

Bradford – Calderdale - Kirklees Suicide Audit 2019-2021

Summary of Key Findings for Kirklees Council

Published May 2024

Table of Contents

Bradford – Calderdale - Kirklees Suicide Audit 2019-2021	1
Summary of Key Findings for Kirklees Council	1
Published May 2024.....	1
Foreword.....	2
Acknowledgement.....	3
Introduction.....	3
The audit: Coroner’s office data collection.....	4
Method.....	4
What we did	4
Limitations and consideration.....	5
Key findings.....	5
Section 1 - Suicide rates and demographics	5
Section 2 – Health related risk factors.....	7
Section 3 – Adverse life events.....	8
Section 4 – Access to services and help-seeking behaviour.....	8
Section 5 – Circumstances of death.....	9
Section 6 – Factors relating to the COVID-19 pandemic.....	9
Recommendations.....	10
References	10

Foreword

Rachel Spencer-Henshall, Strategic Director: Corporate Strategy, Commissioning & Public Health

Every suicide is a tragedy, which has far reaching consequences for families and communities, and this is why it is a high priority for Kirklees. The audit is an important public health approach to tackling suicide, enabling us to better understand trends and risk factors for suicide within our population. The audit provides an opportunity for us to understand the reasons people may take their own lives and the circumstances which lead to this kind of tragedy. The findings from the audit also contribute to informing the local suicide prevention and self-harm awareness action plan, which enables us to develop, shape and implement suicide prevention activity.

Suicide remains a challenge for Kirklees. In 2020-2022 Kirklees had a suicide rate of 11.9 per 100,000 population. This rate increased from a rate of 11.4 per 100,000 population in 2019-2021. However, the rate is similar or lower than the rates across West Yorkshire.

Suicide is multi-faceted and rarely caused by one thing, which brings opportunity for us all to play our part. Suicide can be a complex mix of social, cultural, psychological and economic factors which can all interact to increase a person's risk of suicide. By making suicide prevention everybody's business we can work together to ensure people get the right help and support at the right time.

This audit would not have been possible without close collaboration with Calderdale and Bradford Public Health Teams and the West Yorkshire Coroners Office.

Christian Smith, bereaved by suicide.

"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."

Authors: Jo James, Diane Weedy, Rebecca Elliott, Kate Horne, Vicki Spencer-Hughes, Paula Holden, Julie Hunneybell.

Project contributors: Jo Holt, Olumayowa Agyo, Jenniefer Eastwood, Eugenia Cronin, Sulia Celebi, Emily Parry-Harries

Acknowledgement

We would like to thank all of those who have taken their time and shared their experiences with us to help inform and undertake this audit.

We would like to give special thanks to several people without whom we would not have been able to produce this report.

Thanks to HM Coroner Martin Fleming, Marian Connell and the staff and the coroner's office for their assistance and support with the data collection.

Thanks to Vicky Leith and the staff at Birksland archive for their help in accessing inquest files.

Thanks to Paige Davies and Louise Warwick-Booth for their expertise and time undertaking the special analysis of Covid related factors.

Thanks to Jayne James for her expertise and the wellbeing support offered to the data collection.

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

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 the Kirklees area.

Since 2014, ONS data shows suicide rates in Kirklees have remained higher than the England average but lower than the Yorkshire and Humber average rate. However, in recent years rates for Kirklees appear to show a longer-term gradual increase, having recently reached 11.9 per 100,000 in 2020-2022.

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. Suicide 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 we did

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 consideration

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

Key findings

Data collected from the total audit population 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 suppressed in order that individual information cannot be identified.

Analysis was also undertaken for each local authority. It has been detailed below where there were any differences in the findings for the overall audit population and for Kirklees area.

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

- The overall rate for people who died by suicide from this audit is 13.7 people per 100,000. According to the most recent ONS figures, the Kirklees rate is 11.9 per 100,000 people.
- Nearly 4 out of 5 deaths of those who died by suicide were males, 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. 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.
- When split by age and gender, the highest suicide rate for females was those aged 36-45 years at 6.8 per 100,000. The highest rate for males was those aged 46-55 years at 25.1 per 100,000.

- Kirklees: highest rates by age band for Kirklees are ages 36-45 and 46-55 which are significantly above the rate for all ages in Kirklees.
- The rate for all ages was 10.1 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.

- Relationships and living circumstances.
- The suicide rate for people 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 Kirklees audit population since the last audit (39.9%).
- 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. We recorded 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.

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 at 36.7 people compared to 13.7 people (per 100,000). This was the case for each Local Authority.
- When broken down by gender, the rate for females who died by suicide 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. REF3*

*** 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)*

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 than in males; 80% and 60.5% respectively. 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 Kirklees 61.5% of females who died by suicide had a previous attempt recorded, and 44.2% 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 Kirklees, 21.4% of problematic alcohol use was within the last 12 months and 14.3% 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 abuse (victim or perpetrator, relationship stress, and issues with a job or job loss or debt).

**Definition of Childhood experience used*

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 services was in Primary Care. 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 (44%).
- Mental health was the second most common reason for attending the last appointment in primary care (39%).
- 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 had disclosed self-harming or feeling suicidal at their last Primary care appointment.
- Over half of those who died by suicide had a record of non-professional support. This included support from a spouse, family or friend.

Mental health services:

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

- 19.5% within the 3 months preceding death.
- Of those with a SMH referral record, 32% were actively under care at the time of death and 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 also 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, we collected information relating to 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 contributory factor to death. This figure was similar when broken down for each local authority.

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.

Recommendations

How the findings can be used to inform suicide prevention

Detailed recommendations informed by this audit can be found in the framework mapped against the national strategy: [the key findings and recommendations framework](#).

A summary of recommendations:

- Continue to improve data collection and sharing to ensure that effective, evidence-based, and timely interventions are enabled for people at risk of suicide. Improve the future recording of demographics, including ethnicity, to better understand the high-risk groups and risk factors of those who die by suicide.
- 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 needs.
- 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.
- Make information and support easily available and 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.
- Make the most of every contact, (using findings from this audit e.g. age, gender, living and relationship status, employment status) to be curious and ask questions about mental health and suicide.

References

[Office for National Statistics, Suicides in England and Wales: 2022 registrations:](#)

[Samaritans media guidelines for reporting suicide, April 2020.](#)

[Industry and occupation, England and Wales: Census 2021; December 2022](#)

For further information about this report or any queries relating to suicide and suicide prevention activities in the Kirklees area please contact: Rebecca.elliott@kirklees.gov.uk