Champs Public Health Collaborative

NO MORE Suicide
Preventing suicide in Cheshire & Merseyside

Cheshire and Merseyside Suicide Audit Guidance

This Cheshire and Merseyside Suicide Audit Guidance supports the process of gathering and analysing local data to inform the Joint Cheshire Merseyside Suicide Audit Report and implementation.

'NO MORE Suicide, A Zero Strategy for Cheshire and Merseyside 2015-2020' recommends that:

'A joint standardised suicide audit process for Cheshire and Merseyside is developed'

The national strategy 'Preventing Suicides in England' 2012 states:

'Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance'.

'Local suicide prevention planning - A practice resource' (PHE 2016), states:

'Collecting and analysing local data on the number of suicides, the context in which they occur, the groups most at risk and how the picture is changing over time is critical for effective suicide prevention work.'

Guidance on Conducting a Suicide Audit

There are three coroner offices across Cheshire Merseyside from where data is collected; Southport, Liverpool and Warrington. Suicide audits are prepared for the calendar year, January to December.

1. **Planning the audit and identifying the scope**
   Contact the Coroner's office and book time to go in and do the audit. The audit can be quite time consuming, so two to three consecutive days, or days in consecutive weeks works well. It's worth booking a date and a room at the Coroner office's for the audit, several months or weeks in advance, as a free room is not always available.
   Time per suicide case
   Estimated time per case to provide information to Public Health Intelligence for a Suicide Audit Report is 2.5 hours

2. Identify to the Coroner's staff the information you will need for the audit, be clear about:
   - **Time period** - Whether the start and finish date of the time period the audit covers are the dates people died, or the dates their inquests closed.
   - **Conclusions** (Verdicts) **the audit will include** –look at all suicide, open and narrative verdicts in the relevant time period. Also check all drug and alcohol related deaths in the time period, in case they were suicide.
   - **Geography** – the geographical area the audit will cover. Ask for files relating to people who died in the LA area (with one of the verdicts above). This will flag up any geographical "suicide hot spots" that people from outside the LA might use and which need addressing.

3. **Exclusions**
   People who died in X local hospital as a result of suicide aren't included in the X LA audit if they aren't X LA residents and the actions which caused their death occur outside X LA.

4. **Process**
   Input into the standard data collection form (Appendix A) information from files with a suicide verdict (and from files with any other verdict which appears to be suicide). Should you have access to a laptop whilst at the Coroners' office you may key the data straight on the data collection spreadsheet (Appendix B) if you wish.

   Ask the Coroner's staff to locate the relevant files numbers and if possible the files themselves.

   Staff from the Coroner's office provide a list of file numbers and PH staff have to locate the files needed for the audit. This can take several hours. Taking a member of Public Health administration staff to help locate the files and then put them away again afterwards is worth considering.

   Ask Public Health Analyst colleagues to check ONS data and pull off relevant information which correlates with the time period and cause of death, i.e.

either suicide (ICD10 X60-X84 – all ages) or injury undetermined (ICD10 Y10-Y34 – ages 15+ only).

Look through the Coroner's files and discount any which are obviously not suicide. (Often the open or narrative verdicts are asbestos related deaths or death by natural causes). When people with open, narrative, or drug/alcohol related verdicts aren't included in the suicide audit make a note of why this was (e.g. cause of death was natural causes) also make a note of the person's date of birth, date of death and date the inquest closed. This will enable Public Health Analyst colleagues to cross reference information from the Coroner's office with the ONS data, and to ensure that the Coroner's staff have provided records of all deaths classed as suicide or injury undetermined (open verdicts).

Cross reference data collected from the Coroner's files with ONS data, to check all local suicides in the time period the audit covers are included.

Cross referencing isn't as straightforward as it might seem as the data collected by the ONS and the Coroner's office isn't coded, or worded in the same way. (Coroners code deaths by verdicts, ONS by cause of death). The death records received by the Public Health Team don't use people's names, whilst the Coroner does not systematically use people's NHS numbers.

Input the data from the data collection sheet onto the electronic spreadsheet (Appendix B), referring to guidelines provided (Appendix C).

5. **Reports**

   Local Authority Reports:
   Pass the spreadsheets with data collected from the Coroner's office and the notes about the files with open, narrative and drug/alcohol verdicts, which weren't included in the audit, to Public Health Analyst colleagues to write the suicide report.

   Discuss with Analyst colleagues any particular trends or areas of data you'd like highlighted or analysed.

   Joint Cheshire Merseyside Reports:
   Send summary spreadsheet to the CM PH Intelligence Analyst for preparation of the annual Joint CM Suicide Audit Report

6. **Differences between the Coroner's information and ONS data**

   The LA suicide audit report includes two different sections of analysis, one based on ONS data which looks at national, regional and local. The other based on the local data collected from the suicide audit conducted at the Coroner's office.

   There can be significant differences between the information collected from Coroner's office and that provided by ONS, the reasons for this are outlined below:

- People who died by suicide in X LA, but who weren't X LA residents are included in the suicide audit which is completed from the information that the Coroner's staff provide. However these people are not included in the ONS data for X LA, which would only list deaths of people who are X LA residents.
- Another discrepancy between the information collected from the Coroner's office and the ONS figures is that the ONS data includes X LA residents who took their own lives outside X LA.
- For these reasons the number of suicides listed by ONS and the Coroner, for the same time period, rarely correlates.

N.B. This guidance originated from Warrington Public HealthTeam, based upon national guidance and contributions from the Audit Task Group of Cheshire Merseyside Suicide Reduction Network.

References

[1] Cheshire and Merseyside Suicide Audit Joint Report 2014, November 2014,Cheshire and Merseyside Suicide Reduction Network, Champs collaborative
[1] Champs 2015 NO MORE Zero Suicide Strategy for Cheshire and Merseyside 2015-2020
DH 2012 Preventing suicide in England - A cross-government outcomes strategy to save lives
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[1]

APPENDICES

Appendix A

Data Collection Form: use this form to capture the audit data prior to entering onto the spreadsheet

Suicide Audit Data Collection Form

Appendix B

Suicide Audit Tool: enter the data from the data collection form onto this spreadsheet and then pass onto your Public Health Analysts to produce the suicide audit report.

Suicide Audit Tool

Appendix C

Audit Tool Guidelines: this document provides guidance with regards to interpreting column headings and completing the sucide audit tool.

Audit Tool Spreadsheet Guidelin