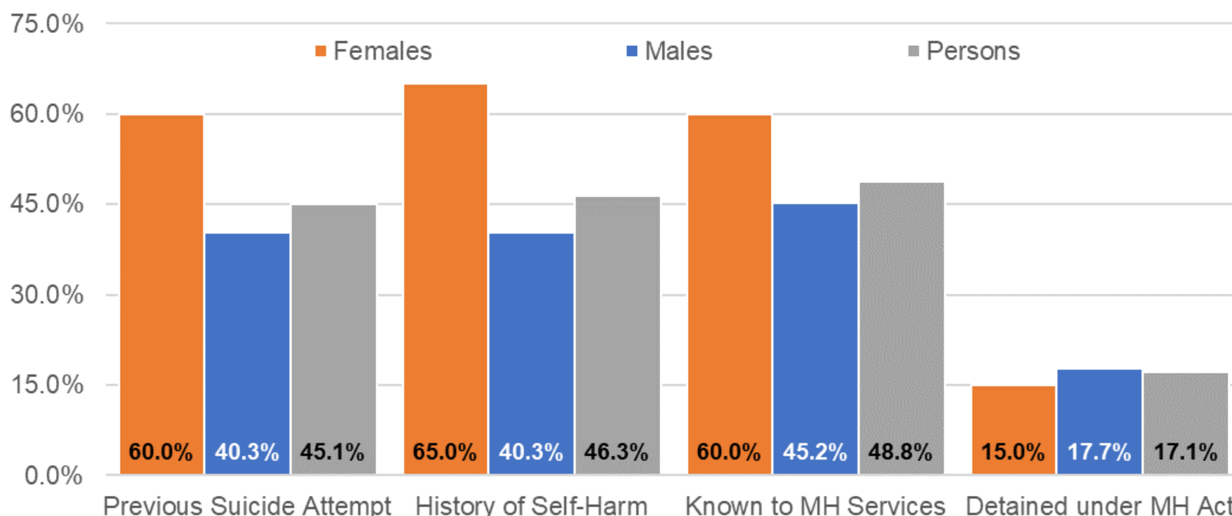


As with all issues noted in the coroners records, reporting relies on accurate and/or up to date medical records, or relatives disclosing a full and frank history to the coroner. It is possible therefore, that the figures above for confirmed issues with drugs or alcohol may understate both issues. In over a third of cases (31 of 82 cases or 38%), individuals had ethanol present at the time of the post-mortem (detected from either blood or stomach contents). However, this is not always indicative that the deceased had recently consumed alcohol, as ethanol is naturally produced by the body after death.

History of mental health issues

As has been the case in previous Wirral audits[4], a large proportion of suicides were either currently or previously known to mental health services – just under half of males and just under two-thirds of females (45% and 60% respectively).

Figure 9: Individuals (%) with a history of mental health related issues, by gender, 2020-22



Notes: 'Known to MH services' is ever having a recorded instance of contact with mental health services.

As **Figure 9** above also shows that around than one in six (17%) of both females and males (15% and 18% respectively) had previously been detained under the Mental Health Act[11]. It also shows that in Wirral between 2020-22, 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 2022/23, the rate of emergency admissions related to intentional self-harm was significantly higher for females compared to males, for both Wirral and England[12].

Prescribed medications

For the 82 cases, there were 104 drugs prescribed for mental health reasons; this does not mean that each individual was prescribed mental health medication. The three most prescribed medications were, in fact, for mental health; Sertraline (16), Mirtazapine (16) and Diazepam (11). The fourth most commonly prescribed medication was Zopiclone (10), which is used to treat insomnia; disturbed sleep can cause/increase feelings of anxiety, depression, isolation and irritation as well as causing episodes psychosis, mania and/or paranoia[13].

Other potential contributory factors

As with all the issues and history detailed in these audits, 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 in 2020-22 were physical health problems – see **Figure 10**. This is not to suggest that these were the cause of the suicide, rather than 38% had at least one physical

health issue of some kind. In over 12% of cases, the individual had a chronic or terminal illness.

One in five cases had relationship problems recorded with a similar proportion recording a history of domestic abuse; this can relate to both victims and perpetrators.

Table 5: Cases (%) where various potential contributory antecedents recorded, 2020-22

Potential Risk Factor	%
Physical Health Problems	37.8%
Relationship problems	20.7%
History of Domestic Abuse	17.1%
Bereavement	15.9%
Chronic/Terminal Illness	12.2%
Pending Criminal Proceedings	9.8%
Financial problems	8.5%
History of Violence	7.3%
History of Sexual Assault	6.1%
Welfare Reform Concerns	3.7%
History of Prison or YOI (prev 12 months)	1.2%

References

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8. Trends in suicide by marital status in England and Wales, 2002–2015
9. Suicide by occupation, England: 2020 to 2022, Office for National Statistics
10. Mathieu S, Treloar A, Hawgood J, Ross V, Kõlves K. The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviors and Interventions to Mitigate Their Impact: A Review, Front Public Health. 2022
11. Mental Health Act, nhs.uk, 2022
12. Emergency Hospital Admissions for Intentional Self-Harm, 2010-2023, Office for Health Inequality and Disparity, 2024
13. How to cope with sleep problems, MIND, 2020

Appendix

Appendix One

Cheshire & Merseyside Suicide Audit template

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					

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 below). 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 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.

Contact details

For further details please contact us at: phintelligence@wirral.gov.uk

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