Bradford-Calderdale-Kirklees Suicide Audit

2019-2021

Summary of Key Findings

For

Bradford District

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Contents:

Foreword

In Bradford we believe that every life lost to suicide is one too many. Death by suicide is tragic and devastating for the people it leaves behind. With the right support it can be prevented, however, we know that suicide prevention is challenging due to the deeply individualistic nature of suicide and the events that might lead to it. The findings of this audit provide us with an opportunity to deepen our understanding of the lives lived of those who have died by suicide in our district, to learn from this and to identify where prevention opportunities may lie. This will enable us to work with partners in health, police, and the community more effectively so we can take those opportunities and work together to prevent future lives being lost to suicide of people living in Bradford.

Sarah Muckle, Director of Public Health, Bradford.

“It was important to me that suicide prevention was being looked at systemically, and that trends, risks and patterns were being explored and acknowledged.

Amongst the stats it can be difficult to understand the lived experience of the ripple effect of suicide.

For me, suicide audits are an opportunity to acknowledge that more can be done to prevent deaths by suicide in our communities, and to work together to this end.

We can't prevent the deaths of those we have already lost, but we can work together with them in mind, as we strive to prevent future losses.”

Christian Smith, bereaved by suicide.

This report is dedicated to all those who have lost their lives to suicide and to the people they have left behind.

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Introduction

This report summarises the work and key findings of the Bradford, Calderdale, and Kirklees suicide audit for 2019-2021. In 2023 the three local authorities undertook an audit of the coroner's files for people who had died in our districts where a conclusion of suicide was reached by the coroner at inquest. Bradford, Calderdale, and Kirklees have worked in partnership to deliver this audit and produce its findings and recommendations. The findings included in this report have been localised to Bradford District.

Since 2014, ONS data shows suicide rates in Bradford District have remained below the England average. However, in recent years rates have been gradually rising and are now similar to the average for England which has remained stable and is currently 10.5 per 100,000 people (1).

Suicide should be a never event, yet it is a leading cause of years of life lost. Suicide is a significant cause of death in young adults and is seen as an indicator of underlying rates of mental ill-health across the population.

Each death by suicide has a far-reaching and long-lasting impact on the people, families, and communities left behind. It is is often the end point of a complex history of risk factors and/or difficult life events - but there are ways in which services, communities, individuals, and society, can help to prevent it.

Effective suicide prevention relies on good quality local intelligence to identify risk factors associated with suicide to inform local action plans. These action plans allow us to work better together to prevent future deaths by suicide. The findings from this audit will allow each of the local authorities to tailor their local action plans to the needs of their residents, giving us a greater opportunity to understand, intervene and prevent future lives being lost to suicide in our areas.

The Audit: coroner's office data collection

Method

The aim of this audit was to review information collected as part of the coronial inquest for all deaths of people who died in the years 2019, 2020 and 2021 where a conclusion of suicide had been reached. It includes residents from Bradford, Calderdale, and Kirklees. This is because Bradford, Calderdale and Kirklees share the same coroner and working together enables us to draw more conclusions from the data due to a larger population size which means that our findings may be more reliable. It also helps us to identify differences amongst neighbouring authorities so that our local prevention efforts can be targeted to local need.

What did we do?

- Bradford, Calderdale, and Kirklees set up a project management group to steer and deliver the audit work, including agreeing methods, data collection and analysis. The group included members from the Public Health teams of all three local authorities. Members were recruited based on their skills and experience of data intelligence and subject expertise.

- The project management group developed a data collection tool to be used in the audit process. This was informed by data collection tools used in previous audits and feedback from system partners, with the aims of:
    - Minimising subjectivity and increasing objectivity in data collection by the auditors.
    - Enabling comparisons of the data collected between the previous audit cycle and this audit.
    - Enabling the data collected to be standardised and compared with other data sets such as those from the Office of National Statistics.
    - Collecting new data that could be analysed to further improve our understanding.
- The data collection tool was used by a small team of trained auditors to collect data from all available evidence submitted as part of the coroner's inquest. This included information from services such as primary and secondary care, social care, police, witness testimonies and family statements.
- The data was then analysed to identify rates, trends and potential risk factors that have informed our recommendations.

Limitations and considerations

The coroner's office for Bradford, Calderdale and Kirklees recorded 325 deaths by suicide of people of all ages across the 3 local authorities in the years of 2019, 2020 and 2021. However, 11 of these casefiles were unavailable to us at time of data collection, meaning 314 casefiles were used to inform this report.

There was also a small number of deaths recorded in the years 2019, 2020 and 2021 where the inquest was not complete at the time of our data collection. These cases remained open to the coroner and did not have a conclusion recorded for cause of death. Therefore, any of these cases that were later concluded as suicide will not be included in our data and any findings of this report should be interpreted with this in mind.

A further note of context; the specific period of time that this audit is concerned with spanned the years 2020 and 2021 when the UK experienced the Covid pandemic and lockdown periods. This was an unprecedented time in our recent history. We have attempted to capture any Covid related factors identified as being contributary to a person's death in this report, however, the overall findings should also be considered within this unique social context.

Key findings

The following section of this report contains information about individuals and their lives leading up to their death which some may find upsetting. We do not publish sensitive information about the circumstances of death in line with the Samaritan media guidelines for reporting suicide (2).

If you are struggling with the content of this report or if you know someone who might be, there is help available.

- Call Samaritans for **free on 116 123**, email them at **jo@samaritans.org**, or visit www.samaritans.org
- Or visit this page for more ideas of where you can get support in West Yorkshire:

https://suicidepreventionwestyorkshire.co.uk/

Data collected from the total audit population (this includes residents of Bradford, Calderdale, and Kirklees) has been used to inform the key findings of this report. This allows us to understand and publish findings on a wider range of risk factors and indicators. Following Protective Data Management best practice, any cases under 5 are supressed in or order that individual information cannot be identified.

Analysis of risk factors was also undertaken for each local authority separately. It has been detailed in this report where there were any differences in the findings for the overall audit population (Bradford, Calderdale, and Kirklees residents) and for Bradford District (Bradford residents only).

Section 1 - Suicide Rates and demographics.

The data collected for this audit has been analysed and expressed here as rates per 100,000 people. This is usual practice when looking at data for populations and allows us to make fairer comparisons between groups.

Gender and age

- **Nearly 4 out of 5 deaths of those who died by suicide were males, 1 out of 5 deaths were female** which is similar to trends in previous years.
- **The rate of suicide for children and young people**, specifically those under 26 years-old, was 5.1 per 100, 000 people. This **is significantly lower** than the overall rate for all ages (10.13 per 100,000). There were 37 people under the age of 26 years old and fewer than 5 of these were under 18 years old for the whole audit population.
- For the overall audit population, the suicide rate for 46–55 year-olds is significantly higher than the suicide rate for all ages. However, this was not true for **Bradford where there was a more even spread across all age bands from ages 26 and above** and the highest rates by age band for Bradford were 36-45 and 56-65.
- When split by age and gender, **the highest suicide rate for females was those aged 36-45** years at 6.8 per 100,000.

Ethnicity and Religion

Ethnicity and religion are not recorded on death certificates in the UK. This means that this information is not routinely collected as part of the coronial inquest. In over 50% of casefiles ethnicity was not recorded as part of the evidence submitted, and in over 90% religion was not

recorded as part of the evidence submitted. Whilst Public Health teams do hold intelligence about ethnicity and suspected suicide from other sources, it would be misleading to share any analysis of the data collected as part of this audit, given there was so much information was unknown. Identifying ways to improve this has formed a key recommendation of this audit (see page 12).

Relationships and living circumstances.

- The suicide rate for **people from the whole audit population who were recorded as gay or lesbian was significantly higher** at 31.3 per 100,000 than the rate for all people who died by suicide.
- **43.6% of people who died by suicide were single,** compared to 26.7% of people who are single in the general population**.** The proportion of people who were single who died by suicide has increased for the audit population as whole since the last audit, but this was not true for Bradford.
- **23.2% of people who died by suicide were separated or divorced**, compared to 9% of people who are separated or divorced in the general population.
- **42.7% of people who died by suicide lived alone,** compared to 31.4% of the general population who live alone.
- **In their lifetime**, **62% of those who died by suicide had children**. 9.6% of those who died, were living with one or more people under the age of 18 at time of death. This equates to 62 children under the age of 18, across the 3 local authorities lost someone that they lived with to suicide.
- Data was collected on whether those who died by suicide had been pregnant in the 2 years prior to death. There were less than 5 people recorded against this indicator from our audit population.
- **There was no clear link between suicide and deprivation**, when looking at the IMD quintile of where people who died by suicide lived. Whilst the **highest** suicide rates were recorded for those living in the **least deprived areas of the district**, there was **no significant difference between the most and least deprived areas of Bradford.**

Employment factors

- **Just over half of people who died by suicide were economically inactive***
- For those who were economically active, the rate of people who worked in a **skilled trade occupation** who died by suicide was significantly higher** than the rate for all occupations.
- When broken down by gender, **the rate for females who worked in the professional *** sector was significantly higher** than the rate for all females.
- Data was collected for frontline worker status and veteran status, but small numbers were recorded.

**Taken from ONS Census 2021 groups: economically inactive – (those who did not have a job and were not looking for work) – this includes being retired, studying, looking after home or family, and long-term sick or disabled.*

*** ONS Skilled trades occupations definition=A substantial period of training, often provided by means of a work-based training programme. This includes skilled industrial trades, such as welders and machinist; Skilled construction trades, such as plumbers and carpenters; Skilled service trades, such as nurses and hair stylists. OR skilled trades occupations (minor groups including construction and building trades; food preparation and hospitality trades; agricultural and related trades)*

**** Professional occupations (minor groups including teaching and other educational professionals; information technology professionals; nursing and midwifery professionals)* (3)

Migration and Immigration

Data was collected on immigration status, migration history, and migration to England in the last 12 months, but meaningful analysis was not possible due to small numbers being recorded for many of the data collection categories.

Section 2 - Health related risk factors

Most people who died by suicide had multiple identified risk factors.

- **Having a mental health condition is the biggest risk factor for suicide**. 64.6% of those who died by suicide had a diagnosed mental health condition. This was **higher** in **females (80%)** than in **males (60.5%)**. A further 10.5% had a suspected undiagnosed mental health condition.
- **21.3% of people had a recorded history of self-harm**. Of the females in the audit population 35.4% had a record of self-harm compared to 17.7% of males**.**
- **46.1%** of those who died by suicide **had a history of suicidal ideation.**
- 45.8% of the total population had a history of suicide attempts**. For Bradford 68.2% of females who died by suicide had a previous attempt recorded, and 39.8% of males had a previous suicide attempt recorded.**
- **Having a physical health condition could be a risk factor -** of those who died by suicide, **57% had at least 1 physical health condition**; **19% had 3 or more diagnosed physical illnesses**. A **higher proportion** of **females** (**63.1%**) compared with **males (55.6%)** who died by suicide reported a **physical illness diagnosis**.
- **48.6% of those who died by suicide had a record of problematic use of either drugs, alcohol or both at some point in their lifetime***. In Bradford 15.5% of problematic alcohol use was within the last 12 months and 17.2% of problematic drug use was within the last 12 months of the person's life. **Males were more likely** than females **to have history of problematic drug use**. Problematic alcohol use figures were similar when broken down by gender.

  **problematic alcohol or drug use includes anything from recorded addiction, to family, friends or a professional having mentioned alcohol or recreational drug use was a problem for the person before their death in their evidence submitted to the inquest.*

Section 3 - Adverse life events

Adverse life events can be a risk factor for suicide.

- **Bereavement was the highest common factor recorded** with 42.4% of the audit population having a bereavement recorded as an adverse life event (in their lifetime).
- **25.8% of people had previous contact with the criminal justice system**.
- **23.2%** of people **suffered from isolation and loneliness** which has increased since the last audit.
- **22%** of those who died by suicide had **suffered at least one Adverse Childhood Experience***.
- There was **a higher proportion of females** than males whose file recorded they **had suffered adverse childhood experiences, bereavement or had been a victim of abuse.**
- There was **a higher proportion of males** than females whose files recorded **contact with the criminal justice system or were a perpetrator of abuse.**
- Other significant risk factors included **relationship stress and issues with work or job loss or debt.**

**Categories used for Adverse Childhood Experience: Household challenges, Abuse, Neglect, Household challenges and abuse, Household challenges and neglect, Abuse and neglect, Household challenges, abuse and neglect.*

Section 4 - Access to services and help seeking behaviour.

Nearly everyone who died by suicide had a record of contact with health services and/or the police. The most accessed services were Primary care, Mental health services and Secondary care services (the majority of which were A&E attendances).

Primary Care:

91.4% of those who had died by suicide had a record of a **primary care contact** at their GP practice.

- **57.4% had accessed their GP practice within 3 months of death.**
- **37.3%** of those who died by suicide had accessed their **GP practice in the month preceding death.**
- **For 81.3% of people their last recorded contact with Primary care was with a GP** rather than other allied health professionals.
- **78% of last appointments were requested by the person** and 22% were a result of being invited into the practice for a health check, review of a long-term condition or prescribed medication.
- **Physical health was the most common reason for attending the last appointment in Primary care.**

- **Mental health was the second most common reason for attending the last appointment in primary care.**
- **Depression** and **anxiety were the most frequently cited reasons** for someone to contact their GP practice in relation to their mental health.
- **Only 7% of people disclosed self-harming or feeling suicidal at their last Primary care appointment.**

Mental Health services:

51.6% of people had been **referred to Specialist Mental Health (SMH)** services at some point in their lifetime:

- **19.5% had been referred within the 3 months preceding death.**
- Of those with record of SHM referral**, 32% were actively under care at the time of death.**
- **28.7%** had accessed **SMH services within the 3 months** preceding death.
- **18.5% of people who had been referred to SMH services had been discharged within 12 months of their death.**
- **17.8% of people who died by suicide had been referred or signposted to talking therapies**.
- **Those people who were referred rather than signposted to other services were much more likely to make contact with services.**

Other forms of support:

- **29.3%** of the total audit population had accessed **A&E within the 12 months** preceding death.
- **14.3%** of people **had police contact** as a form of help within **3 months before death.**
- Of those with a history of substance use**, 33.6**% **had been referred or signposted** to **addiction services at some point in their lifetime.**
- **Only 12.1% of people who died had no record of contact with any service in the 12 months preceding their death.**
- **Over half** of those who died by suicide **had a record of non-professional support.** This was most commonly a family member but included friends, neighbours and faith groups.

Section 5 - Circumstances of death

- **71.3% of those who died by suicide, died in a private location**, as opposed to a public location.
- **20% of people died in a residential location whilst other occupants were at home.**

- **45.5% of people who died left some form of a "suicide note".** This included letters, brief notes and text messages.

Section 6 - Factors relating to the COVID-19 Pandemic

Nationally, there was no observed increase in the number of deaths by suicide during the years covered by this audit. However, to understand if and how the pandemic may have had an impact we collected information on any Covid related factors that were included in the inquest evidence for people who died in 2020 and 2021.

- Of those who died, **it does not appear that testing positive for Covid, having symptoms of Covid or suffering from long Covid were significant** contributors to suicide.
- However, **28.8% of deaths** for the total audit population who died in the years 2020 and 2021 **had a record of Covid and related factors as a contributary factor to death**.
- A thematic analysis identified the following themes of contributing factors:
    - Employment and study disruptions including Furlough or working from home, Job loss or redundancy, school, and university closure.
    - Impacted relationships including isolation and loneliness, separation from children, conflict and tension, relationship breakdown.
    - Impacted physical and mental health including exacerbated mental illness, changes to healthcare delivery and pandemic related anxieties, Covid related guilt and use of alcohol as a coping mechanism.
    - Impacted routines including disruption to travel plans, difficulties accessing usual escapisms and boredom.

Concluding comments

The findings detailed in this report help to identify key risk factors and illuminate potential opportunities for us to take action to prevent suicide. Although this data does have its limitations, we must take learning from this where we can to adapt, share and work together to reduce the number of lives lost to suicide of people living in Bradford.

Recommendations

How can these findings be used to inform suicide prevention?

Full detail of the recommendations informed by this audit's findings can be found in the following document: A framework of the suicide audit 2019-2021 findings and recommendations for Bradford, Calderdale, and Kirklees**.** The framework can be accessed at https://jsna.bradford.gov.uk/.

Summary of recommendations:

- Continue to improve data collection and sharing to ensure that effective, evidence-informed, and timely interventions are enabled for people at risk of suicide. In particular, improve recording of demographics, including ethnicity, to better understand risk factors associated with suicide in our local authority.
- The findings of this report should be shared with each local authority Suicide Prevention group to inform their action plans and make them as relevant as possible to local need.
- The findings of this report should be shared with local services and employers to inform service provision and support and identify training needs, particularly with those services/employers who have the greatest opportunity to prevent suicide.
- Work with system leaders to address common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Improve access to local support services for people experiencing mental health crisis or suicidal thoughts.
- Use the finding of this audit to inform public facing campaigns and support messaging with the aim of preventing suicide.
- Make information and support easily accessible for people who may have a concern about someone they know or for someone who is feeling suicidal so that they can access support when they need it.

References:

Office for National Statistics, Suicides in England and Wales: 2022 registrations: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/previousReleases

Samaritans media guidelines for reporting suicide, April 2020. https://www.samaritans.org/about-samaritans/media-guidelines/media-guidelines-reporting-suicide/

Industry and occupation, England and Wales: Census 2021; December 2022 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/industryandoccupationenglandandwales/census2021#occupation

For further information about this report or any queries relating to suicide and suicide prevention activities in the Bradford area please contact: jo.james@bradford.gov.uk