SUICIDE PREVENTION AND AUDIT UPDATE

Health and Wellbeing Board; 4th October 2018

SUICIDE PREVENTION

The last report to Health and Wellbeing Board on suicide prevention was in October 2015. This report provided assurance to the Board that the local system for suicide prevention was fully aligned with the national strategy and guidance.

Suicide prevention continues to be an important public health issue. In 2017 there were 5,821 deaths by suicide registered in the UK. Each one of those deaths is not only a personal tragedy, but has a major impact on the families, friends and colleagues of those who died and on society as a whole. Suicide prevention strategies can be effective by;

- Promoting mental and emotional wellbeing and reducing risk factors that led to suicidal ideation
- Providing appropriate and effective support and treatment to enable people to continue to live their lives and decide not to take their own lives
- Protecting people and keeping them safe through influencing the media, culture, stigma and reducing the availability and lethality of suicide methods

Local leadership for suicide prevention continues to be provided by the Office of the Director of Public Health and through the Plymouth Suicide Prevention Strategic Partnership. The Partnership has been in existence since 2012 and continues to meet quarterly. The group has contributed to and approved an updated strategic statement on suicide prevention in conjunction with the strategic partnerships in Devon and Torbay. The strategic statement is provided here as Appendix 1. Each area has also adopted a locally appropriate action plan and the current action plan for Plymouth is provided here as Appendix 2. The action plan is fully aligned to the national strategy and planning guidance.

SUICIDE AUDIT UPDATE

Plymouth City Council Office of the Director of Public Health conduct a citywide audit each year into deaths by suicide and undetermined injury. This year a more in depth audit report has been produced to inform future audit and prevention activity. The latest audit report is provided here as Appendix 3.

RECOMMENDATIONS

1. The Health and Wellbeing Board is asked to note the latest suicide audit report.
2. The Health and Wellbeing Board is asked to note the progress being made by the Plymouth Suicide Prevention Strategic Partnership on delivering the annual action plan.
3. The Health and Wellbeing Board is asked to support the proposal by Plymouth Suicide Prevention Strategic Partnership to review the scope of the citywide audit and to amend it to make it locally more appropriate [in absence of new national guidance]
4. The Health and Wellbeing Board is asked to support the Office of the Director of Public Health in exploring the adoption of an avoidable deaths approach to consider deaths by suicide alongside drug and alcohol related deaths, to widen the scope of future audits and to develop proactive and timely sharing of information and the development of shared learning.

Appendix 1

Devon-wide Suicide Prevention Strategic Statement

Working together to make all communities in Devon, Plymouth and Torbay suicide safer communities

Devon County Council

Torbay Council

Plymouth City Council

1 Vision

The Wider Devon Sustainability and Transformation Partnership (STP) includes the local authority areas of Devon, Torbay and Plymouth and sets out ambitious plans to improve health and transform care services. A key theme across the STP is an increased focus on prevention, and specifically prevention of mental ill-health, supported by the recent publication of the *'PHE Better Mental Health Prevention Concordat'.*

Partners across Devon, Torbay and Plymouth are committed to working to together to reduce suicides. This strategic statement gives an overview of the strategic intent across the STP area. We recognise that each local authority area has its distinct make up of population demographics, environmental and social economic factors, therefore, more detailed local implementation plans will be developed for each area, detailing how organisations will work in partnership to reduce suicide among respective populations.

In 2016, there were **29 deaths** in Wider Devon as a result of **land transport accidents**

In the same year, **115 people** died as a result of **suicide or unintentional injury**

We believe that suicide is preventable and each of these deaths could potentially have been avoided. We aim to ensure that the whole of Devon is a place where people do not consider suicide as a solution to the challenges they face. We will aspire to make Devon a place that supports people in times of personal crisis and builds individual and community resilience to improve lives.

2 Introduction

Local Health and Wellbeing Boards provide the governance for suicide prevention and leadership of suicide prevention work is the responsibility of local authority public health teams. This leadership is provided through local strategic partnerships.

Suicide is a traumatic event; the impact is felt not only by immediate family and friends, but by people in workplaces, communities and wider society. It is estimated that every suicide costs the economy £1.67 million. This estimate includes direct costs which are involvement of the emergency services, healthcare interventions and investigations carried out by the police and coroner. There are additional indirect costs attributed which include the lost opportunity to contribute productively to the economy, including paid work, voluntary activities and looking after children or parents. Arguably though, the most fundamental impact of all is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value. It is these intangible costs that make-up approximately 70% of the total costs of suicide.

Suicide can often be the end of a complex history of risk factors and stressing events, and the risk for suicide reflects wider inequalities in social and economic circumstances. Suicide is preventable; however, the prevention approach must address the complexity of the issue. There are many effective ways in which individuals, communities and services can help to prevent suicide and this strategic statement is intended to recognise the contributions that can be made across all sectors of society.

This document sets out the local suicide prevention statement and implementation plans which are supported by national guidance. The *'Cross-Government Suicide Prevention Strategy',* published in 2012 and subsequently updated in 2015 and 2017, sets out the Government's priorities for addressing suicide and self-harm. The national strategy fits with the aim of the *'Five Year Forward View for Mental Health'* and sets the ambition to reduce the number of people who take their own lives in 2020/21 by 10% compared to 2016/17 levels.

It is acknowledged that, although there are some risk groups emerging through national trend data that require a focus for population approaches (eg middle-aged men and those with undiagnosed depression), there is great variation between local areas, therefore, the national ambition is for local delivery of suicide prevention with the target for every local area to have in place a multi-agency suicide prevention strategic partnership and action plan. To aid in this, Public Health England published "*Guidance for developing a local suicide prevention action plan"* in 2016 which provides specific guidance to Local Authorities to develop local plans and ambitions.

3 Why are we doing this?

3.1 The national picture

The most recent figures for suicide in the United Kingdom (2016 registrations) were published by the Office for National Statistics on 7th September 2017. The National Statistics definition of suicide (updated in 2016) includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over.

A reduction in suicide rates will only be achieved if prevention is prioritised by the NHS, local government, charities, British Transport Police and others, and a population approach is taken.

The headlines:

In 2016, there were **5,688** suicides among people in Great Britain. This is **202 less** than in 2015 and represents a reduction of **3.4%**.

There has been a fall in the age-standardised suicide rate for both males and females in England from 2015 to 2016. The overall suicide rate has fallen from **10.1 in 2015 to 9.5 per 100,000** people in 2016.

Suicide continues to affect more males than females. Suicide is the leading cause of death in men under 50 years old and across all broad age groups, the suicide rate for males is around **3 times** higher than for females.

The highest suicide rate is seen in middle-aged men. Males aged 40 to 44 have the highest rate at **23.7 per 100,000 people**. In females, the highest rate is seen in the 50 to 54 age group who have a rate of **8.1 per 100,000 people**.

The most common suicide method in the UK in 2016 was hanging, accounting for **59%** of male

suicides and **43%** of female suicides respectively.

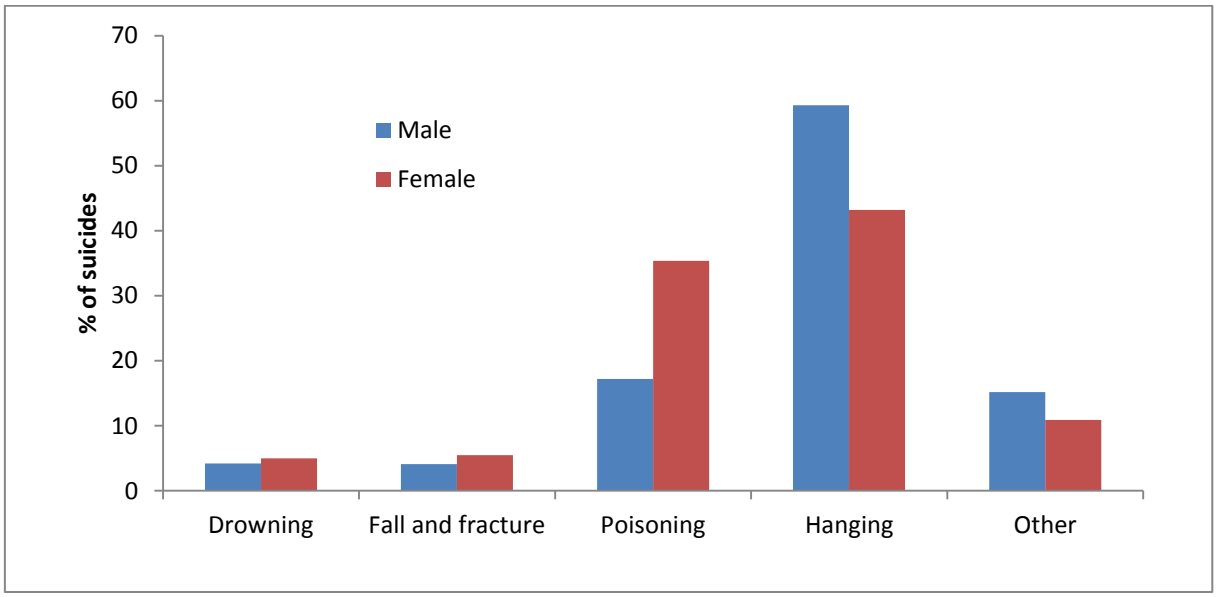

Figure 1. The proportion of suicide by method and sex, Great Britain, registered in 2016 (Office for National Statistics, National Records of Scotland)

In 2016, the South West had the highest age-standardised suicide rate for any English region at **11.2 per 100,000 people**. London has the lowest at **7.8 per 100,000 people.**

As well as gender and age, other known risk factors for suicide include self-harm, mental illness, employment status, marital status and physical ill-health.

It is estimated that the around a **third of people** who die by suicide are in current or recent contact with **mental health services**.

It is also estimated that around a **third of people** who die by suicide have had contact with their **GP** in the lead up to their death, and around a **third of people** are not known to any **health or care services.**

3.2 Local Picture

The Wider Devon STP area includes the local authority areas of Plymouth, Torbay and Devon. Each local authority area holds mortality data for its resident population, including data on deaths from suicide and undetermined injury.

Since 2014, there have been **339** deaths from suicide or unintentional injury Devon-wide *(Suicides in England and Wales by Local Authority: Office for National Statistics: 2017).* Of these, over **three-quarters** of deaths occurred in **males**.

There are suggestions that, following a peak in 2014, the directly age-standardised suicide rate is decreasing Devon-wide but there is local variation. (see Appendix 1).

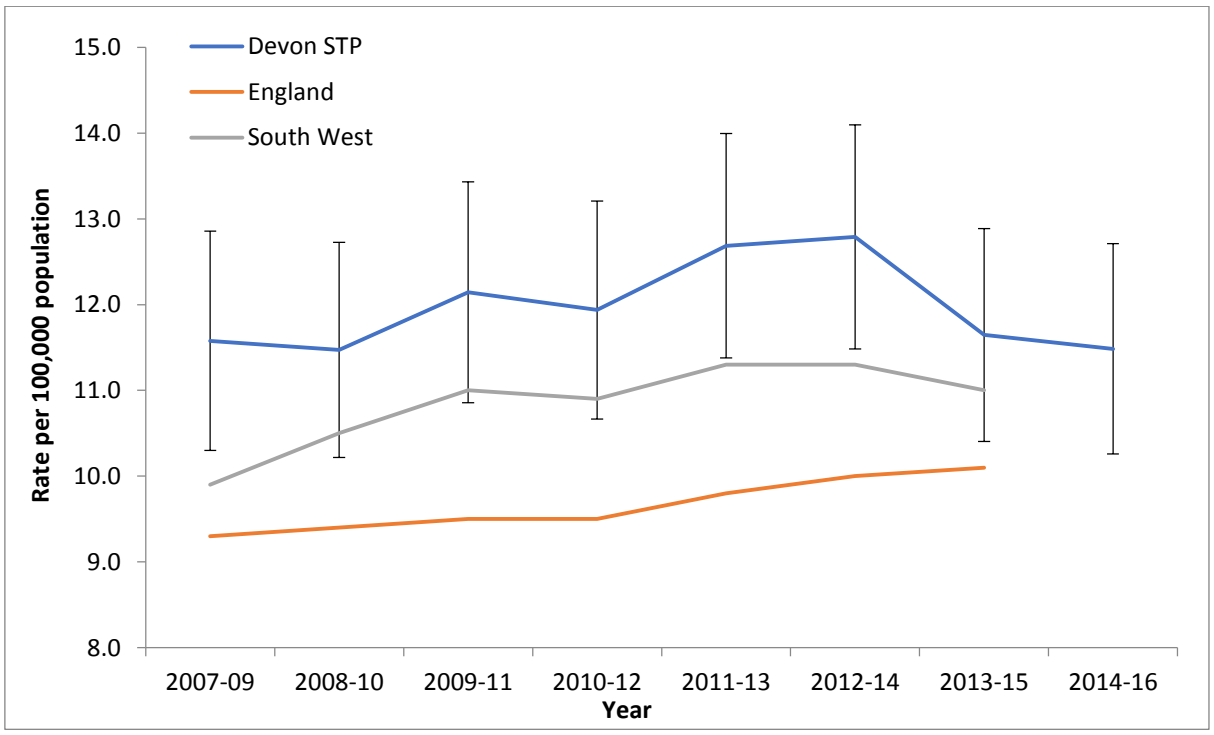

Figure 2. Trend in mortality from suicide and injury of undetermined intent Devon-wide. PHE Suicide Prevention Profiles - https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

However, presenting the overall picture may mask any trends occurring within specific risk groups.

Most deaths occur in the home (Figure 3). Deaths that are recorded as occurring in a hospital or communal establishment include those where the suicide attempt was made at home and the death occurred later in time.

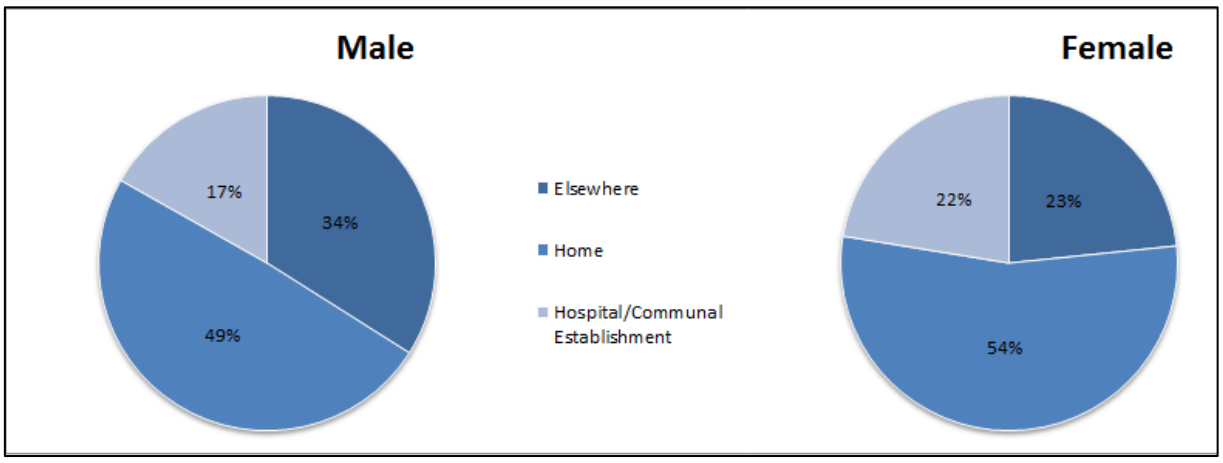

Figure 3. Place of death by gender, Devon-wide, 2014-2016 (Primary Care Mortality Database; Residents of Devon, Plymouth and Torbay)

Similarly, to the national picture the most common method of suicide Devon-wide was **hanging,** accounting for **55% of all male deaths** and **36% of female deaths**. Also reflecting the national picture, poisoning is the next most common method used, accounting for **37% of female deaths** and **16% of male deaths** (Figure 4).

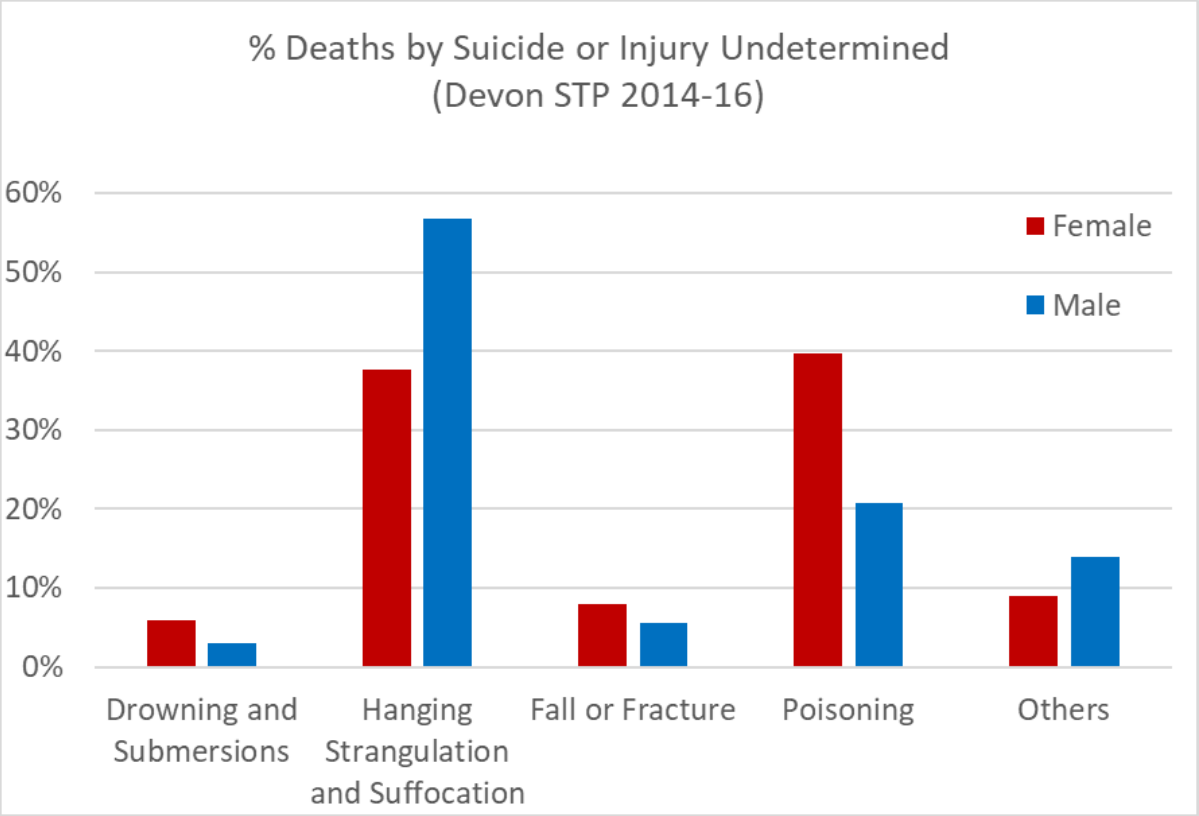

Figure 4. Method of suicide by gender, Devon-wide, 2014-2016 (Primary Care Mortality Database; Residents of Devon, Plymouth and Torbay)

The financial cost of a death by suicide is estimated at **£1.67 million** in terms of care and lost productivity. This means that the **115 suicides** Devon-wide in 2016 cost the local economy **£192 million**.

4 What is the ambition?

The aim of this strategic statement is to set a bold target for suicide prevention, based upon local, regional and national ambitions. In 2014, the South West Regional Zero Suicide Collaborative set the highly ambitious target to reduce suicides across the South West to zero by October 2018. This was followed by national publication of '*The Five Year Forward View for Mental Health*' in 2016 which sets the ambition that the number of people taking their own lives in 2020/21 will be reduced by 10% nationally compared to 2016/17 levels.

Devon-wide, we are committed to work in collaboration to reduce the number of suicides to zero. To start this process by 2020/21, we aim to reduce the number of people who take their own lives by 10% based on 2016/17 levels.

To achieve this reduction in suicide rates there needs to be a much stronger focus on suicide prevention and commitment from system leaders to make suicide prevention a priority.

"Working together to make all communities in Devon, Plymouth and Torbay suicide safer communities"

5 How do we aim to achieve this?

Suicide must be recognised as avoidable and therefore preventable. There are many effective ways that individuals, communities and services can work together to support people differently so that they do not see suicide as their only option.

Devon-wide partners will recognise the important contribution they can make and take a whole-community approach, recognising the contributions that can be made across all sectors of society. The approach will cover two tiers of action:

- **Level 1 Universal Interventions**: to build resilience and promote wellbeing at all ages for residents of Devon, Plymouth and Torbay.
- **Level 2 Targeted and vulnerable population groups:** targeted prevention of mental ill-health and early intervention for people at risk of mental health problems.

Improving the mental health of the population will support a reduction in suicide rates and this will be supported in ongoing work, at a local and strategic level, in support of the PHE Prevention Concordat for Better Mental Health.

To deliver the stated ambition, we will adopt the National Suicide Prevention Strategy which identifies seven key areas for actions. These are:

1. Reducing the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to the means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring; and
7. Reducing rates of self-harm as a key indicator of suicide risk.

The national strategy will be implemented locally in two ways:

The **two multi-agency suicide prevention groups** will bring together the statutory and voluntary organisations necessary to support the development and implementation of the local suicide prevention implementation plans. One group will cover Devon and Torbay local authority areas and one will cover Plymouth.

There will be **localised suicide prevention implementation plans** based on the national strategy and local intelligence on suicide risk. Each local authority area (Plymouth, Torbay and Devon) will be responsible for developing and delivering their own local implementation plan that best suits the needs of their population.

6 Developing local implementation plans:

We intend to adopt the national strategy and using local data and knowledge, produce a set of local priorities for suicide prevention. The implementation plans will be developed following the steps set out below:

1. Review the national evidence base, best practice from other areas and local data to inform local priorities

2. Collate and review the current prevention activities in place and identify gaps in provision

3. Draft implementation plans with full engagement from stakeholders through the local strategic partnerships

4. Develop monitoring and evaluation plans for the suicide prevention groups.

The plans will be co-owned by a range of statutory and voluntary agencies, which will all participate by incorporating organisations' actions into the plans and working collaboratively to identify priority areas.

Once complete, the implementation plans will be made available on the local authority websites and will undergo annual review. A Devon-wide review of the data will be undertaken with sharing of best practice and, where it is appropriate, work will be undertaken on a Devon-wide level.

7 References

Office for National Statistics. Statistical Bulleting, 2016. Suicides in the UK: 2015 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations

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HM Government: Preventing Suicide in England. A cross-government outcomes strategy to save lives. 2012. Available at: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

HM Government: Preventing Suicide in England. Third Progress report of the cross-government outcomes strategy to save lives. 2017Available at: https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

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Platt s, McClean J, McCollam A, et al (2006) Evaluation of the first phase of 'Choose Life': The national strategy and action plan to prevent suicide in Scotland. Scottish Executive Social Research. Edinburgh

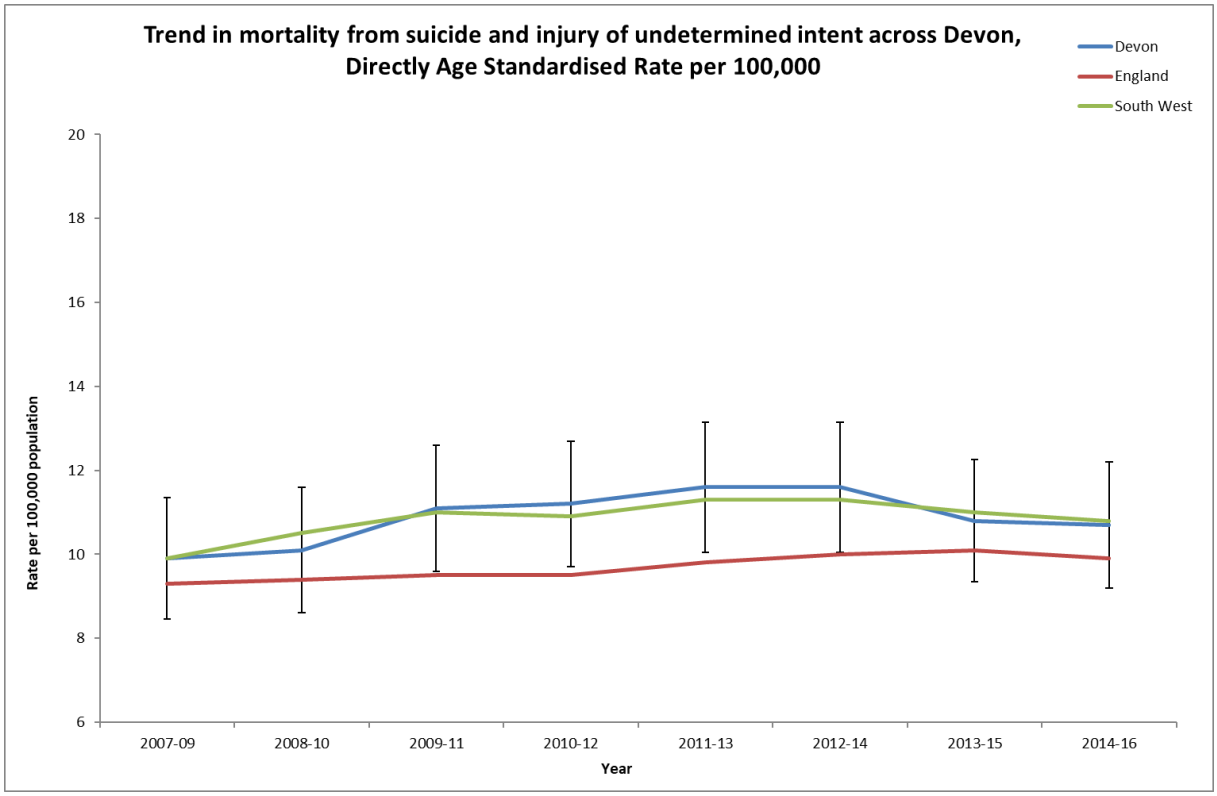
8 Glossary

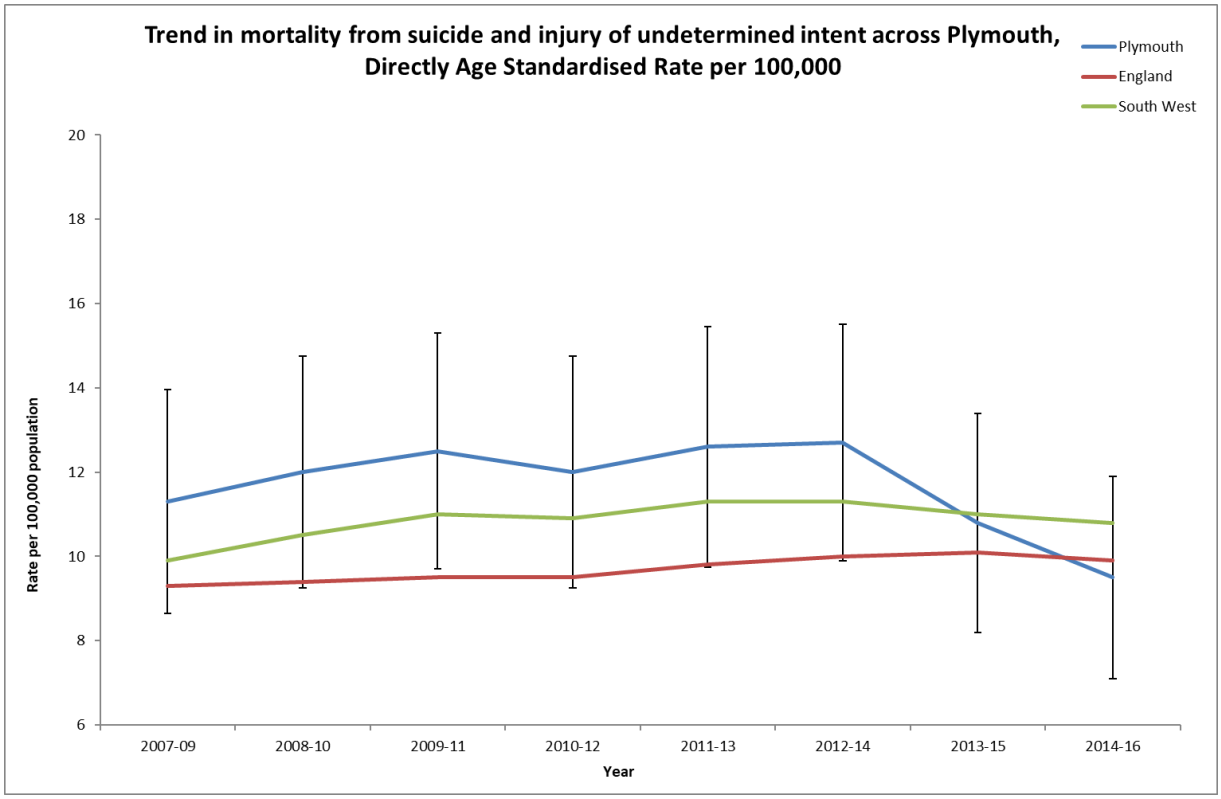
STP	Sustainable Transformation Partnership
PHE	Public Health England
LA	Local Authority
OPCC	Office of the Police and Crime Commissioner

APPENDIX 1

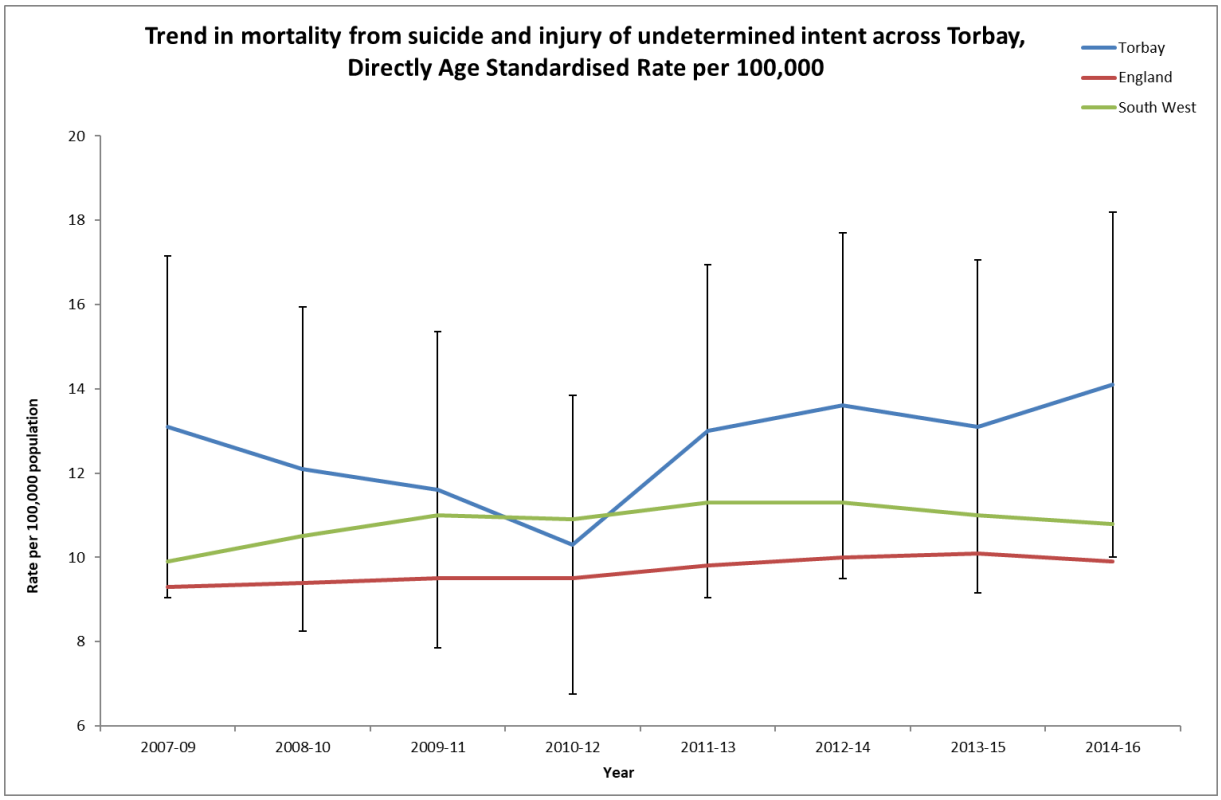
Public Health England – Suicide Prevention Profiles

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide





APPENDIX 1


Trend in mortality from suicide and injury of undetermined intent across Torbay, Directly Age Standardised Rate per 100,000
Torbay
England
South West
Rate per 100,000 population
20
18
16
14
12
10
8
6
2007-09
2008-10
2009-11
2010-12
2011-13
2012-14
2013-15
2014-16
Year

Appendix 2

PLYMOUTH SUICIDE PREVENTION STRATEGIC PARTNERSHIP ACTION PLAN 2018-2019

Local Areas should *aim* to tackle all seven areas of the national strategy alongside the eight priorities for coordinated whole system working.

1.	Seven Areas if the National Strategy	2.	Eight priorities for coordinated whole system working
1.1	**Reduce the risk of suicide in key high-risk groups.**	2.1	**Reducing risk in men** - especially in middle age and with a focus on lifestyle factors and the treatment/settings men are prepared to use.
1.2	**Tailor approaches to improve mental health in specific groups.**	2.2	**Preventing and responding to self harm** – with a range of services for people in crisis and access to psychosocial assessment.
1.3	**Reduce access to the means of suicide.**	2.3	**Mental health of children and young people** – with joint working and plans to address suicide risk in 15-19 year olds.
1.4	**Provide better information and support to those bereaved or affected by suicide.**	2.4	**Treatment of depression in primary care** – with safe prescribing of painkillers and antidepressants.
1.5	**Support the media in delivering sensitive approaches to suicide and suicidal behaviour.**	2.5	**Acute mental health care** – with safer wards and safe discharge, adequate bed numbers and no out of are admissions.
1.6	**Support research, data collection and monitoring**	2.6	**Tackling high frequency locations** – including working with local media to prevent imitative suicides
1.7	**Reducing rates of self-harm as a key indicator of suicide risk**	2.7	**Reducing isolation** – for example through community based support, transport links and working with the third sector.
		2.8	**Bereavement support** – especially for people bereaved by suicide.

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
1. Reduce the risk of suicide in key high-risk groups. Men, specific occupational groups, people; who self harm, misuse drugs and alcohol, in the care of mental health services, in contact with the criminal justice system. ➢ **Priority Action 2.1: Reducing risk in men** - especially in middle age and with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use.							
1.1	Deliver 'Men's Peer Support groups' in community based settings to reduce the impact of social isolation. Facilitated by experienced mental health practitioner. Focus on early intervention.	Provide signposting information to support services for high risk individuals [Enable seamless access to Recovery College provision to support the development of self-management skills and self-confidence]		Ongoing		Plymouth & District Mind	Service Providers	Ongoing initiative
1.2	Deliver in-school 'Life is a Rollercoaster' courses to young people at risk of, or currently, self-harming	Increased self-awareness of how to manage negative thoughts and coping behaviours.	01/09/17	2021		Plymouth & District Mind	The Zone (Progeny)	Ongoing initiative
1.3	Suicide Training of Risk Management (STORM) conducted with all clinical mental health staff.	Mandatory for all mental health staff. Data reviewed on a regular basis.		Ongoing		Paul O'Shea	All staff within Livewell SW	Ongoing initiative.

Appendix 2

1.4	Through the incident and Serious Incident Requiring Investigation (SIRI) processes all incident of suspected suicides and serious self-harm are reviewed in line with National and Local guidance. Action plans created and shared throughout LSW.	Regular reporting via the Safety and Quality Group. All SIRI reports are reviewed by the CCG before closing to the organisation.		Ongoing		Nicky Varker and Graham Burton	Livewell SW staff. External Providers e.g. Harbour, Care Agencies. CCG.	SIRI panels run each month for attended by Senior staff from the Organisation and some external agencies.
1.5	Applied Suicide Intervention Skills Training (ASIST) and SafeTALK training offered to internal and external staff and agencies prioritising those in contact with high-risk groups.	Number of courses delivered in Applied Suicide Intervention Skills Training (ASIST) Number of people trained in Applied Suicide Intervention Skills Training (ASIST) Number of courses delivered in SafeTALK Number of people trained in SafeTALK		Ongoing		Jan Potter Cathryn Keeble	Livewell SW, Public Health	Priority Groups for 18/19 Blue Light services, Debt advice services, Wellbeing Hub services, substance misuse services, homeless services, sports clubs, court services, coroners officers, church and faith groups, PCC Bereavement Service, Youth services, Universities and Colleges

Appendix 2

1.6	Early intervention activities with offenders and the wider community at Magistrates' Court [primarily offenders or at risk of offending]	Specialist Court advice and support Supported sign-posting to local specialist agencies located in the community		Ongoing [subject to funding]		CASS+	Links to all partners across sectors	Priority group low level/non-statutory offenders but work with a wider range client group including Family cases, Tribunals and drop-in's. Strong model of easy access support to complex and vulnerable clients
1.7	Insight [EIP Psychosis] developed to work with people aged up to 65 years.		01/04/17	Ongoing		The Zone	Livewell SW	NICE compliant service with access to employability services, welfare advice etc.
1.8	Men's mental health promotion through local sports clubs	Resources available and promoted – Time to Change, SafeTALK, 5 ways to wellbeing	01/06/18	31/12/18		Public Health	PAFC Community Trust, Plymouth Albion, Raiders	Identify links to sports clubs for circulation and support. Resources provided by Public Health and online
1.9	Ensure Recovery Devon "Letter of Hope" available in service and community settings used by high risk groups	Availability in wide range of settings. Numbers of letters supplied	01/06/18	31/12/18		Public Health	Partnership members Wellbeing Hubs	Agreement from Recovery Devon to use "Letter of Hope" and print a Plymouth branded version

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
2. Tailor approaches to improve mental health in specific groups. Community based programmes, suicide prevention training, people who are vulnerable due to economic circumstances, pregnant women and those who have given birth in the last year, children and young people, survivors of abuse, veterans, people with long term physical health conditions, LGBT, BME groups and asylum seekers. ➢ **Priority Action 2.2: Preventing and responding to self harm** – with a range of services for adults and young people in crisis and access to psychosocial assessment for self-harm patients. ➢ **Priority Action 2.3: Mental health of children and young people** – with joint working between health & social care, schools & youth justice, and plans to address drastic increase in suicide risk in 15-19 year olds.							
2.1	Deliver weekly 'Mums Connect' peer support group (for mums in the perinatal period at risk of or currently experiencing mental health issues).	Provide signposting information to support services for high risk individuals		Ongoing		Plymouth & District Mind	Livewell Public Health	Ongoing initiative
2.2	Deliver in-school 'Life is a Rollercoaster' courses to young people at risk of, or currently, self-harming	Increased self-awareness of how to manage negative thoughts and coping behaviours.	01/09/17	2021		Plymouth & District Mind	The Zone (Progeny) Schools	Ongoing initiative
2.3	Maintain level of provision offered through Recovery College activities to promote mental wellbeing and recovery.	Information sharing through steering group to include numbers of high risk individuals who present at the Recovery College		Ongoing		Plymouth & District Mind	Service Providers	Ongoing initiative

Appendix 2

3.3	Develop co-located service delivery in GP surgeries. Specialist mental health practitioner to offer tailored support for high risk patients in a surgery setting.	Access to training and specialist knowledge for GPs and nurse practitioners.	01/04/17	31/03/19		Plymouth & District Mind	GPs in Plymouth	Ongoing initiative
3.4	Progeny provision of whole school training in mental health to 26 secondary schools in Plymouth	Bespoke action plan for each school with training roll-out including ASIST and SafeTALK. Development of improved pathways for specific at risk groups	01/09/17	01/07/19		The Zone	School Mental Health Leads PCC Mind Young Devon CAMHS Beacon Medical Group	Additional funding in 17/18 from HEE re needs of most vulnerable CYP for additional schools training and training in Primary Care and CVSE
3.5	Review outputs from CYP worksho to identify top 5 actions for CYP system on suicide and self-harm prevention then add to action plan	Clarified and agreed priority actions relating to CYP		01/01/19		Public Health	CYP Partnership members	Refer back to CYP Emotional Health and Wellbeing group for agreement and to Safeguarding Board lead. Work needed to consult with CYP on final plan.
3.6	Promote 5 ways to wellbeing as whole population approach to mental health improvement	Increased awareness of 5 ways to wellbeing Number of partners using 5 ways to wellbeing with clients	10/10/17	16/10/18		Public Health	Partnership members Thrive Plymouth network	Focus for Thrive Plymouth Year 4 and will continue. Need to develop CYP appropriate materials for 5 ways to wellbeing. Targeted work for 16-24 year olds and those supporting them

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
3. Reduce access to the means of suicide.								
3.1	Tamar Bridge and Torpoint Ferry Joint Committee to review and where reasonable implement prevention measures on ongoing basis.	1] Samaritans signage has installed on the bridge 2017.		Complete		Tamar Bridge and Torpoint Ferry Joint Committee	Samaritans Public Health [PCC and CC] Police, Fire, Ambulance and Coastguard Services STORM	
		2] Bespoke STORM suicide intervention training for employees, contractors and emergency services		Ongoing				To date Tamar Crossings have trained 124 people. Initial and refresher training will be offered to all employees, relevant contractors and emergency services responding to the bridge on a routine basis.
		3] Intelligent CCTV cameras installed across the bridge structure to assist control room with identifying potential concerns for welfare and		Installation complete Learning phase ongoing				Learning phase programmed to help identify potential concern for welfare behaviours

		to aid quicker intervention 4] Review of concern for welfare multi-agency response plan 5] Investigate feasibility of raising pedestrian parapets including consultation with emergency services to ensure engineered changes considered in risk assessments and safe working methods if rescue required		In progress In progress				Review by Tamar Crossings with Police, Fire, Ambulance and Coastguard. Will be distributed to emergency responders for comment. Table top exercise to test plan in 2018 Information on attempts to climb bridge structure and numbers of people attending bridge in distress to be collected and analysed by Tamar Crossings. Data will be shared with Public Health, strategic group and other partners on ongoing basis
3.2	Ligature audits for LSW for inpatient units.	Ongoing annual programme	Current	Ongoing		Modern Matrons	Livewell SW staff	
3.3	Ligature and suicide prevention policy implemented on site	Ongoing review programme and learning	April 17	Ongoing		The Zone	Livewell SW	Policy reviewed May 2017
3.4	Monitoring and response to planning applications for high buildings, multi-storey car parks, public place developments to	Number of responses provided Modifications achieved and prevention measures built in	April 17	Ongoing		Public Health	PCC Planning Department	This is now done as routine. Some evidence of impact on modification to existing buildings to meet guidance.

	recommend compliance with PHE guidance							
3.5	Create working relationship with Highways to enable prevention to be embedded relating to road network and car parks	Opportunities for improvements identified and delivered Training to relevant staff delivered	01/05/18	31/12/18		Public Health	PCC Highways PCC Car Parks Commercial car park operators	

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
4. Provide better information and support to those bereaved or affected by suicide. ➢ **Priority Action 2.8: Bereavement support** – especially for people bereaved by suicide.								
4.1	Duty of candour applied to all suicides. Signposted to support agencies. Support given by clinical teams involved.	All duty of Candour applied. Support given to all affected.		Ongoing		Nicky Varker via SIRI group.	Bereavement support services and information	Copies of Help is at Hand to be available and provided to bereaved.
4.2	Promote availability of complex bereavement service as well as Cruse, Life Beyond Loss etc	Seek uptake data from service providers.	01/07/18	Review Spring 19		Public Health	Partnership members	Promote through Wellbeing Hubs network and all partnership services.
4.3	Provide Bereavement care and support training for staff in primary and secondary care mental health teams with focus on suicide	At least one member of staff from each team trained to support those bereaved, affected or at risk of bereavement where suicidal ideation a known risk factor	May 17	March 18		The Zone	Livewell SW	UPDATE REPORT REQUIRED ON PROGRESS AND CURRENT STATUS
4.4	Make the Help is at Hand leaflet readily available for bereaved families	Leaflet available in variety of locations; numbers of leaflets provided	From May 18			Public Health	Coroners Office Livewell SW Police Funeral Directors Bereavement Service [PCC]	Stock of leaflets ordered and available for circulation.

Appendix 2

4.5	Establish website presence for Suicide Prevention Partnership to promote work of partnership and to provide links to local support services	Web presence to share action plan, audit reports etc Links to partners websites and sources of support Link to new website being developed to service Wellbeing Hubs	01/07/18	31/12/18		Public Health	Partnership members PCC DELT	

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour. ➢ **Priority Action 2.6: Tackling high frequency locations** – including working with local media to prevent imitative suicides							
5.1	Continue to work with local media re reporting of suicide and attempted suicides and in not highlighting high-risk locations – with reference to Samaritans Media Guidelines and Editors Code of Practice.	Monitor compliance of local reporting with media guidelines and provide challenge and support where non-compliance found. DPH to write to new Editor of The Herald.	Current	Ongoing		Public Health PCC Comms Team	Livewell SW Comms Team NEW Devon CCG Comms Team Partnership members	Too early to tell if initiative to date has had any substantial impact. Some more positive mental health reporting recently especially around mens' mental health
5.2	Support local media to report general mental health and illness in positive way	DPH to write to new Editor of The Herald. Examples of positive reporting	12/05/18	Ongoing		Public Health	PCC Comms Team Livewell SW Comms Team	Initiate contact with new Editor for Mental Health Awareness week
5.3	Prepare draft media statements in advance in relation to client cohorts to ensure appropriate information provided to the media in timely way specific for client group/known risks or contributory factors	Outcome more sensitive reporting and more informed about specific client groups and suspected or known conditions e.g. psychosis, depression	01/05/18	Ongoing		The Zone Livewell SW UHP Trust	Partnership members for other client groups Public Health	Pre-prepared statements to be co-produced and shared by service providers.

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
6. Support research, data collection and monitoring								
6.1	Support the collection and dissemination of local information on suicide and self-harm	Regular updates by all members at Strategic Partnership meetings	Current	Ongoing		Strategic Partnership members		Confidential data sharing at Partnership meetings.
6.2	Use range of data to produce Plymouth Suicide Audits	• Update at each Partnership meeting • Annual publication of audit summary • Presentation of annual audit summary to Health and Wellbeing Board	Current	Ongoing		Public Health	Coroners Office, Livewell SW GP Practices UHP NHS Trust	Annual update and short report will also go to Safeguarding Board.
6.3	Use PHE Suicide Prevention Profile for routine monitoring	Update report to Partnership meetings when profile updated or annually	Current	Ongoing		Public Health	Public Health England [PHE]	Available at https://fingertips.phe.org.uk/
6.4	Work to align suicide audit reports across Devon STP and coordinate format and publication dates	3 PH teams to work to common framework to produce short form annual summary	1/06/18	31/12/18		Public Health	Devon CC PH Torbay PH	Will enable a STP wide view and update as well as local authority area reports.
6.5	New life course Mental Health Needs Assessment for Plymouth	Published and available on JSNA website	1/4/18	31/10/18		Public Health	NEW Devon CCG Livewell SW	Last report dated 2012 so updated assessment of need required

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
7. Reducing rates of self-harm as a key indicator of suicide risk ➢ **Priority Action 2.2: Preventing and responding to self-harm** – with a range of services for adults and young people in crisis and access to psychosocial assessment for self-harm patients.							
7.1	Review current service provision for people who self-harm to ensure compliance with NICE standards and pathways	Compliance with CG 16 and CG 133	1/09/18	31/12/18		Public Health	Livewell SW UHP NHS Trust The Zone	Limited audit to review compliance. Review training need of staff in A+E, MIU etc
7.2	Undertake an all age needs assessment for self-harm	Completed needs assessment with recommendations to inform future action plans	1/8/18	31/12/18		Public Health	Partnership members	Aim to include focus group work especially with CYP
7.3	Contribute to Public Health England Local Knowledge Intelligence Service review of Self Harm in the South West	Comparative report and explanation of regional data on self-harm admission rates	1/6/18	30/9/18		Public Health	PHE LKIS	Regional project to understand high rates of self-harm across whole of SW region. Local data and information provided. Awaiting final report.

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
8. Primary & Secondary Care ➢ **Priority Action 2.4: Treatment of depression in primary care** – with safe prescribing of painkillers and antidepressants. ➢ **Priority Action 2.5: Acute mental health care** – with safer wards and safe discharge, adequate bed numbers and no out of area admissions.							
	Primary Care						
8.1	Increase access to IAPT	Nationally set trajectories for increased access	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Extension of offer to those with long term conditions.
8.2	Review advice to Primary Care on safe prescribing of anti-depressants and pain medication especially relating to high risk groups	Compliance with best practice	01/07/18	31/12/18		Public Health NEW Devon CCG Meds Opt Team	LMC LPC	Build on existing work with pain medications
8.3	Review policies for controlled drugs and protocols for returning unused meds. Raise awareness with first responders and palliative care teams. Provide guidance for families/public	Returns of unused medications and safe disposal	01/07/18	31/12/18		Public Health NEW Devon CCG Meds Opt Team	LMC LPC Livewell SW First Responders	CDLIN NHSE

Appendix 2

	Secondary Care							
8.4	Discharge follow up within 48hrs	Services monitored - % achieved	Current	Ongoing		NEW Devon CCG	Livewell SW UHP NHS Trust	
8.5	Daily monitoring of bed numbers	Number of available beds	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Overall bed numbers are adequate though male female bed ratio maybe a problem
8.6	Out of area acute admissions	No inappropriate out of area admission	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Occasional out of area admissions are required for clinical reasons eg family working on the wards
8.7	PICU – Psychiatric intensive care beds	Achieve max use of 4 PICU beds	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	There is currently no PICU unit in Devon. DPT are building one and this will provide 4 beds for the Plymouth area

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
9. Isolation ➢ **Priority Action 2.7: Reducing isolation** – for example through community based support, transport links and working with the third sector.								
9.1	Increased provision of social prescribing through GP practices, Wellbeing Hubs and IAPT	Numbers of people supported through social prescribing programmes Numbers of people supported through Wellbeing Hubs	10/1/18	09/07/19		Public Health PCC Strategic Commissioners	CVSE Wellbeing Hub Network	Review ASCOF scores for social contact for service users and carers. Additional funding for Wolseley Trust through successful DH funding bid is enabling provision in more practices
9.2	Reconfigured EI service to use evidence based group activities	Reduction in those excluded from mainstream activities	April 17	Ongoing		The Zone [Icebreak] [Insight]	Livewell SW	UPDATE REPORT NEEDED

PLYMOUTH SUICIDE AUDIT REPORT

Deaths registered 2014 to 2016

Appendix 3

Author: Office of the Director of Public Health, Plymouth City Council

Date: September 2018 (v1.0) DRAFT

This document is produced as part of Plymouth's Joint Strategic Needs Assessment.

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Contents

Introduction: Purpose and focus

This report provides an overview of the deaths of Plymouth residents by suicide and undetermined injury. It updates the information provided in the previous Plymouth Suicide Audit Summary (2013-2015)[1] and also provides additional information about contact with local health and wellbeing services. The data presented refers to the deaths of residents (10 years and older) registered during calendar years 2014, 2015 and 2016. However, not all of these deaths will have occurred during these three years, as deaths by suicide and undetermined injury are registered only after an inquest has taken place and the coroner has reached a conclusion (previously referred to as a verdict). Deaths of Plymouth residents are included in this audit whether they died in Plymouth or elsewhere in the UK.

Death by suicide or undetermined injury is a rare event in Plymouth and the numbers fluctuate from year to year. Suicide audit reports for Plymouth present data for deaths registered in particular calendar years averaged for three year periods. This enables direct comparisons to be made with national mortality data which is also presented by year of registration.

Our suicide audits are undertaken to monitor local trends and to compare these with national data. Our audit also supports suicide prevention initiatives in the city. The Plymouth Suicide Prevention Strategic Partnership is a multi-agency group led by Plymouth City Council which has responsibility for suicide prevention in the city. Information from the suicide audit process is provided to meetings of the partnership and suicide audit reports are discussed with and distributed to members of the group.

Definition of suicide and undetermined injury

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their life. Deaths that are 'undetermined' are where the coroner at inquest reaches an open or narrative conclusion because the intention of the person is uncertain. Only open and narrative conclusions which are considered deaths by undetermined injury (UI) are included in the suicide audit.

Audit process and data sources

The local suicide audit process involves monitoring all deaths where the coroner has given a conclusion of suicide, or an open or a narrative conclusion. During the year information is collected from weekly death registrations, from the Primary Care Mortality Database, and from HM Coroners Office in Plymouth:

- Deaths included in this audit have been checked and verified using the Annual Mortality Extract for Plymouth from NHS Digital. Deaths from suicide are confirmed using the International Classification of Diseases (ICD10) codes X60-X84 ('intentional self-harm') and deaths from undetermined injury are identified using ICD10 codes Y10-Y34, excluding Y33.9 ('event of undetermined intent').[2]

- Information on the trend in mortality rates is drawn from the Public Health Outcomes Framework (PHOF). [3]
- In line with national guidance on suicide audits published by the National Institute for Mental Health in England in 2006,[4] the local suicide audit process requests information about the deceased's contact with local health and wellbeing services prior to their death. The service information has been drawn together and collated for this audit report.

This report provides a city-wide overview of deaths by suicide and undetermined injury whether or not the deceased person had been in contact with local services. An overview is by definition limited in scope.

Detailed investigations into the circumstances of individual deaths are undertaken by appropriate services in the city. The coroner's inquest is the most important investigation that takes place and establishes whether or not the person intended to take their life. Other investigations may also take place if the deceased was in contact with local health and wellbeing services:

- In primary care services, a general practice may undertake a Serious Event Audit (SEA) if one of their patients dies by suicide/UI.
- In mental health services, a Serious Incident Requiring Investigation (SIRI) is undertaken for every patient death by suicide/UI.

Reports of the SEA and the SIRI investigations are not shared with the public health team and therefore are not directly considered in our suicide audit process.

Outline of the report

In preparing this audit we have drawn on six sources of information: the register of weekly deaths, official mortality data and the coroner files, as well as requests for information from local NHS services: including primary care, mental health and hospital services. The report is divided into three sections with each section presenting information drawn from particular sources:

- **Section One** presents summary information drawn from official statistics: the register of deaths in Plymouth and mortality data (this information is the basis for previous Plymouth Suicide Audit Data Summary reports).
- **Section Two** draws together information provided by primary care, mental health and hospital services.
- **Section Three** presents a range of contextual information drawn from coroner records.

Section One: Information drawn from official statistics

Official statistics provide information about the number of deaths and the mortality rates for death by suicide/UI (making it possible to compare Plymouth with England and our neighbours). Demographic information including the sex and age of the deceased, and details about where the deceased were born and the place of their death are also given. The post-codes of where they lived in the city are shown on a map which reveals that suicide is a concern across the city.

(1) Numbers

(a) Total deaths: 2014-16

A total of 64 deaths by suicide/UI were registered in the years 2014, 2015 and 2016. The majority of deaths were by suicide:

- 56 residents died by suicide
- 8 residents died by undetermined injury

Fewer deaths were registered in 2016 than in 2015 or in 2014:

- 19 deaths were registered in 2016
- 21 deaths were registered in 2015
- 24 deaths were registered in 2014

Over the three year period, the average number of deaths is one to 2 deaths a month.

9 non-residents died by suicide in Plymouth (this information is drawn from the inquest conclusions noted in weekly death registrations). Non-resident deaths are not discussed in our audit as they would be included in the audit undertaken for the place where they lived.

(b) Number of deaths by sex and age group: 2014-16

More than four times as many male than female deaths by suicide/UI were registered in the three year period:

- 52 males died (47 by suicide and 5 by UI)
- 12 females died (9 by suicide and 3 by UI)

Most of those who died (38 of the 64 deaths) were between 35 and 59 years old. In addition:

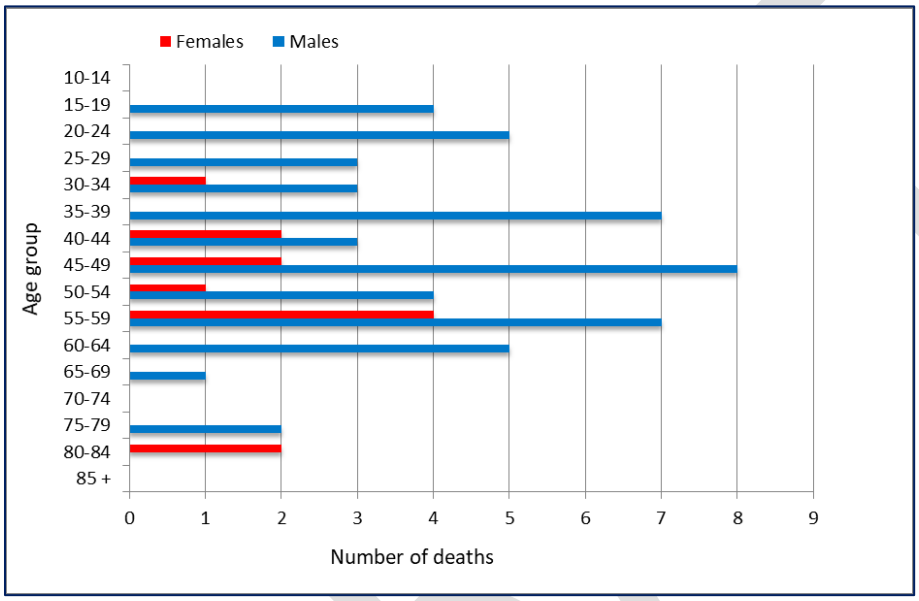
- The youngest person who died was 16 years old
- The oldest who died was 82 years old

- 9 people who died were younger than 25 years old
- 4 people who died were older than 75 years old

The chart below shows that number of deaths varies by sex and age group and reveals the following differences:

- Deaths among males are highest between the ages of 45 and 59 (19 of the 52 male deaths)
- All the females who died were over the age of 30

Number of deaths by age group and sex



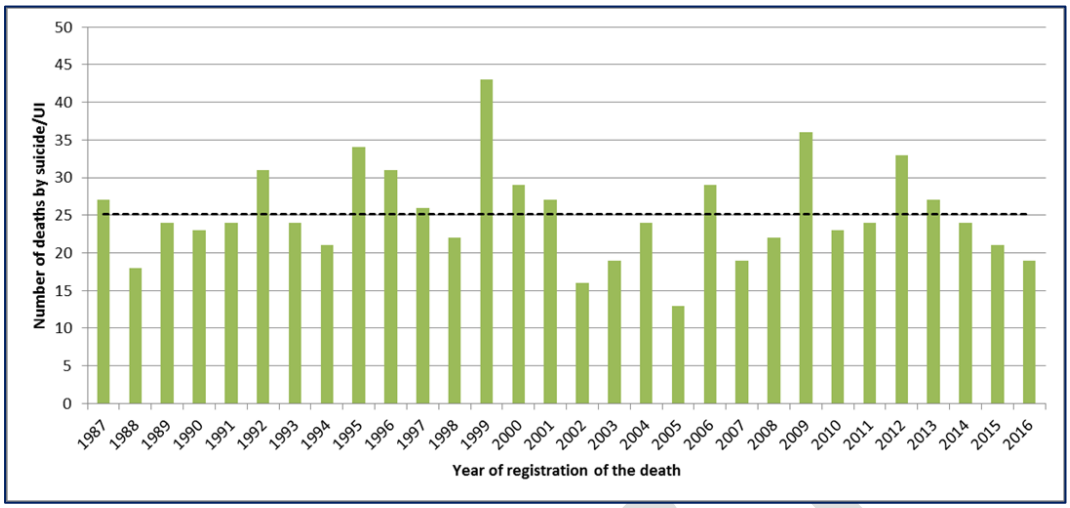
(c) Trend in the number of deaths: 1987-2016

A total of 753 deaths of residents by suicide/UI have been registered over the past 30 years. Calculating the long-term averages for the city reveals:

- Around 25 deaths each year
- Around 2 deaths a month

The figure on the following page shows the number of deaths registered for each year. The number of deaths ranges from a high of 43 deaths in 1999 to a low of 13 deaths in 2005. The black dotted line indicates the long term average of 25 deaths.

Trend in numbers of deaths by suicide/UI: 1987-2016



Source: Annual Death Extracts, ONS and NHS Digital.

(2) Mortality rates

Official mortality rates are given for the number of deaths for three year periods (expressed as the number of deaths per 100,000 of the relevant population). Statistical methods are used to control for variations in population structure by age to produce standardised rates enabling us to compare rates for different areas.

(a) Mortality rates for Plymouth and England: 2014-16

For deaths by suicide/UI, the directly age-standardised mortality rate (DASR) for Plymouth is in line with England for persons, for males, and for females:

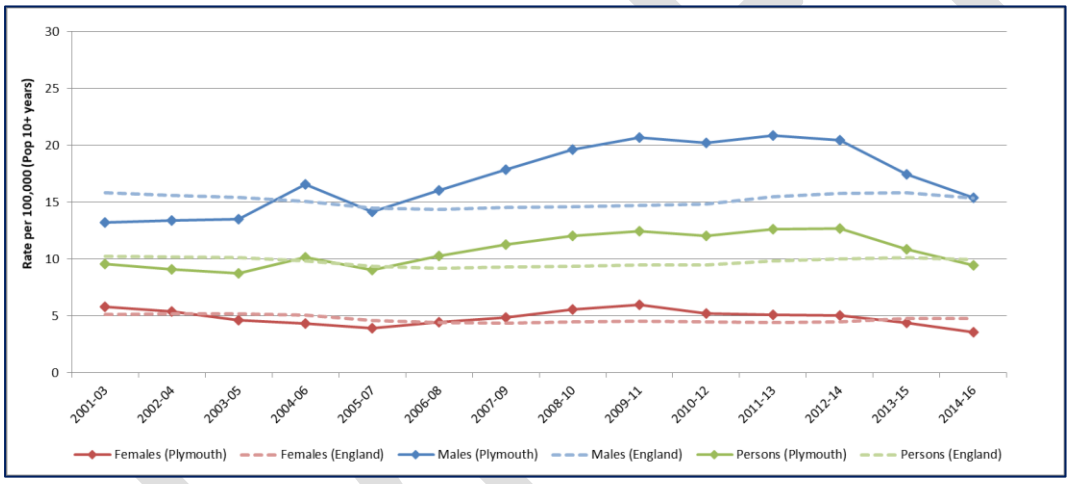
- The DASR for Plymouth **persons** is 9.5 deaths which is in line with the rate for England of 9.9 deaths per 100,000 population
- The DASR for Plymouth **males** is 15.4 deaths which is in line with the rate for England of 15.3 deaths per 100,000 population
- The DASR for Plymouth **females** is 3.6 deaths which is in line with the rate for England of 4.8 deaths per 100,000 population

(b) Trend in mortality rates for Plymouth and England: 2001-2016

The DASR for Plymouth deaths by suicide/UI has varied over the past 15 years for persons and the pattern differs for males and females. The rates are shown in the figure below which compares the DASR for Plymouth persons (green line), males (blue line) and females (red line) with those for England (the dotted lines in the same colours):

- The DASR for Plymouth **persons** is below England until 2007-09 when it rises above England and stays above to 2012-14. It falls in line with England for the period 2013-15 and remains in line with England to 2014-16.
- The DASR for Plymouth **males** follows a similar pattern to that for persons (which is expected as males comprise the majority of all deaths). It is above England from 2007-09 until 2012-14 and is in line with England from 2013-15.
- The DASR for Plymouth **females** follows a different pattern – it remains in line with England for the past 15 years.

Trend in mortality from suicide/UI, England and Plymouth: 2001-03 to 2014-16



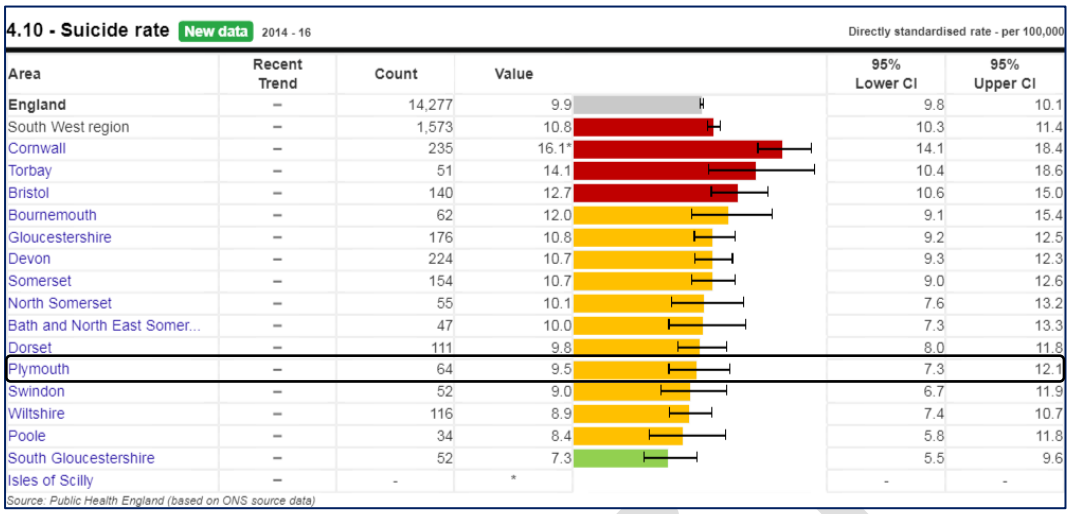
Source: PHOF (November 2017 download)

(c) Mortality rates: Plymouth ranked within the South West region

The England mortality rate for suicide/UI is 9.9 per 100,000 population for 2014-16. The rates per 100,000 population for the nine regions in England range from a high of 11.6 (North East) to a low of 8.7 (London). The South West region is ranked third highest in England (below the North East and the North West regions).

Plymouth is ranked 11th out of 15 when the DASR for Plymouth persons is compared to our neighbours in the South West region. The rates in the South West region range from a high of 16.1 (Cornwall & the Isles of Scilly) to a low of 7.3 (South Gloucestershire). Plymouth's rate of 9.5 is fourth from bottom (the lowest rate). Rates for the South West region are presented in the figure on the following page.

Mortality rate from suicide/UI, South West region and Plymouth: 2014-16



4.10 - Suicide rate New data 2014 - 16 — Directly standardised rate - per 100,000

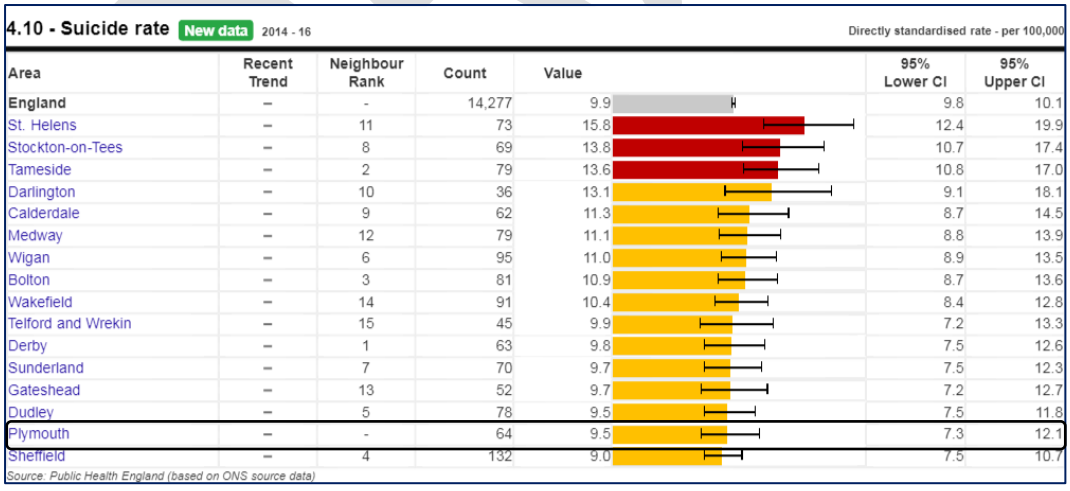
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,277	9.9	9.8	10.1
South West region	–	1,573	10.8	10.3	11.4
Cornwall	–	235	16.1*	14.1	18.4
Torbay	–	51	14.1	10.4	18.6
Bristol	–	140	12.7	10.6	15.0
Bournemouth	–	62	12.0	9.1	15.4
Gloucestershire	–	176	10.8	9.2	12.5
Devon	–	224	10.7	9.3	12.3
Somerset	–	154	10.7	9.0	12.6
North Somerset	–	55	10.1	7.6	13.2
Bath and North East Somer...	–	47	10.0	7.3	13.3
Dorset	–	111	9.8	8.0	11.8
Plymouth	–	64	9.5	7.3	12.1
Swindon	–	52	9.0	6.7	11.9
Wiltshire	–	116	8.9	7.4	10.7
Poole	–	34	8.4	5.8	11.8
South Gloucestershire	–	52	7.3	5.5	9.6
Isles of Scilly	–	-	*	-	-

Source: Public Health England (based on ONS source data)

(d) Mortality rates: Plymouth ranked within the CIPRA group

Plymouth is ranked 15th out of 16 when the DASR for persons is compared to neighbours in our CIPRA group (a set of local authorities considered most similar to Plymouth). The rates per 100,000 population in the CIPRA group range from a high of 15.8 (St. Helens) to a low of 9.0 (Sheffield). Plymouth's rate of 9.5 is second from bottom (the lowest rate). Rates for the CIPRA group are presented in the figure below.

Mortality rate from suicide/UI, CIPRA group and Plymouth: 2014-16



4.10 - Suicide rate New data 2014 - 16 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,277	9.9	9.8	10.1
St. Helens	–	11	73	15.8	12.4	19.9
Stockton-on-Tees	–	8	69	13.8	10.7	17.4
Tameside	–	2	79	13.6	10.8	17.0
Darlington	–	10	36	13.1	9.1	18.1
Calderdale	–	9	62	11.3	8.7	14.5
Medway	–	12	79	11.1	8.8	13.9
Wigan	–	6	95	11.0	8.9	13.5
Bolton	–	3	81	10.9	8.7	13.6
Wakefield	–	14	91	10.4	8.4	12.8
Telford and Wrekin	–	15	45	9.9	7.2	13.3
Derby	–	1	63	9.8	7.5	12.6
Sunderland	–	7	70	9.7	7.5	12.3
Gateshead	–	13	52	9.7	7.2	12.7
Dudley	–	5	78	9.5	7.5	11.8
Plymouth	–	-	64	9.5	7.3	12.1
Sheffield	–	4	132	9.0	7.5	10.7

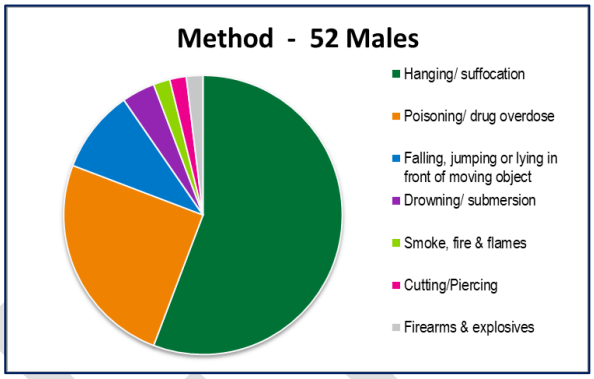
Source: Public Health England (based on ONS source data)

(3) Methods

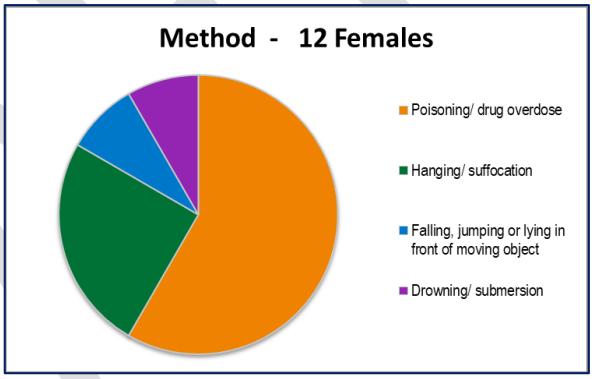
Hanging/suffocation is the most common method overall (32 of the 64 deaths) followed by poisoning/drug overdose (20 deaths). Other methods include death by falling, jumping or lying in front of a moving object (6 deaths), by drowning/submersion (3 deaths), and one death each for deaths by cutting/piercing, by firearms, and by smoke, fire and flames.

There are differences in the methods used by males and females. These are shown in the adjacent charts:

- The majority of **males** died by hanging/suffocation (29 deaths) and poisoning/drug overdose (13 deaths).



- Most **females** died by poisoning/drug overdose (7 deaths) followed by hanging/suffocation.



(4) Places

(a) Where they were born

The majority of the deceased (56 of the 64 residents) were born in the UK:

- 26 were born in Plymouth
- 30 were born elsewhere in the UK

8 of the deceased were born outside the UK.

(b) Where they died

The majority of the deceased (50 of the 64 residents) died in Plymouth:

- 35 died at home
- 8 died elsewhere in the city
- 7 had their place of death noted as Derriford Hospital (the injuries leading to death would have been initiated prior to reaching hospital, either at home or elsewhere in the city).

14 residents died by suicide/UI outside the city.

(c) Where they lived in the city

Death by suicide/UI is a concern across the city with the majority of electoral wards in the city and the majority of neighbourhoods in the city having at least one death by suicide/UI registered in the three year period.

- **Electoral wards:** 19 out of the 20 wards in the city had at least one resident die by suicide/UI.

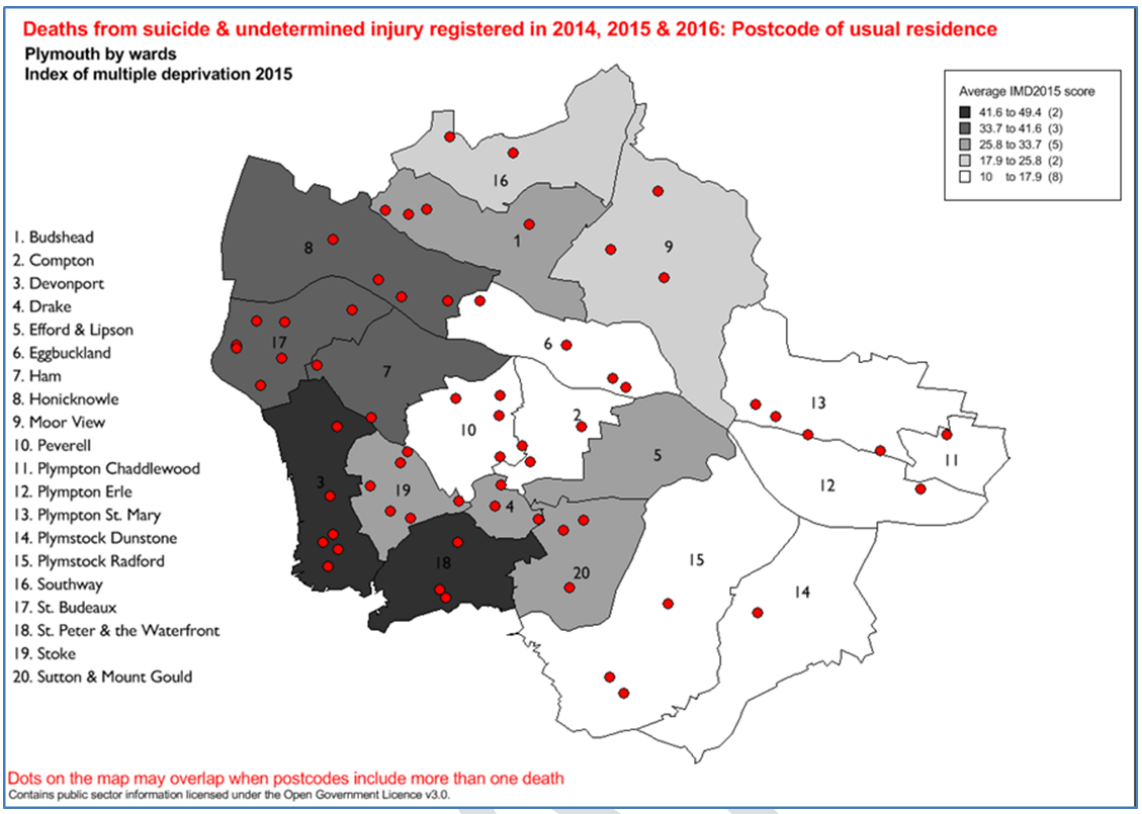
The number of deaths registered is highest in St Budeaux ward (7 deaths) followed by Devonport ward and Stoke ward. No deaths were registered for residents of Efford & Lipson ward.

- **Neighbourhoods:** 33 out of the 39 neighbourhoods in the city had at least one resident die by suicide/UI.

The number of deaths registered is highest in Barne Barton neighbourhood (5 deaths) followed by Devonport neighbourhood and Stoke neighbourhood. No deaths were registered for residents of six neighbourhoods: Efford, Goosewell, Ham & Pennycross, Leigham & Mainstone, and Lipson.

The map on the following page shows the post-code of the usual residence for those who died in the three year period.

Postcode of usual residence for deaths by suicide/UI registered 2014-16



Section Two: Information received from local NHS health and wellbeing services

Additional information about residents whose deaths were registered in the three year period was requested from primary care, mental health, and hospital services in the city. The information sought from these services asks whether and when the person had been in contact with the service and the reasons for the contact. The focus is on the period 12 months prior to death and information for this period is presented in this section.

Some information from local services is available for 50 residents who had been in contact with one or more local services in the 12 months prior to death. It reveals the following:

- 40 residents were in contact with primary care services
- 29 residents were in contact with local hospital services
- 16 residents were in contact with mental health services

Information received from local services for the period 12 months prior to death is discussed, first, by following each person's record across the three services and, then, by focusing separately on each service and summarising the information they provided.

(1) Focus on each person and their contacts with services

The information available for the 50 residents includes details of the date of their last contact with one or more of the three services in the 12 months prior to their death. Following each person's record made it possible to find out how many services were contacted:

- **One service:** 26 people were in contact with only one service. The majority of them (18 of the 26) had contact only with primary care services.
- **Two services:** 13 people had been in contact with two services. The majority of them (9 of the 13) were in contact with both primary care and hospital services.
- **Three services:** 11 people had been in contact with all three services in the 12 months prior to their death.

Comparing the dates for their last contact with any of the services made it possible to identify which service they had contacted most recently prior to their death:

- 30 people were most recently in contact with primary care services
- 12 people were most recently in contact with mental health services
- 9 people were most recently in contact with hospital services

(Please note that one person was in contact with two services on the same day, so the total number of most recent contacts listed above is 51 rather than 50.)

(2) Focus on each service

(a) Information from primary care

If a death by suicide/UI was confirmed and it was possible to identify the person and their general practice (GP), a letter was sent to the GP asking them to complete the section of the national guidance questionnaire on 'Information relating to contact with Primary Care'.

No request for information was sent if the person who had died could not be identified by name. In some cases, for example, where residents died out of the city no death registration information and no coroner information would be available. In addition, some residents who died may not have been registered with a GP in the city.

Some information was received from primary care for 45 residents, 40 of whom had been in contact with their GP in the 12 months prior to death. Not all questionnaires were completed fully (where information is not available, it is noted).

Information for the 40 residents who had been in contact with their GP in the 12 months prior to death is summarised below giving details of the date of last contact, who they were seen by, and the reason noted for the appointment. Lastly, any lessons learned that may help prevent future suicides are collated.

Date of most recent contact prior to death

The date of the most recent contact is given as the number of days prior to death and refers to the most recent contact with any member of the primary care team (the appointment may have been with a medical doctor or another member of the primary care team):

- 23 people were seen within 30 days of their death, and 10 of the 23 people were seen within seven days of their death.
- 28 people had their most recent appointment with a medical doctor and the remaining 12 were seen by another member of the primary care team.

Most recent contact with primary care services

Number of days prior to death	Count
Up to 7	10
8 to 30	13
31 to 90	7
91 to year	10
Total	40

Reasons noted for last contacts

The reasons noted on the questionnaire for their last appointments included three options: physical health, mental health, or both physical and mental health. Information is available for their last appointment with a medical doctor and also for their last appointment with another member of the primary care team:

- **Last contact with a medical doctor**: Contact for physical health is as common as for mental health in the reasons noted for their last appointment with a medical doctor (17 people were seen for their physical health, 16 people were seen for their mental health, and 5 people were seen for both their physical and mental health. No information is available for 2 people.)

- **Last contact with another member of the primary care team**: Contact for physical health is the primary reason noted for their last appointment with another member of the primary care team (21 people were seen for their physical health, 9 people were seen for their mental health, and 2 people were seen for both their physical and mental health. No information is available for 8 people).

In the 12 months prior to their death, a total of 23 people were seen for their mental health or for both their mental and physical health. During this period, 14 people were diagnosed with a mental illness. Depressive Illness is the most common current or ongoing mental health diagnosis noted. A history of self-harm is noted for 9 of the 40 people, and 4 people were known to have made a previous attempt to take their life.

Lessons learned that might help prevent suicides in future

Comments made in response to the question about whether there are lessons to be learned are grouped into general themes (grouping comments into themes is repeated through the report). Most GP comments were brief and general.

The six main themes identified from the comments highlight:

- ❖ Personal relationships (for example, breakdown of relationships)
- ❖ Bereavement
- ❖ Medication (for example, problems due to changes in prescriptions, also access to medications as a means)
- ❖ Fear an illness had returned (physical ill health)
- ❖ Long-term mental health problems
- ❖ Issues to do with referrals, and patients missing appointments

(b) Information from local mental health services

Mental health records identified that 33 of the residents included in the audit had some contact with mental health services during their lifetime, and 16 of the 33 residents were in contact with mental health services in the 12 months prior to death.

The proportion of persons in contact with mental health services in Plymouth in the 12 months prior to death is 25% (16 out of 64). This proportion is in line with national data for England. In their Annual Report (2017),[5] the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness notes that 27% of general population suicide deaths (occurring in the period 2005 to 2015) were 'patient deaths' in that the person had been in contact with mental health services in the 12 months prior to death.

Information for the 16 residents who had been in contact with mental health services in the 12 months prior to death is summarised below giving details of the date of their last contact, common diagnoses, and inpatient information. Lastly, any lessons learned that may help prevent future suicides are collated.

Date of last contact prior to death

The date of last contact is given as the number of days prior to death and refers to the most recent contact with mental health services:

- 12 of the 16 residents were seen within 30 days of their death, and 5 of the 12 were seen within seven days of their death
- 10 of the 16 residents were on the caseload when they had their last appointment

Most recent contact with mental health services

Number of days prior to death	Count
Up to 7	5
8 to 30	7
31 to year	4
Total	16

Reasons noted for last the contact

The most common diagnoses (9 of the 16 residents) are Depressive Illness and Bipolar Affective Disorder. A history of self-harm is noted for 5 of the 16 residents. No one was known to have a history of violence, 2 were known to have a history of alcohol misuse and one to have a history of drug misuse.

Most of the residents in touch with mental health services in the 12 months prior to death (10 out of 16) had previously been admitted as inpatients (psychiatric). 5 of the 10 people had an admission within 12 months prior to their death, and none of the admissions occurred within 30 days of death.

Lessons learned that might help prevent suicides in future

Issues raised in response to the question about whether there are lessons to be learned have been grouped into general themes. The issues collated below were identified from comments included in the action plans made following investigations undertaken by mental health services.

The five main themes identified from the comments highlight:

- ❖ Patient behaviour (for example, missing appointments and not taking medication as directed)
- ❖ Medications (for example, improving liaison between primary and secondary care concerning medications)
- ❖ Service provision (for example, increasing provision of specialist services for children and young people over weekends)
- ❖ Staff issues (for example, improved supervision, case-load management and risk assessments)
- ❖ Information (for example, sharing and passing on information appropriately to teams, services and agencies)

(c) Information from local hospital services

Hospital records identified information for 29 residents included in the audit who had attended the Emergency Department (ED) or had been admitted to hospital in the 12 months prior to their death. This number excludes residents whose attendance at hospital in the days before their death was solely due to the events that subsequently would lead to them dying from their injuries (and where they had not attended on any other occasion in the 12 months prior to death).

Information for the 29 residents who had been in contact with hospital services in the 12 months prior to death is summarised below giving details of the number and times they had contact, the date of the last contact, and the reason noted for the contact.

Number and type of contact

Information is given separately for attendances at the Emergency Department only, for admissions into hospital only, and for both attendances and admissions in the 12 months prior to death:

- **Emergency Department only:** 9 residents had attended the ED without being admitted into hospital (all 9 attended only once).
- **Admission to hospital only:** 8 residents had attended as inpatients only (4 had attended more than once).

- **Attended ED and had been admitted to hospital**: 12 residents had attended both the ED and as inpatients (7 had attended either the ED or as inpatients more than once).

Date of last contact prior to death

The date of the last contact is given as the number of days prior to death and refers to the most recent contact (irrespective of whether it was attendance at the Emergency Department or as an inpatient):

- 5 people were seen within 30 days of their death
- 15 had their last contact more than 181 days prior to their death

Most recent contact with hospital services

Days prior to death	Count
Up to 30	5
31 to 90	0
91 to 180	9
181 to year	15
Total	29

Of the 29 persons, 12 were most recently seen in the Emergency Department, 11 were seen as admissions into hospital, and 6 were seen in the Emergency Department and admitted on the same day.

Reasons noted for last the contact

The reasons noted for their last contact are given below in terms of the type of attendance at hospital:

- The majority of those who had attended the Emergency Department only attended for their physical health (7 of the 9 people).
- Almost all those who were admitted as inpatients only were in hospital for their physical health (7 of the 8 people, and no information is available for the other person).
- Half of those who attended both the Emergency Department and were admitted into hospital did so for their physical health (6 of the 12 people). Reasons noted for the other 6 people included mental health/psychological, self-poisoning, and dementia.

Section Three: Information drawn from coroner records

There are local coroner records for 54 of the 64 residents included in the audit. These residents died within the boundaries of the coroner service for Plymouth, Torbay and South Devon.

Information drawn from the coroner files for the 54 residents is summarised below giving further demographic details and the health and well-being concerns mentioned. The main focus is on our notes concerning the social context which offer a broader perspective on suicide and suicide prevention.

(1) Relationship and employment status

- **Relationship status**: 21 of the 54 residents were married or cohabiting at the time of their death, 11 were separated, divorced or widowed, and 19 were single.

Relationship status	Count
Single	19
Married/cohabiting	21
Separated/Divorced/Widowed	11
No information	3
Total	54

- **Employment status:** 29 of the 54 residents were employed at the time of their death, 15 were unemployed and 7 were retired.

Employment status	Count
Employed	29
Unemployed/off sick	15
Retired	7
Not yet economically active	2
No information	1
Total	54

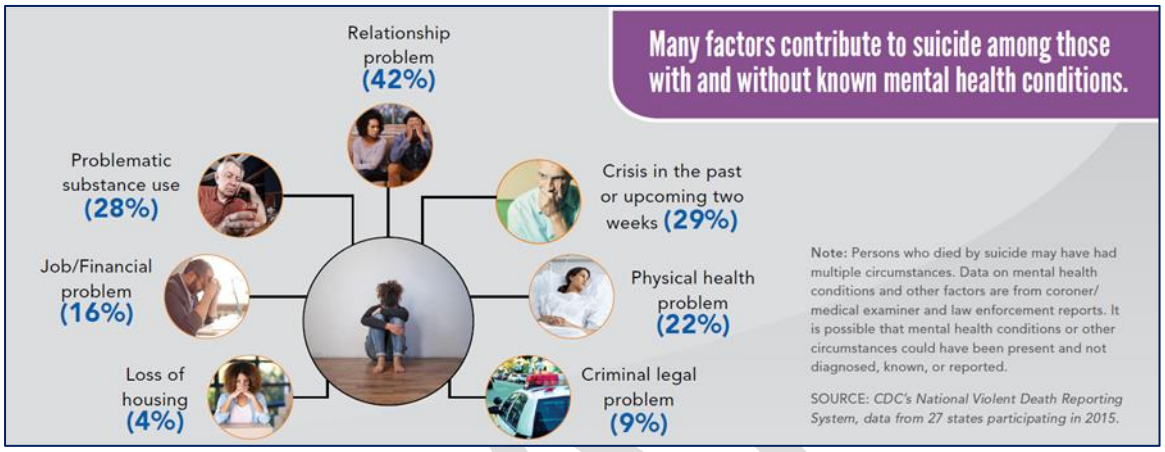
(2) Health and wellbeing concerns

The three health and wellbeing concerns most frequently noted are listed below. The categories overlap and all have been mentioned previously in this report:

- Depression
- Physical health problems
- Mental health problems

(3) Notes on social context and factors contributing to suicide

Notes were taken on the social context mentioned in coroner records. The framework chosen to help arrange our notes is taken from the Centers for Disease Control and Prevention (CDC) in the United States.[6] The broad factors identified as contributing to suicide are illustrated in the diagram below. These factors include: Relationship problem; Crisis in the past or upcoming two weeks; Problematic substance use; Physical health problem; Job/Financial problem; Criminal legal problem; and, Loss of housing.



Source: CDC 2018

The categories in the framework have been amended for the purpose of this audit, and may be further refined in future audits. Our notes on the social context are collated below.

The most common contributing factors are listed first, followed by other contributing factors that were noted less often:

Most common 'contributing factors'

- Personal relationship issues (for example, breakdown of relationships and lack of access to children following separation)
- Immediate crisis (for example, diagnosis of illness or suspected return of illness, unexpected redundancy and threatened loss of benefits, relationship problems and arguments)
- Criminal Justice history (for example, interviewed and awaiting trial)
- Bereavement (for example, death of a family member or friend)
- Living arrangements (for example, insecure housing and social isolation)

Other 'contributing factors'

- Adverse childhood experiences (for example, abused when younger)
- Job issues (for example, insecure work and unemployment)
- Financial issues (for example, debt and loss of income)
- Suicide, experience of (for example, suicide of a family member or friend)
- Access to means (for example, access to medication)
- Welfare system (for example, changes to welfare benefits)
- Substance misuse (for example, drugs and alcohol)

Conclusion

This report provides a city-wide overview of deaths by suicide/UI in Plymouth and covers deaths registered over a three year period (2014-16). Mapping their place of residence shows that the 64 residents included in this audit lived in different areas of the city and that suicide prevention is a concern across the city.

In concluding the report we ask: first, whether the audit process was successful in obtaining additional information and, second, whether the range and type of additional information collected is appropriate and timely enough.

Scope of the local suicide audit process

Official mortality data is available for all 64 residents included in the audit. Some additional information was available for the majority of the deceased from coroner records and from local NHS services. No additional information was available for 7 of the 64 residents. Overall, the local audit process has been successful in accessing additional information about the Plymouth residents who died by suicide/UI.

The scope of the additional information is currently limited to three NHS services. It is possible that other local services could be included in future (for example, substance misuse services).

An inclusive audit process for 'avoidable deaths'

The public health team is exploring whether an 'avoidable deaths' approach would be preferable for the city. This inclusive approach would consider suicide deaths alongside drug-related and alcohol-related deaths in the city and would share relevant information across services available to residents in Plymouth. It would seek to assess the wider social factors that contribute to suicides and other deaths in the city.

Sources cited

1. Maconachie M & Hoad S (2016) Plymouth Suicide Audit Summary (deaths registered in 2013, 2014 & 2015). Plymouth City Council: Office of the Director of Public Health.

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3. Public Health Outcomes Framework indicator 4.10 - Suicide rate

4. National Institute for Mental Health in England (2006) Suicide audit in Primary Care Trust localities: a tool to support population based audit of suicides and open verdicts. Leeds: National Institute for Mental Health in England.

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6. Centers for Disease Control and Prevention (2018) Suicide rates rose across the US from 1999 to 2016. Vital Signs, June: www.cdc.gov/vitalsigns/suicide