Tameside Suicide Audit 2023

Executive Summary

PLEASE NOTE, THIS REPORT CONTAINS IN-DEPTH DISCUSSION OF MANY TOPICS RELATING TO SUICIDE INCLUDING THE CIRCUMSTANCES OF AND AROUND THE DEATHS OF THOSE WHO HAVE TAKEN THEIR OWN LIVES. SOME CONTENT IN THIS DOCUMENT MAY SIGNIFICANTLY AFFECT YOU. PLEASE CONSIDER THIS BEFORE DECIDING TO READ FURTHER.

With thanks to Coroner Munch and the officers of the South Manchester Coroner's Court for their support and assistance in the data-collection process, and to Benjamin Jackson and Evangelie Dunn for their contribution to the data collection process.

1. Introduction

1.1 Context

Every suicide represents the end of someone's life, and the loss, grief, distress, lasting trauma and life challenges experienced by people and communities affected by suicide. This audit aims to support Tameside commissioners, services and providers to better respond to and prevent suicide.

When considering these findings, it is important to note that the lives and deaths reviewed in this audit are those that ended in suicide. Many more people are supported well within our communities. The role of this audit is to review deaths by suicide and understand what led to those deaths.

1.2 What is a suicide Audit?

A Suicide Audit is defined as "*the systematic collection of local data on suicides in order to learn lessons and inform suicide prevention plans*" (Owens et al, 2014). While Local Authorities are not required to conduct suicide audits, audits are advised and are considered a valuable tool in understanding, responding to and preventing suicide. The completion of a Suicide Audit was also a key aim of the Tameside and Glossop Suicide Prevention Strategy 2019-2023.

The last Suicide Audit for Tameside was conducted in 2017 covering the years 2013-2016. That Audit reviewed mortality data alone; whereas this report considers mortality data alongside an in-depth review of inquest reports. As such, this report contains more detail than was available for the previous audit.

1.4 Data sources

In-depth reviews were conducted at the South Manchester Coroner's Office of 34 inquest reports: six were from 2019, seven from 2020, 18 from 2021 and three from 2022. The inquest report reviews provide a more in-depth analysis.

A further 94 records were coroner mortality data, which provides a broader data-set, such as age, gender, deprivation, employment status and event details, over a longer period of time.

Academic papers and national reports such as those from the Office for National Statistics (ONS) and the National Confidential Inquiry into Safety in Mental Health (NCISH) have also been used within this audit.

1.5 Data limitations

The number of suicides in Tameside is low in statistical terms, which means that only inferences can be made, rather than robust conclusions.

Different definitions of suicide are also used. ONS uses the descriptor, "all deaths from intentional self-harm for persons aged 10 years and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over." (Office for National Statistics, 2022). Whereas Coroners only conclude a death was suicide 'based on the balance of probabilities', with intent often being a deciding factor in a conclusion of suicide over a narrative or open verdict. This may mean that fewer deaths are categorised by the coroner as suicide compared to ONS data.

2. Event details

2.1 Time of death

This information was only found in 28 of the 34 inquest reports reviewed.

Nearly half of deaths occurred during the afternoon (noon to 6pm), and almost a third happened between during the morning (6am and noon). Therefore, over three-quarters (78.5%) of suicides that had a time of death recorded, happened during the day (6am to 6pm), compared to 21.4% overnight (6pm and 6am).

Factors associated with the timeframe of event included the house being empty (where the individual did not live alone), waking hours and items having been bought for the method of death.

2.2 Month and season of death

While there is considerable variation from year to year, January most often saw the highest proportion of monthly suicides, followed by June, then May and July, with October having the lowest number of suicides.

When grouping months into seasons[1], summer has a marginally higher number of suicides (29.7%), winter and spring a similar proportion (27.3%) and autumn considerably lower (15.6%).

2.3 Residence of people that died

There is notable variation in the number of suicides in MSOAs (Middle Super Output Areas[2]) year by year, with some areas not having anyone, or very few residents, being lost to suicide. There appears to be some consistency in the areas where there are fewer suicides and some consistency in the areas where there are more suicides.

- No resident of Godley was shown to have died by suicide in the review period and only 0.2% of all suicides analysed (2016-2021) were amongst people that lived in Carrbrook & Mickelhurst, Dane Bank and Dukinfield & Hough Hill.
- Eight people died by suicide from Mossley and Ashton Central.

2.4 Site of suicide

Most suicides (84%) occurred within the person's home/residence compared to 16% occurring elsewhere.

2.5 Method

Across all years reviewed, hanging accounted for most suicides (62.5%), and almost all hangings took place within the individual's home or where they were staying at the time, i.e. the home of a friend or family member. The prevalence of hanging as a method for suicide is in-line with national findings from both NCISH and the ONS.

Self-poisoning is the next most common method, accounting for just under 20% of all suicides during the review period, including deaths by overdose of illicit and prescription medication. There is likely an under-representation of suicides by self-poisoning as coroners only determine a death to be suicide when an intent to die is present. Those who die by illicit drugs may be more likely to have their inquest come to a 'drug related death' conclusion.

[1] December to February as winter, March to May as spring, June to August as summer and September to November as autumn.
[2] MSOAs are relatively small, nationally defined geographical areas of similar population sizes which together form local authorities.

Other methods accounted for less than 4% each, such as people that have died via motorway bridges and railways.

Males are marginally more likely than females to die by ‘Hanging/Strangulation’ and ‘Cutting or Stabbing’. This follows established data which indicates males are more likely to choose more violent means than females. Females are marginally more likely than males to die by ‘Self Poisoning’.

2.6 Intent

In Tameside, just over half (55.2% of people) left a note, text or email indicating that their death was an intentional act. Almost a third (32.4%) had made or were reported to have made known their intention to take their own lives, or thoughts of suicide. Over one third (38.2%) had made previous attempts on their lives. It is likely that the number of previous attempts is under-reported as this relies upon a professional or family member reporting the attempt.

2.7 Self-harm

From the review of inquests, there was evidence that 18% had a history of self-harm. However, this may be an under-reporting as there was limited information regarding any history of self-harm. Self-harm may not have been disclosed or have resulted in medical treatment.

3. Demographics

3.1 Sex

In Tameside, 74% of suicides represented in the full dataset were male and 26% female, which matches the rates for 2021 in England and Wales (ONS, 2023).

Although the 2021 census recorded 0.5% of people recording their gender as different to that on their birth certificate, there was no indication that any of the suicides reviewed within this audit were transgender or identified as non-binary, although this data may not have been collected at inquest.

3.2 Age

Certain age groups are more likely to die by suicide in Tameside than others: the 45–54 years age group experienced the highest number of suicides (31.3%), although the 35 to 49 years and 50 to 60 years age groups also have the highest number of people living in Tameside.

The age groups 25-34, 35-49 and 50-64 years have similar proportions of deaths by suicide: 18-22%. There are very few deaths from suicide amongst people aged under 18 and over 84 years: around 2% each.

The average age of people that have died by suicide was 47, with the most common age being 48.

3.3 Ethnicity

Ethnicity data was only available for half (17) of the inquest review dataset and was not available within the mortality dataset. From the available data, 82% were White British, 6% were of ‘Any other White background’, 6% were of Indian and 6% were of Pakistani ethnicity. However, due to the small numbers involved, it is not possible to draw conclusions from the ethnicity data.

3.4 Sexuality

Less than 6% of cases from 2019 -2021 were identified as gay, however, the in most of the inquest or mortality record cases, sexuality was not recorded or addressed. It is therefore not possible to

draw conclusions regarding suicide amongst the Lesbian, Gay, Bisexual or Pansexual community in Tameside.

3.5 Parental status

Of the 34 people whose inquest reports were reviewed, 29.4% of those who died by suicide were parents. This included 11.8% who were living with their children, 8.8% whose children lived with a family member and 8.8% who had adult children. It is important to note that bereavement by suicide, particularly for young children, increases the risk of dying by suicide in the future.

The parental status of those who died by suicide was only available within the inquest files when specifically referenced and was not available within the mortality data. It is therefore likely that the data reflects an underreporting of parents who died by suicide.

3.6 Employment status

Employment status is associated with a range of factors which are known to impact emotional wellbeing and mental health. The loss of income and resulting financial pressures can impact other social factors such as housing and family cohesion, and the lack of employment can impact a person's feeling of purpose and level of regular social interaction.

From the inquest reports, it can be determined that people in some form of active employment or education accounted for 46.6% of local suicides. Those known to not have been in active employment or education 46.7%, which is higher than the general population, suggesting that the absence of active employment of education increasing the risk of suicide. This aligns with national and international findings regarding unemployment/workforce inactivity and suicide risk.

Transportation & Distribution, Trades and Manufacturing account for 58% of the employment type of Tameside residents who lost their lives to suicide between 2016 and 2021, with Management & Clerical being the next largest occupation represented (24%). Evidence indicates that there is a higher risk for people with manual occupations (ONS, 2021[3]).

3.7 Neurodiversity

There was no indication of any confirmed or diagnosed neurodiversity, or any clear indication of neurodiversity in the group of individuals whose inquest reports were reviewed. However, this only indicates that neurodiversity was not recorded, and not that there were no neurodiverse people amongst those that had died by suicide.

4. Contributing Factors

Reviewing and understanding the factors which contribute to a person's suicide risk help to ensure the right signs are spotted and the right measures taken to support people at risk of distress, crisis and suicide. A factor has been included in this report when mentioned in the inquest report:

- as having a significant impact on the person's life
- as impacting on the support received
- as increasing the risk of suicide.

The most common factor was mental health diagnosis/es, bereavement, health issues, breakdown of relationship, financial issues and social isolation. Other issues include recent contact with police,

[3]Suicide by occupation, England and Wales, 2011 to 2020 registrations

problematic alcohol and drug issues, domestic abuse, adverse childhood experiences (ACE), historic and ongoing abuse, housing issues, and suicide of another.

4.1 Deprivation

Over half of people who died by suicide lived in the areas that fall within the 20% most deprived areas in Tameside: 26% from the most deprived decile and a further 28.6% from the second most deprived decile.

4.2 Mental Health diagnosis

Of the individuals whose inquest reports were reviewed, 58.8% had at least 1 mental health diagnosis (most often by a GP), with 41.2% having at least 2 and 8.8% having 3 diagnoses. The most common combination of diagnoses was Depressive illness and an Anxiety disorder. This is largely consistent with NCISH findings that nationally, 40% of patient suicides were among those with an affective disorder. However, anxiety disorders were only diagnosed in 6% of patients who had died by suicide. This may be due to the different diagnostic approaches between GPs and mental health services.

4.3 Bereavement

As well as the loss of their loved one, bereaved people often see a significant change in their day-to-day life. Bereavement was a factor in 35.3% of the suicides reviewed. In a number of these cases, the bereaved person had been the carer for, or was cared for by, the person they had lost. In other cases, the person had been struggling with the loss of a parent, grandparent or child who had died many years before. Multiple close bereavements were reported in four of the suicide inquest reports.

4.4 Social isolation

Social isolation is multi-factorial as many single people live alone and maintain their connections and wellbeing. However, living situation, marital status and relationship status were heavily correlated with suicide risk locally, a finding which is consistent with national ONS and NCISH reports.

Among those who died by suicide, 59.3% lived alone, this is almost twice the proportion of the Tameside population estimated to live alone. Relationship breakdown was indicated as a factor in 29.4% of suicides and social isolation was indicated in 20.6% of deaths.

Approximately 50% of the 16+ population is married compared to 11.1% within the audit; similarly, while 60% of the population live with a partner, only 25.9% of those who died by suicide lived with a partner, while 70.4% of those who took their own lives were not in a relationship.

4.5 COVID – 19 pandemic

The pandemic impacted people in a variety of ways including isolation, health anxiety, loss and uncertainty. HealthWatch surveys (as reported to the Health & Wellbeing Board in 2020) during the pandemic indicated Tameside residents felt lonelier and more isolated than other communities across Greater Manchester.

The pandemic was mentioned as a factor in over 60% of the reviewed suicides between 2020 and 2022.

4.6 Involvement with the Criminal Justice System

Involvement with a criminal investigation, particularly when accused of a sexual offence, poses an increased risk of suicide. 29% of cases were either arrested and remanded or bailed. Offences for

which people had been arrested or investigated included assault, domestic assault, sexual assault and organised criminal activity. The majority of these crimes were alleged to have taken place months or years prior to the person's death.

In the police reports within the inquest documents, it was not clear what, if any, support had been offered to those who had been arrested.

4.7 Substance misuse

Substance Misuse is associated with a higher suicide risk and is also reported to co-occur with mental health diagnoses for between 20% and 37% of those accessing mental health services, bringing together two significant suicide risks.

14.7% of people who died by suicide had had alcohol misuse related issues within the year prior to their deaths and 11.8% had substance misuse related issues within the year prior to their deaths.

However, a greater proportion of people had substance misuse issues at some point in their lifetime: 26.5% of the individuals had a history of alcohol problems, and one third of those had previous contact with substance misuse services. 23.5% had a history of problematic drug use, with almost two thirds of those having been in drug treatment at some point in their lives.

Casual alcohol use also featured at a number of sites and in post-mortems of suicides in Tameside. Indications in the inquest reports suggest alcohol was an aggravating factor with people using its inhibition dulling effects to allow them to take their lives.

4.8 Physical health

Poor physical health or a disability can limit a person's ability to maintain their emotional wellbeing, engage with their community or go to work, with 32.4% of people dying by suicide recorded as having a physical health problem. In addition, 5.9% of people who died by suicide were recorded as having a disability compared to estimated 17.8% of the general population in England and Wales that consider themselves disabled. In contrast, national figures suggest a considerably higher risk among disabled people (ONS, 2023). This discrepancy may be due to limitations in the recording and reporting of disability at inquest.

A significant proportion of those reviewed in this audit had prescriptions for pain killers. This may indicate that chronic pain is a factor contributing to suicides in Tameside.

4.9 Multiple risk factors

The audit also indicates that it is often a combination of these factors acting together which ultimately leads someone to take their own life. Of the inquest reports reviewed, all had at least 2 contributing factors, 64.7% had 3 or more, 41.2% had 4 or more and 17.6% had 5 or more.

5. Service Contact

This review of 34 inquest reports indicates that the majority of those who died had some form of contact with a service in the weeks or months before their deaths. Others had been supported in the past by the wider network of support across the Local Authority, NHS and VCSE.

5.1 Mental health services

11 people had had contact with primary mental health service and nine had had contact with specialist mental health services.

5.2 Accident and Emergency

For many in crisis, A&E is the place they know or have been taken for assessment in acute circumstances. During the years reviewed in this Audit, SAFE Tameside (a comfortable, trusted and more welcoming VCSE-led space for people in crisis) had not yet been established.

The 11 people who have recorded A&E attendances in mental health crisis, attended 25 times over the 12 month period prior to their deaths. Six psychosocial assessments were recorded in the inquest reports.

5.3 Primary Care

Just over a third (35.3%) of the inquest reports showed no record of the individual visiting their GP. However,

- 20.6% of reports recorded contact with their GP within 1 week of their death.
- 32.4% within a month of their death
- 52.9% visited their GP within one year of their death. Of these, 22.7% did so for Physical Health, 4.5% for Long Term Illness and 72.7% for Mental Health.

5.4 Further insight

Some qualitative details from the inquest report can highlight potential areas for development within the system. The details have come from the medical and police records, witness statements and other evidence contained within each inquest file. Themes for these areas of development have been guided by the Prevention of Future Deaths Reports Review (ONS, 2023) key areas of concern and are in line with the concerns raised through the Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022 (ONS, 2023).

5.4.1 Access

While services have thresholds to protect the care they give their patients, there were cases within the Audit review in which the person disengaged due to a long wait, was discharged or died waiting for an appointment.

An individual was referred by his GP to a support service but were rejected due to their recent suicidality

5.4.2 Assessment

The current assessments in both A&E and in General Practice appear to focus on signs of an altered state or a diagnosable mental illness rather than a holistic view of their wider circumstances.

The assessments recorded seem to have not been effective for establishing suicide risk and included repeated reliance on the person self-referring into a mental health service.

5.4.3 Did not attend and discharge process & communication

While pressures on services remain high, strict approaches to people not attending appointments may leave vulnerable and at risk people unsupported.

Patients prescribed anti-depressants, sleeping tablets and pain medication do not appear to have had regular medication reviews leaving open the possibility of prescription medication stockpiling, a suicide means risk.

6. Summary

6.1 Event details

- Most suicides happened during the day (78.5%), compared to overnight (21.4%).
- There is an apparent recurring peak in January and in June to July each year, whereas there are consistently fewer suicides in October.
- Most suicides (84%) happen at home.
- Hanging is the most common method of suicide (62.5%), followed by self-poisoning (19.5%).
- Males are marginally more likely to use hanging or self-injury, whereas females appear to be marginally more likely than males to use self-poisoning.
- Over half of people that died by suicide leave a note or message indicating their intent, and almost a third of inquest-reviewed suicides had made their suicidal ideation known and a third had attempted suicide before.
- 18% of inquest-reviewed suicides involve people with a history of self-harm.

6.2 Demographics

- The risk among males is approximately 3 times that of females.
- There was no data to indicate that any of those who lost their lives were transgender or nonbinary.
- While there are suicides across the age groups, the 45-54 age group was consistently the group with the highest number and proportion of suicides.
- The recording of ethnicity is inconsistent and/or incomplete which limits the capacity to understand local risks.
- The recording of sexuality was inconsistent, which limits the capacity to understand local risks.
- Approximately 30% of those who died by suicide were parents, split between those living with younger children, those whose children are with a family member and those who have adult children. This poses a risk of generational trauma associated with suicide and future suicide risk.
- Approximately the same proportion of people who die by suicide are not in active employment as are in active employment. This is a considerable over-representation of the inactive group, suggesting a higher risk.
- No data was available regarding the neurodiversity of any of those who died by suicide, which limits the capacity to understand local risks.

6.3 Contributing factors

- There is a strong correlation between deprivation and suicide risk, with 54.7% of those who lost their lives to suicide lived in areas within the 20% most deprived nationally.
- 58.8% of people that died by suicide had at least 1 mental health diagnosis; 41.2% had 2 diagnoses, with the most common being Depressive Illness and Anxiety disorder.
- 35.3% of those who died by suicide had been bereaved.
- 59.3% of those who took their lives lived alone, 20.6% were socially isolated, and 29.5% had experienced a relationship breakdown.
- While 50% of the population is married, and 60% live with a partner, 70.4% of those who took their own lives were not in a relationship.
- Covid-19 was a factor in 60.7% of the reviewed inquests.
- 29% of suicide deaths reviewed at inquest had been arrested or investigated for an offence
- 26.5% had a history of problematic alcohol use and 23.5% had a history of problematic drug use

- 5.9% of those who died by suicide had a disability and 32.4% had physical health problems
- Every individual had at least two, and the majority had two or three, core factors of increased suicide risk.
- Certain factors seem to cluster and co-occur: mental health diagnoses, Covid-19, bereavement, health issues, the breakdown of a relationship and financial issues.
- Many of the contributing factors are classed as traumatic, both childhood and adult.

6.4 Service contact

- The majority of people reviewed in this Audit period who have taken their own life sought support in the weeks and months prior to their deaths, including GP, Drugs and Alcohol support or Primary/Specialist Mental Health service.
- The most accessed service was the GP, and a significant proportion of people accessed their GP in the weeks before their death for Mental Health support.
- Approximately a third of those who took their own lives attended A&E multiple times in the year before their death.
- Mental health assessments may miss social factors.
- Individuals are encouraged to self-refer into mental health support.
- Those reviewed in this Audit also faced thresholds, long waiting times and robust Did Not Attend procedures which left them unsupported.
- Patients prescribed medication did not appear to have had regular medication reviews leaving open the possibility of prescription medication stockpiling, a suicide means risk

7. Areas for attention

Suicide Rates do not follow levels of mental disorder (as currently understood), and within the inquest reports reviewed, interactions between those who died by suicide and GPs, A&E and mental health services do not appear to capture the range of social factors the individuals faced or the risk those factors posed to people's health and lives.

A significant proportion of those who died by suicide made their intention known, had previously attempted suicide and/or had contact with a service in the weeks before their deaths. This suggests opportunities for intervention are present.

In the absence of more comprehensive local data, national data suggests that those from ethnic minority communities, the LGBTQ+ community, neurodiverse people and disabled people are at considerably greater risk of suicide than the general population.

8. Conclusion

Every suicide reviewed through this Audit is a tragedy for the person's loved ones and for the Tameside community. The findings from this Audit indicate that suicides in Tameside are caused and affected by a wide range of factors, which call for careful consideration in the efforts to prevent suicide in Tameside, to design and develop services to support residents when they face significant challenges, and to pursue a healthy and resilient community.

This Audit has deepened and broadened the understanding of suicide in Tameside and provides an evidence-base for the development of the next Tameside Suicide Prevention Strategy.