**AGENDA SUPPLEMENT**

**Health and Wellbeing Board**

**To:** Councillors Coles (Chair), Runciman, Webb and Mason
Siân Balsom – Manager, Healthwatch York
Dr Emma Broughton – Joint Chair of York Health & Care Collaborative
Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust
Sarah Coltman-Lovell - York Place Director
Sara Storey – Corporate Director, Adults and Integration
Martin Kelly - Corporate Director of Children's and Education, City of York Council
Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust
Mike Padgham – Chair, Independent Care Group
Alison Semmence - Chief Executive, York CVS
Peter Roderick - Director of Public Health, City of York Council
Tim Forber - Chief Constable, North Yorkshire Police

**Date:** Wednesday, 8 May 2024

**Time:** 4.30 pm

**Venue:** West Offices - Station Rise, York YO1 6GA

The Agenda for the above meeting was published on **26 April 2024.** The attached additional documents are now available for the following agenda item:

**6. Update on Goal 7 of the Joint Health and Wellbeing Strategy 2022-2032: 'Reduce both the suicide rate and the self-harm rate in the city by 20%'** (Pages 1 - 46)

This paper provides the Board with an update on the implementation and delivery of one of the ten big goals within the Local Joint Health and Wellbeing Strategy 2022-2032. It also includes information on performance monitoring.

The supplement contains the Final Suicide Audit Report 2023: A review of deaths by suicide within the City of York between 2016 and 2021.

This agenda supplement was published on **7 May 2024**

Agenda Item 6

# City of York Suicide Audit 2023

A review of deaths by suicide within the City of York between 2016 and 2021

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# Overview

Suicide represents the tragic loss of a human life. Alongside the knowledge of the pain and suffering that led someone to take their own life, it leaves a pepetual sadness the lives of others affected. It is an event that can have profound impacts on the individual's loved ones, friends, and society as a whole. There is often a sense of helplessness and despair surrounding suicide, as it is seen as a permanent solution to what may have been temporary problems or difficulties. Additionally, suicide can leave behind unanswered questions and feelings of guilt or regret for those who knew the person. The sadness associated with suicide stems from the understanding of the immense pain and turmoil that the individual must have been experiencing to reach such a desperate decision.

By reterospectively analysing those deaths that occurred in the city we aim to gain insight into the cirumstamces surrounding those deaths and the related trends, to be able to identify opportunities where we could identify risk and protective factors around suicide the future. This brings a measure of hope that – across society – it is possible to reduce the rate of suicide, and to prevent deaths.

# Executive Summary

The York audit provides retrospective intelligence of deaths in the city by suicide. It reviews 51 deaths which took place between 2016 and 2021. All deaths were registered between 1st April 2018 and 31st March 2021; therefore this data includes the initial period of the covid-19 pandemic and associated lockdowns. Alongside the audit we also looked at the the data from the Office of National Statistics and the Primary Care Mortality data 2015-2021 to give us a broader picture of deaths in York, and to compare with other areas and trends over time.

***(Please note therefore that numbers in this report will not tally, due to slightly different methodologies and date periods in the two data sources used)***

The audit review relates to both to coroner's inquest conclusions of suicide and deaths by 'accident or poisoning of undetermined intent'. The audit was conducted in line with national guidance in order to enable better understanding of the pattern of suicide in the local area. Findings will inform the York suicide prevention plans and activities to continue developing the local aspiration for York to become a 'Suicide-Safer Community'.

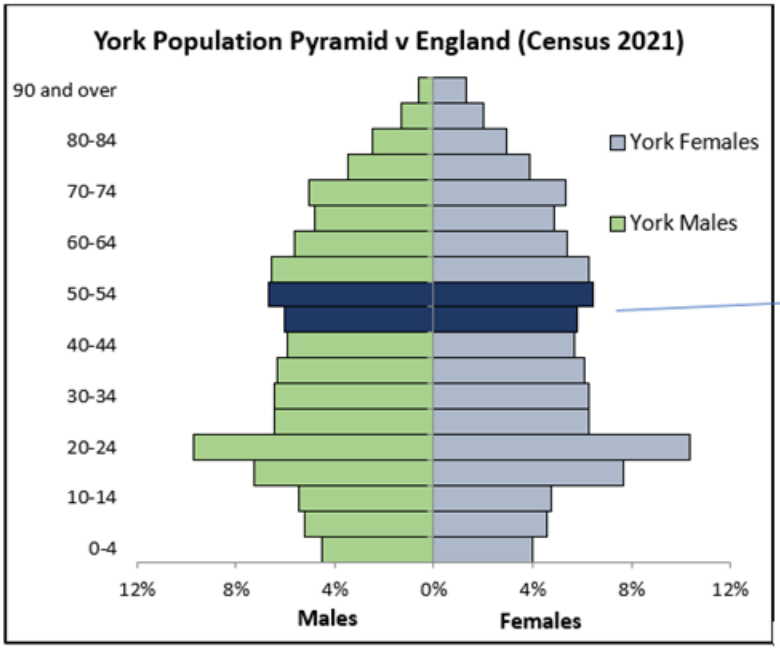
An audit template was used to record information obtained from coroner's files which contain evidence and information relevant to individual deaths by suicide- see **Appendix 2**. The infographics below summarises the findings from the data and thematic analysis carried out across those 51 people who died by suicide in York and whose deaths were registered between 1st April 2018 and 31st March 2021:

# 2023 Suicide Audit Key Findings

**10** **More** female deaths by suicide in 2023 compared to 2016. **27%** vs **17%**

**73%** Of males died by suicide in 2023. A **lower** rate compared to 2016 (83%)

**49 years** Average age at death in 2023, higher compared to 2016




Most deaths by suicide occurred in age bands 45-50 and 51-54 for both men and women

**4,585** Estimated years of life lost to suicide. An average of **32** years per person.

**90** per 100,000 deaths were of people from York's most deprived areas.

**49** per 100,000 deaths were of people from York's least deprived areas.

**45%** of people who died left a suicide note, a lower proportion compared to **53%** in 2016

**53%** of the deceased displayed warning signs or evidence or risk prior to death.

**55%** of people lived alone at the time of death.

## Employment and occupation

**30%** increase in the proportion of people who died who were employed

**2%** of those who died were students, down from 10% in the previous audit

Largest occupational groups were 'Skilled Trades' **(20%)** and 'Elementary' **(18%)**

## Contact with Services


**39%** of people who died were known to the local authority, an increase since the 2016 audit

21 people out of 51 **(41%)** had seen their GP in the month prior to their death

35 people **(69%)** had a mental health diagnosis. 30 people **(59%)** had received mental health treatment in the last 12 months.

Perceived financial issues and concerns, relationship breakdown, COVID pandemic and bereavement were other factors which were identified from Coroner's files.

## Published Data on Suicide

- In the latest 3 year period (2019-2021) there were 72 deaths by suicide amongst York residents (13.3 per 100,000). 54 of these were males (20.2 per 100,000) and 18 were females (6.3 per 100,000). The rates in York are not significantly different from the England average.

- Suicide rates for all persons and for males only in York peaked in 2013-15. Rates for females only in York peaked in 2015-17.

## Analysis of PCMD Data

- Between January 2015 and March 2021 a total of 143 deaths by suicide of York residents were identified from the Primary Care Mortality Database (PCMD).

- 104 (73%) were men and 39 (27%) were women. Death by suicide occurred in a wide range of age bands from 15-24 up to 85+. The average age at death was 48.8 years overall (48.0 years for men and 51.1 years for women).The most common ten year age band at which people in York took their own lives was 45-54. This was the case for both men and women.

- An estimated 4,585 years of life were lost (an average of 32 years per person). due to suicide amongst the cohort of 143 people based on the age at death of each person and the average life expectancy in York.

- Higher rates of deaths by suicide occurred in the more deprived areas of York. The number of deaths by suicide per 100,000 of population is 90 in the most deprived quintile in York compared with 49 in the least deprived quintile.

- Of the 143 deaths, 113 (79%) were as a result of intentional self harm and 30 (21%) were from injury of undetermined intent. The percentages are the same for both men and women.

- For deaths from intentional self harm, death by hanging, strangulation and suffocation is the most common cause of death (for both males and females) accounting for 54% of deaths.

- For deaths from injury of undetermined intent hanging, strangulation and suffocation and poisoning by and exposure to narcotics and psychodysleptics are the most common causes of death accounting for 50% of deaths.

- Deaths by suicide took place throughout the year but the highest number occurred in the spring months (March to May). By calender month the highest number of suicides occurred in April (17 deaths) followed by January and May (15 deaths). The most common days of the week where people in the York sample took their own lives were Monday and Friday.

- In terms of repeat locations, 7 deaths occurred in rivers (5 times in the Ouse and twice in the Foss). The deaths did not necessarily occur in the same parts of the river. 3 deaths occurred in Clfton Backies and 3 deaths occurred at railway locations.

- During the audit period there were also 17 deaths by suicide registered for non York residents where the death occurred in York. 11 of these were male, 6 were female. The average age of those who died was 42 years. The most common method of suicide was by substance overdose.

## Audit of Coroner's Files

- Coroners files were obtained for 51 York Residents who had died by suicide. All the deaths were registered between 1.4.18 and 31.3.21 which was the chosen period for the audit. Information was extracted from the files onto a template for analysis.

- The majority of deaths occurred in the person's own home (35 incidents, 69%) which is similar to the 2016 audit (68%). A smaller percentage of deaths occurred on the railway (2%) compared with 12% in the 2016 audit.

- 23 out of 51 people (45%) left a suicide note compared with 53% in the 2016 audit. For 27 of the 51 people (53%) there were warning signs or evidence of risk prior to death by suicide.

- The majority of people (55%) were living alone at the time of death which is a higher percentage compared with the 2016 audit (42%). Three quarters of people in the York sample were either single, divorced, widowed or separated (38 out of 51 people, 75%).

- 27 people (53%) were in employment at the time of death, 12 (24%) were unemployed and 9 (18%) were retired. Compared with the 2016 audit there are a higher proportion of retired people (18% v 12%) and a lower proportion of students (2% v 10%).

- The largest occupational groups were 'Skilled Trades' (20%) and 'Elementary' (18%). Compared with the 2016 audit, there were more Elementary Occupations (18% v 8%) and more Managers, Directors and Senior Officials (14% v 3%) and fewer Professional Occupations (10% v 17%) and fewer people who's occupation was unknown (10% v 17%).

- For 14 of the 51 people (27%) alcohol was present at the time of death based on information in the coroners file. This is lower than the figure of 37% from the 2016 audit. 14 of the 51 people (27%) had a history of alcohol misuse (and alcohol was present at the time of death for 8 of these people).

- For 19 of the 51 people (37%) drugs were present at the time of death based on information in the coroners file. 10 of the 51 people (20%) had a history of drug misuse (and drugs were present at the time of death for 5 of these people).

- 18 out of 51 people (35%) had a history of either drug or alcohol misuse (or both). This is a lower figure than the 2016 audit (47%). For only 4 of these 18 people was involvement with drug and alcohol treatment agencies recorded on the coroner's file.
- Based on information recorded on the Coroner's file, 7 out of 51 people had contact with one or more other agencies. 20 people (39%) were known to the City of York Council.

- 21 people out of 51 (41%) had seen their GP in the month prior to their death. This is a higher percentage compared with the 2016 audit (28%).

- Of the 21 people who saw their GP in the month prior to death, 14 had attended for reasons to do with their mental health (including reviews or specific concerns). The other 7 had attended for other medical (non mental health) reviews or specific concerns.

- Previous attendance at an Accident and Emergency Department had been recorded for 20 people (39%). 4 of these people attended A&E less a week prior to death.

- Of the 6 people to attend A&E in the month prior to death, 5 were for reasons relating to mental health (e.g. attempted suicide, overdose, self harm, acute mental health symptoms) and one was for medical (non mental health) reasons.

- 6 of the 51 people (12%) had previous involvement with the Criminal Justice System.

- 35 people (69%) had a mental health diagnosis. 30 people (59%) had received mental health treatment in the last 12 months.

- 7 people (14%) had a risk of harm recorded on the GP records. 12 people (24%) had a history of self harm.

- 23 people (45%) had made at least one suicide attempt in the 12 months prior to death. The number of suicide attempts ranged from 1-9 per person. 6 people had made more than one attempt in the last 12 months. 16 people had attempted an overdose and 6 people had attempted hanging.

- Perceived financial issues and concerns, Relationship breakdown, COVID pandemic and Bereavement were other factors which were identified from Coroner's files.

# Introduction

The aim of the audit is to identify trends in those who die by suicide, and highlight any common themes which may inform public health interventions to reduce deaths by suicide in the future. Public health by definition, considers health at a population scale rather than on an individual level, and this report may at times seem to reduce those people who have died through suicide to statistics and trends. This is necessary to achieve the aim of the audit but the authors would like to acknowledge that this does not adequately reflect the significance of those who have died, and the suffering of friends and family who have been bereaved by suicide.

The numbers of suicides occurring within a timeframe or locality are usually calculated as a rate. Hence the suicide rate is based on how many people out of every 10,000 or 100,000 people in the population are recorded as having taken their own life or died through accident or poisoning of undetermined intent.

Globally 703,000 people die by suicide annually and it is the fourth leading cause of death in 15-29 year olds. Suicide is a global phenomenon but there is a greater burden lower and middle income countries. The United Kingdom had an age standardised suicide rate of 6.88 per 100,000 (6.51-7.32) in 2019, statistically significantly below the European rate of 10.88 per 100,000 (8.33-13.630).

In the UK deaths by suicide (and injury and poisoning of unknown intent) were the leading cause of death in men and women aged 20-34 between 2001 and 2018 (ONS, 2020), with the incidence of suicide peaking in in the 45-49 year old age group at 15.5 deaths by suicide for every 100,000 deaths in 2020 (ONS, 2021). Figure 1 shows that in England rates have remained largely unchanged between 2001 and 2021 at approximately 10 per 100,000.

In York rates of suicide have tended to be higher than England, though not often significantly so. In 2013-15 and 2015-17 the directly standardised rate was significantly higher than England and in the most recent ONS data of 2019-21 York had a directly standardised rate of 13.3 deaths by suicide per 100,000 (95% CI 10.3, 16.8).

In 2018 City of York Council published the 5 year “York Suicide Safer Community Strategy 2018-2023” based in part on the previous 2016 suicide audit. The strategy identified 9 key areas for action in response to the themes identified below:

| |
|---|
| Reducing the risk of suicide in high risk groups |
| Tailoring approaches to improve mental health in specific groups |
| Reducing access to the means of suicide |
| Providing better information and support to those bereaved or affected by suicide |
| Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour |
| Supporting research, data collection and monitoring |
| Reducing rates of self harm |
| Training and awareness raising |
| Preparedness and post incident management |

**The groups identified at highest risk:**

| |
|---|
| Men, particularly those aged 40-55 |
| Untreated mental ill-health |
| Those who self harm |
| Those who have previously attempted suicide |
| Those with untreated substance misuse |

An element of this suicide audit is reflecting on the trends in deaths since the publication of the strategy, to reflect on any progress observed and consider if the targeted groups require refinement with a view to publishing an updated strategy.

# Published Data on Suicide

## Suicide Rates in York

### All Persons

Published suicide figures are calculated as rates per 100,000 of population and are adjusted to take into account differences in the age breakdown of different areas. The latest published rates are for the three year period 2019-2021 (OHID, 2023). The rate in York is 13.3 per 100,000 (72 deaths in the three year period). This is not significantly different from the national (10.4) and regional (12.5) rates.

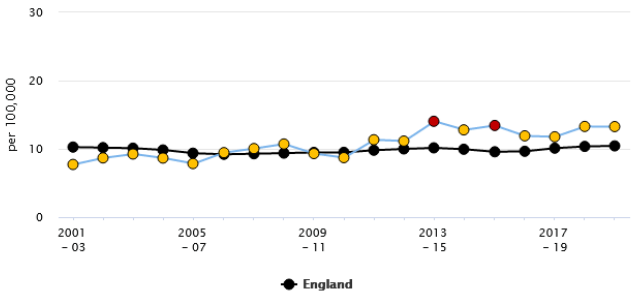
Suicide rates in York peaked in 2013-2015 at 14.0 per 100,000. This rate was significantly above the national average.

**Figure 1: York suicide rates v Region/England: 2001-2021**

Suicide rate (Persons)

Directly standardised rate - per 100,000

Show confidence intervals  Show 99.8% CI values  ▶ More options

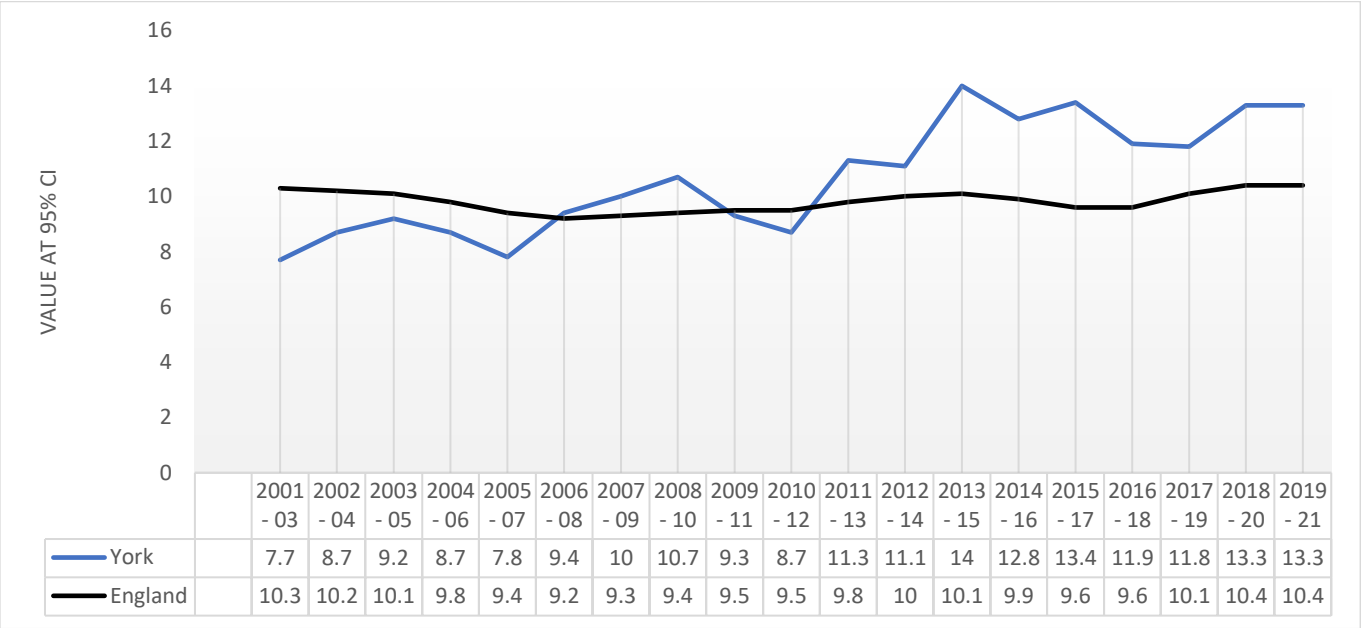



**Recent trend:** Could not be calculated

| Period | | York Count | York Value | York 95% Lower CI | York 95% Upper CI | Yorkshire and the Humber | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | ● | 37 | 7.7 | 5.4 | 10.7 | 10.0 | 10.3 |
| 2002 - 04 | ● | 43 | 8.7 | 6.3 | 11.7 | 10.2 | 10.2 |
| 2003 - 05 | ● | 46 | 9.2 | 6.7 | 12.4 | 10.4 | 10.1 |
| 2004 - 06 | ● | 43 | 8.7 | 6.2 | 11.7 | 10.2 | 9.8 |
| 2005 - 07 | ● | 39 | 7.8 | 5.6 | 10.7 | 9.7 | 9.4 |
| 2006 - 08 | ● | 47 | 9.4 | 6.9 | 12.6 | 9.4 | 9.2 |
| 2007 - 09 | ● | 50 | 10.0 | 7.4 | 13.3 | 9.4 | 9.3 |
| 2008 - 10 | ● | 55 | 10.7 | 8.0 | 14.0 | 9.0 | 9.4 |
| 2009 - 11 | ● | 50 | 9.3 | 6.9 | 12.3 | 9.0 | 9.5 |
| 2010 - 12 | ● | 47 | 8.7 | 6.4 | 11.6 | 9.6 | 9.5 |
| 2011 - 13 | ● | 59 | 11.3 | 8.6 | 14.7 | 10.4 | 9.8 |
| 2012 - 14 | ● | 57 | 11.1 | 8.4 | 14.5 | 10.3 | 10.0 |
| 2013 - 15 | ● | 74 | 14.0 | 11.0 | 17.7 | 10.7 | 10.1 |
| 2014 - 16 | ● | 70 | 12.8 | 9.9 | 16.2 | 10.4 | 9.9 |
| 2015 - 17 | ● | 74 | 13.4 | 10.5 | 16.9 | 10.4 | 9.6 |
| 2016 - 18 | ● | 64 | 11.9 | 9.1 | 15.3 | 10.7 | 9.6 |
| 2017 - 19 | ● | 61 | 11.8 | 9.0 | 15.2 | 12.0 | 10.1 |
| 2018 - 20 | ● | 70 | 13.3 | 10.3 | 16.8 | 12.5 | 10.4 |
| 2019 - 21 | ● | 72 | 13.3 | 10.3 | 16.8 | 12.5 | 10.4 |

*Source: Office for National Statistics*

**Figure 2: Suicide rate (Persons) 2001-2021. York compared to England- Directly standardised rate per 100,000**




| | 2001 - 03 | 2002 - 04 | 2003 - 05 | 2004 - 06 | 2005 - 07 | 2006 - 08 | 2007 - 09 | 2008 - 10 | 2009 - 11 | 2010 - 12 | 2011 - 13 | 2012 - 14 | 2013 - 15 | 2014 - 16 | 2015 - 17 | 2016 - 18 | 2017 - 19 | 2018 - 20 | 2019 - 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York | 7.7 | 8.7 | 9.2 | 8.7 | 7.8 | 9.4 | 10 | 10.7 | 9.3 | 8.7 | 11.3 | 11.1 | 14 | 12.8 | 13.4 | 11.9 | 11.8 | 13.3 | 13.3 |
| England | 10.3 | 10.2 | 10.1 | 9.8 | 9.4 | 9.2 | 9.3 | 9.4 | 9.5 | 9.5 | 9.8 | 10 | 10.1 | 9.9 | 9.6 | 9.6 | 10.1 | 10.4 | 10.4 |

*Source: Office for National Statistics*

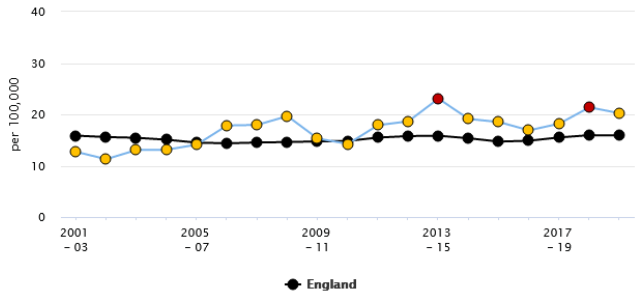
## Males

The latest published rates for Males are for the three year period 2019-2021. The rate in York is 20.2 per 100,000 (54 deaths in the three year period). This is not significantly different from the national (15.9) and regional (18.8) rates.

Suicide rates for Males in York peaked in 2013-2015 at 23.1 per 100,000 This rate was significantly above the national average.

## Figure 3:York Male suicide rates v Region/England: 2001-2021

Show confidence intervals  Show 99.8% CI values  ▶ More options

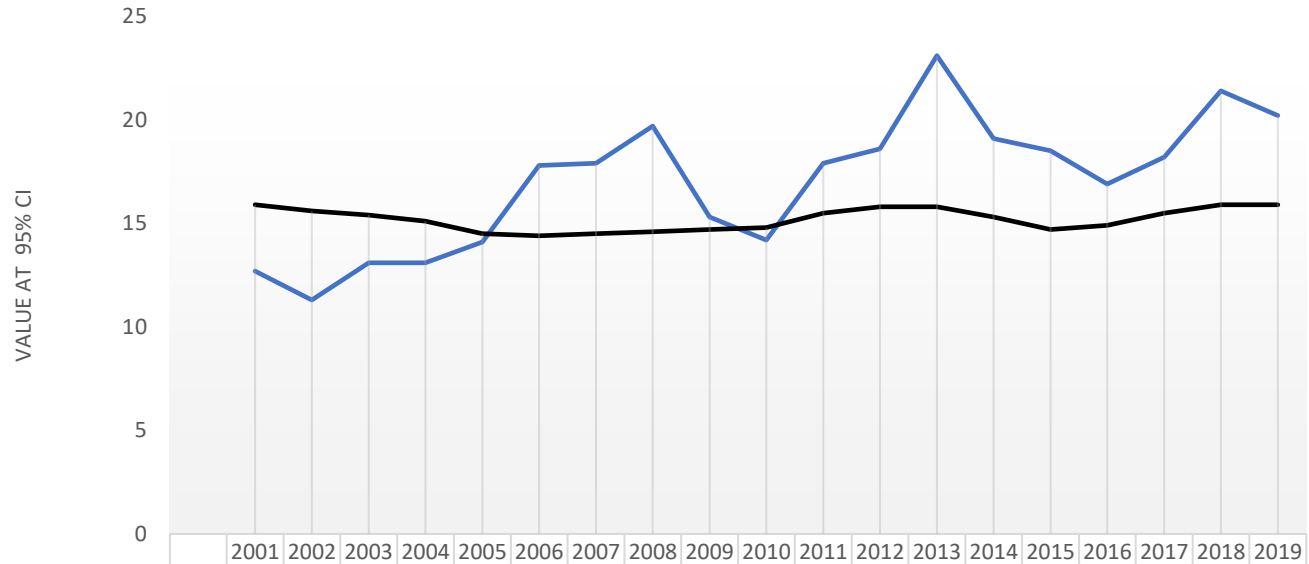



**Recent trend:** Could not be calculated

| Period | | York Count | York Value | York 95% Lower CI | York 95% Upper CI | Yorkshire and the Humber | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | ● | 28 | 12.7 | 8.1 | 18.8 | 15.7 | 15.9 |
| 2002 - 04 | ● | 28 | 11.3 | 7.4 | 16.3 | 15.9 | 15.6 |
| 2003 - 05 | ● | 32 | 13.1 | 8.9 | 18.5 | 15.9 | 15.4 |
| 2004 - 06 | ● | 32 | 13.1 | 8.9 | 18.6 | 15.8 | 15.1 |
| 2005 - 07 | ● | 34 | 14.1 | 9.7 | 19.8 | 15.3 | 14.5 |
| 2006 - 08 | ● | 41 | 17.8 | 12.6 | 24.5 | 15.2 | 14.4 |
| 2007 - 09 | ● | 42 | 17.9 | 12.7 | 24.5 | 15.2 | 14.5 |
| 2008 - 10 | ● | 48 | 19.7 | 14.3 | 26.3 | 14.4 | 14.6 |
| 2009 - 11 | ● | 41 | 15.3 | 10.9 | 20.9 | 14.3 | 14.7 |
| 2010 - 12 | ● | 38 | 14.2 | 10.0 | 19.7 | 15.1 | 14.8 |
| 2011 - 13 | ● | 46 | 17.9 | 13.0 | 24.0 | 16.9 | 15.5 |
| 2012 - 14 | ● | 47 | 18.6 | 13.6 | 24.8 | 16.8 | 15.8 |
| 2013 - 15 | ● | 59 | 23.1 | 17.5 | 29.8 | 17.2 | 15.8 |
| 2014 - 16 | ● | 50 | 19.1 | 14.1 | 25.3 | 16.5 | 15.3 |
| 2015 - 17 | ● | 49 | 18.5 | 13.6 | 24.6 | 16.3 | 14.7 |
| 2016 - 18 | ● | 44 | 16.9 | 12.2 | 22.8 | 16.7 | 14.9 |
| 2017 - 19 | ● | 46 | 18.2 | 13.3 | 24.3 | 18.3 | 15.5 |
| 2018 - 20 | ● | 55 | 21.4 | 16.0 | 27.9 | 19.2 | 15.9 |
| 2019 - 21 | ● | 54 | 20.2 | 15.1 | 26.5 | 18.8 | 15.9 |

*Source: Office for National Statistics*

## Figure 4: Suicide rate (Male) 2001-2021. York compared to England- Directly standardised rate per 100,000




| | 2001 - 03 | 2002 - 04 | 2003 - 05 | 2004 - 06 | 2005 - 07 | 2006 - 08 | 2007 - 09 | 2008 - 10 | 2009 - 11 | 2010 - 12 | 2011 - 13 | 2012 - 14 | 2013 - 15 | 2014 - 16 | 2015 - 17 | 2016 - 18 | 2017 - 19 | 2018 - 20 | 2019 - 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York | 12.7 | 11.3 | 13.1 | 13.1 | 14.1 | 17.8 | 17.9 | 19.7 | 15.3 | 14.2 | 17.9 | 18.6 | 23.1 | 19.1 | 18.5 | 16.9 | 18.2 | 21.4 | 20.2 |
| England | 15.9 | 15.6 | 15.4 | 15.1 | 14.5 | 14.4 | 14.5 | 14.6 | 14.7 | 14.8 | 15.5 | 15.8 | 15.8 | 15.3 | 14.7 | 14.9 | 15.5 | 15.9 | 15.9 |

*Source: Office for National Statistics*

## Females

The latest published rates for Females are for the three year period 2019-2021. The rate in York is 6.3 per 100,000 (18 deaths in the three year period). This is not significantly different from the national (5.2) and regional (6.5) rates.

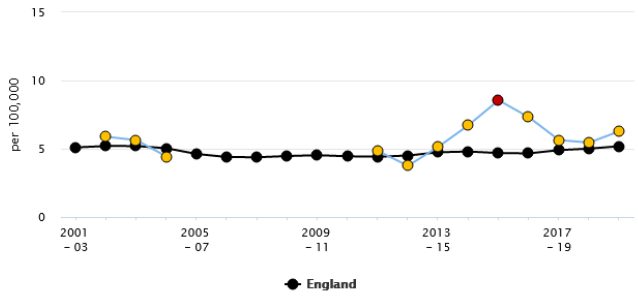
Suicide rates for Females in York peaked in 2015-2017 at 8.6 per 100,000. This rate was signifcanly above the national average.

### Figure 5: York Female suicide rates v Region/England: 2001-2021

Suicide rate (Female)

Directly standardised rate - per 100,000

Show confidence intervals  Show 99.8% CI values  ▶ More options

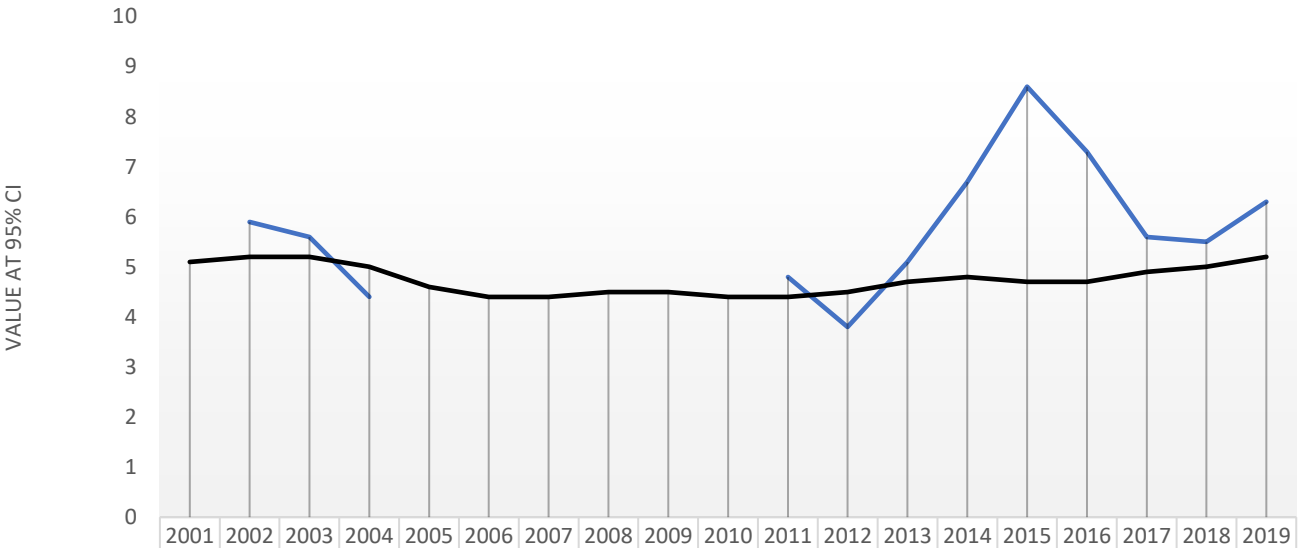



**Recent trend:** Could not be calculated

| Period | | York Count | Value | 95% Lower CI | 95% Upper CI | Yorkshire and the Humber | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | | 9 | * | - | - | 4.8 | 5.1 |
| 2002 - 04 | ● | 15 | 5.9 | 3.3 | 9.7 | 4.9 | 5.2 |
| 2003 - 05 | ● | 14 | 5.6 | 3.1 | 9.5 | 5.2 | 5.2 |
| 2004 - 06 | ● | 11 | 4.4 | 2.2 | 7.9 | 5.0 | 5.0 |
| 2005 - 07 | | 5 | * | - | - | 4.5 | 4.6 |
| 2006 - 08 | | 6 | * | - | - | 4.1 | 4.4 |
| 2007 - 09 | | 8 | * | - | - | 3.9 | 4.4 |
| 2008 - 10 | | 7 | * | - | - | 4.0 | 4.5 |
| 2009 - 11 | | 9 | * | - | - | 4.0 | 4.5 |
| 2010 - 12 | | 9 | * | - | - | 4.2 | 4.4 |
| 2011 - 13 | ● | 13 | 4.8 | 2.6 | 8.3 | 4.2 | 4.4 |
| 2012 - 14 | ● | 10 | 3.8 | 1.8 | 6.9 | 4.1 | 4.5 |
| 2013 - 15 | ● | 15 | 5.1 | 2.8 | 8.6 | 4.6 | 4.7 |
| 2014 - 16 | ● | 20 | 6.7 | 4.0 | 10.5 | 4.6 | 4.8 |
| 2015 - 17 | ● | 25 | 8.6 | 5.4 | 12.7 | 4.8 | 4.7 |
| 2016 - 18 | ● | 20 | 7.3 | 4.4 | 11.4 | 4.8 | 4.7 |
| 2017 - 19 | ● | 15 | 5.6 | 3.1 | 9.4 | 5.9 | 4.9 |
| 2018 - 20 | ● | 15 | 5.5 | 3.0 | 9.1 | 6.1 | 5.0 |
| 2019 - 21 | ● | 18 | 6.3 | 3.6 | 10.0 | 6.5 | 5.2 |

*Source: Office for National Statistics*

**Figure 6: Suicide rate (Female) 2001-2021. York compared to England- Directly standardised rate per 100,000**




| | 2001 - 03 | 2002 - 04 | 2003 - 05 | 2004 - 06 | 2005 - 07 | 2006 - 08 | 2007 - 09 | 2008 - 10 | 2009 - 11 | 2010 - 12 | 2011 - 13 | 2012 - 14 | 2013 - 15 | 2014 - 16 | 2015 - 17 | 2016 - 18 | 2017 - 19 | 2018 - 20 | 2019 - 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York | | 5.9 | 5.6 | 4.4 | | | | | | | 4.8 | 3.8 | 5.1 | 6.7 | 8.6 | 7.3 | 5.6 | 5.5 | 6.3 |
| England | 5.1 | 5.2 | 5.2 | 5 | 4.6 | 4.4 | 4.4 | 4.5 | 4.5 | 4.4 | 4.4 | 4.5 | 4.7 | 4.8 | 4.7 | 4.7 | 4.9 | 5 | 5.2 |

*Source: Office for National Statistics. Blank spaces are for periods when values cannot be calculated as number of cases is too small.*

## Deprivation

In 2019-20, suicide rates in York remain higher compared to rates in all local areas with similar levels of deprivation. Deprivation is a risk factor to suicide because a lager propotion of deaths by suicide are from people who live in deprived deciles.

## Figure 7:York suicide rate (All persons- standardised per 100,000) compared to Local Authorities with similar levels of deprivation 2019-2021

Suicide rate 2019 - 21

Directly standardised rate - per 100,000

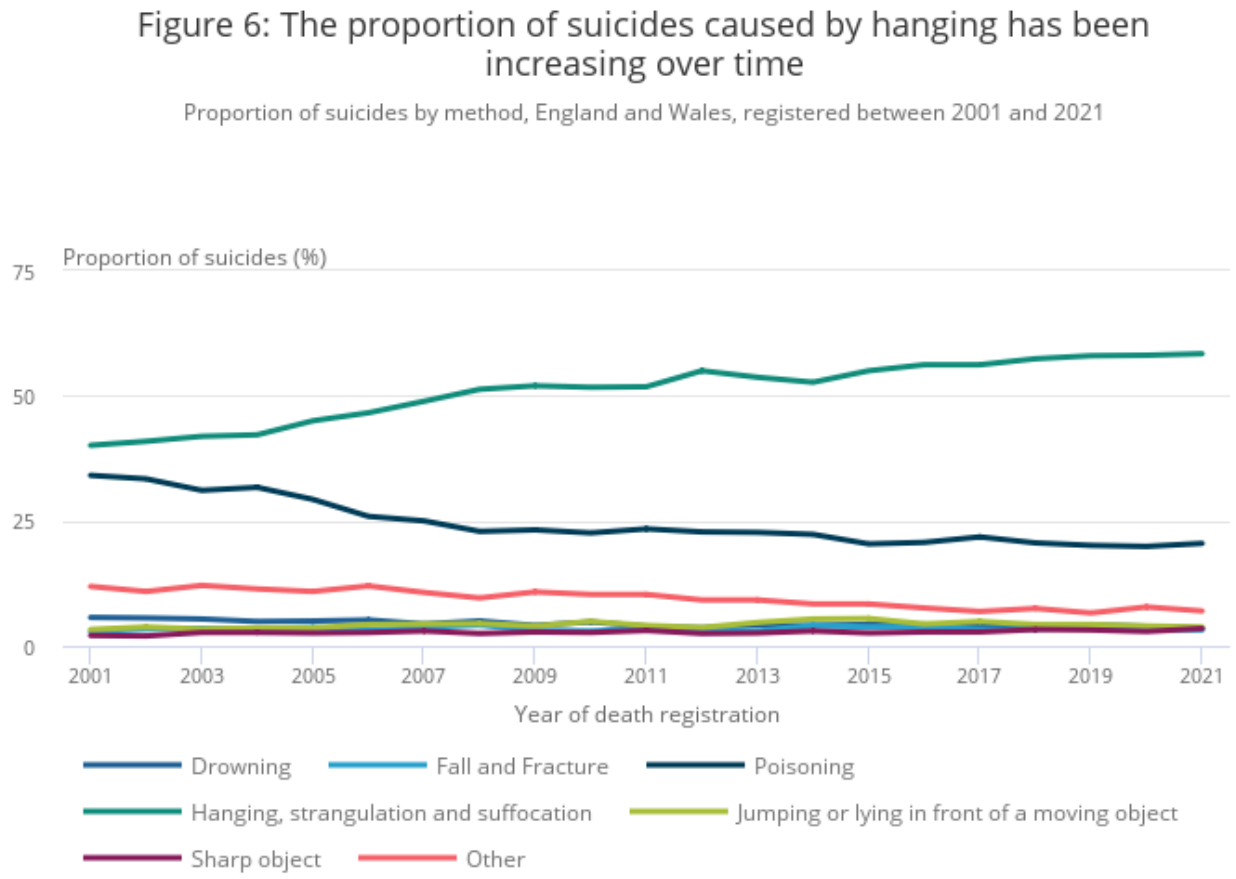
| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | – | 15,447 | 10.4 | 10.3 | 10.6 |
| Second least deprived decile (IMD2010 | – | - | - | - | - |
| York | – | 72 | 13.3 | 10.3 | 16.8 |
| Dorset | – | 119 | 12.4 | 10.1 | 14.8 |
| West Sussex | – | 265 | 11.5 | 10.1 | 12.9 |
| Wiltshire | – | 150 | 11.5 | 9.7 | 13.4 |
| North Yorkshire UA | – | 183 | 11.3* | 9.7 | 13.0 |
| Gloucestershire | – | 192 | 11.3 | 9.7 | 12.9 |
| Warwickshire | – | 172 | 11.2 | 9.5 | 12.9 |
| Sutton | – | 56 | 10.6 | 8.0 | 13.8 |
| Cambridgeshire | – | 180 | 10.4 | 8.8 | 11.9 |
| Cheshire East | – | 100 | 10.1 | 8.1 | 12.1 |
| Leicestershire | – | 164 | 8.7 | 7.4 | 10.0 |
| Merton | – | 37 | 6.5 | 4.5 | 9.0 |
| Harrow | – | 34 | 5.4 | 3.7 | 7.5 |
| Bromley | – | 43 | 5.1 | 3.7 | 6.9 |
| City of London | – | 3 | * | - | - |

*Source: Office for National Statistics*

**Methods used for suicide**

The most common method of suicide in England and Wales for both males and females continued to be hanging, strangulation and suffocation (all grouped together).

**Figure 8: Propotion suicides by method, England and Wales, registered between 2001 and 2021**




**Source: Office for National Statistics – Suicides in England and Wales**

# Analysis of Primary Care Mortality Database: Jan 2015 to March 2021

## Background

A report was run from the City of York Council Database which holds the local records from the Primary Care Mortality Database (PCMD). All deaths by suicide which were registered between 1.1.2015 and 31.3.2021 were identified (147 deaths). There were 4 duplicate deaths identified. In each of these cases there were two deaths noted with different (supposedly unique) PCMD identification numbers where all the details of the death were identical. It was assumed that an error had occurred with the PCMD process and the 4 duplicate deaths were removed from the records leaving 143 deaths for analysis.

## Demographics

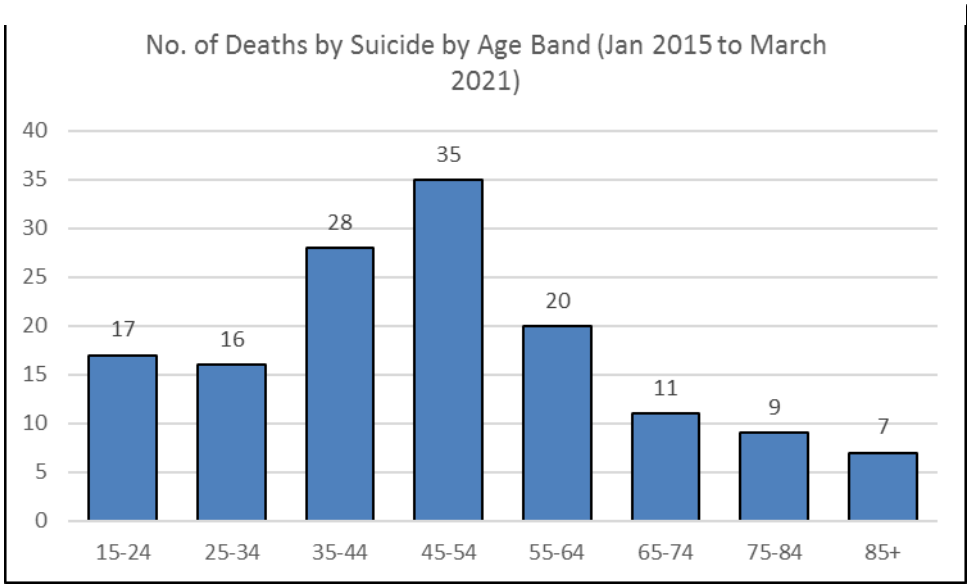
### Gender

- Of the 143 people, 104 (73%) were men and 39 (27%) were women.

### Age at Death

- Death by suicide occurred in a wide range of age bands from 15-24 up to 85+.
- The average age at death was 48.8 years overall (48.0 years for men and 51.1 years for women).
- The most common ten year age band at which people in York took their own lives was 45-54. This was the case for both men and women.

## Figure 9: Age at which people took their own lives

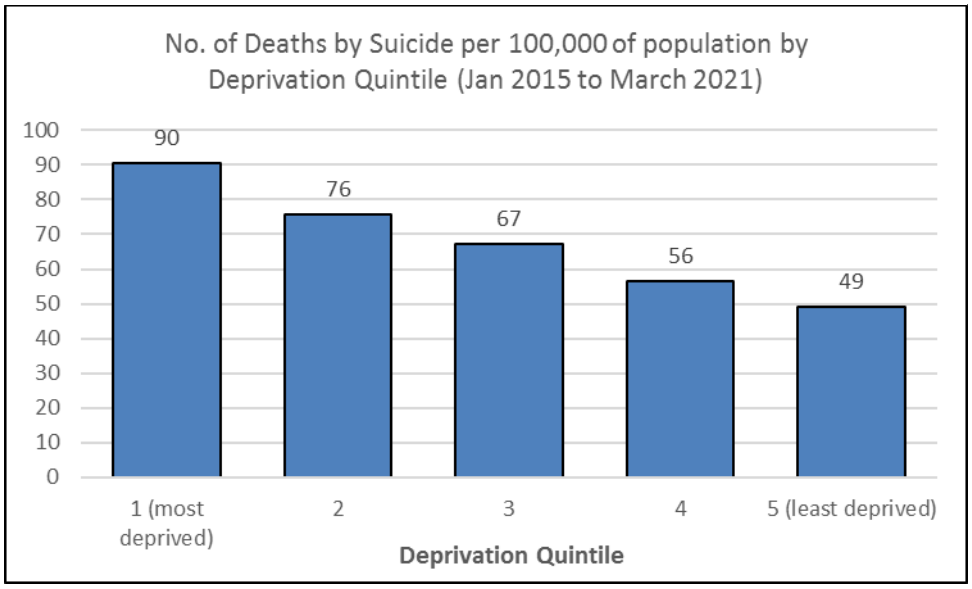



**Years of Life Lost**

Based on the age at death of each person and the average life expectancy at birth in York (using the 2018-20 estimates for each gender), the 143 people taken together were deprived of 4,585 'years of lost life' as a result of suicide (an average of 32 years per person).

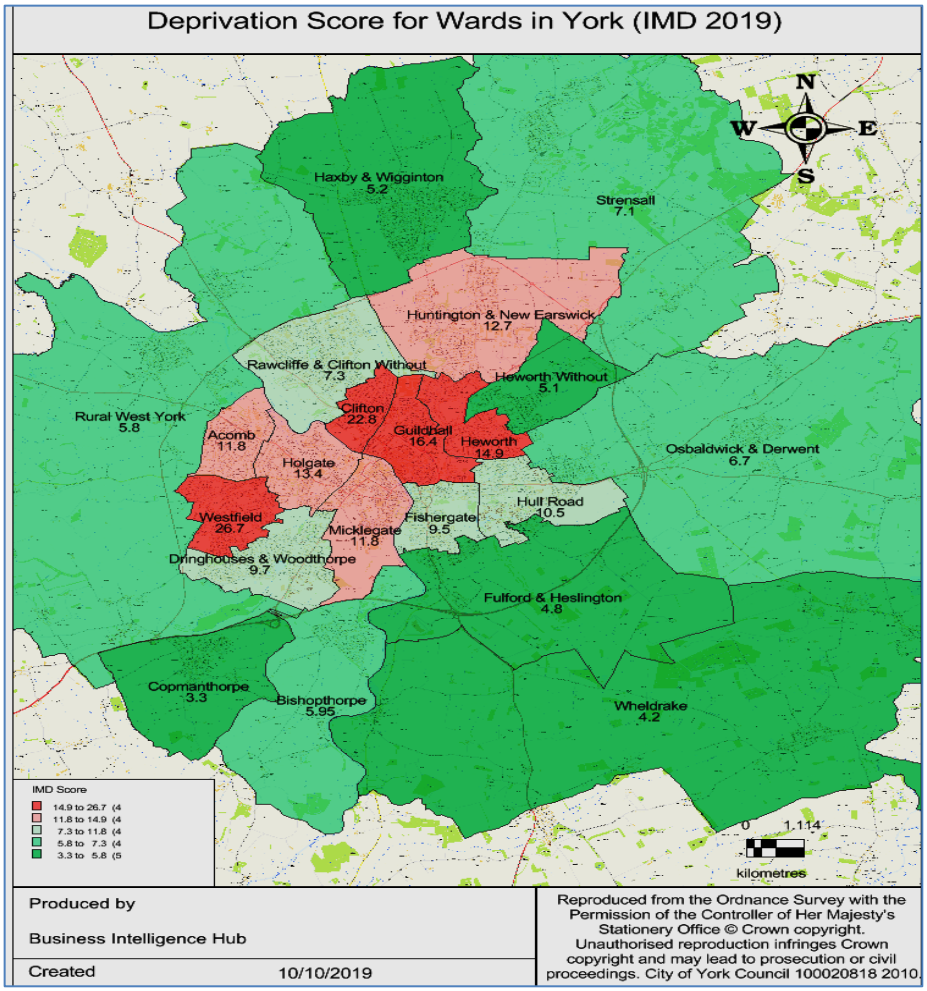
## Deprivation Decile

### Figure 10: Number of deaths by suicide per 100,000 by deprivation quintile




The relative level of deprivation of the areas in which the people in the York sample lived prior to their death can be obtained using the usual postcode of residence.
Figure 10 above, shows that there is over-representation from people living in more deprived areas. The number of deaths by suicide per 100,000 of population is 90 in the most deprived quintile in York compared with 49 in the least deprived quintile. (The 2019 Index of Multiple Deprivation has been used to calculate the within York deprivation quintiles).
Figure 12, below shows the that the wards with higher relative overall deprivation (red and pink shaded areas are mainly located within the York outer ring road.

## Figure 11: York City - Index of Multiple Deprivation



# Suicide Event

## Intent

Deaths by suicide are coded as occurring either as a result of intentional self harm or from injury of undetermined intent. Of the 143 deaths 113 (79%) were as a result of intentional self harm and 30 (21%) were from injury of undetermined intent. The percentages are the same for both men and women.

## Deaths from Intentional Self Harm.

For deaths from intentional self harm, death by hanging, strangulation and suffocation is the most common cause of death (for both males and females) accounting for 54% of deaths.

**Table 1: Method of suicide: Intentional Self Harm**

| Cause of Death | No. |
|---|---|
| Intentional self-harm by hanging, strangulation and suffocation | 61 |
| Intentional self-poisoning by and exposure to other gases and vapours | 10 |
| Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified | 9 |
| Intentional self-harm by drowning and submersion | 7 |
| Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances | 7 |
| Intentional self-harm by sharp object | 4 |
| Intentional self-poisoning by and exposure to antiepileptic, sedativehypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified | 4 |
| Intentional self-harm by jumping or lying before moving object | 3 |
| Intentional self-harm by unspecified means | 3 |
| Intentional self-harm by jumping from a high place | 2 |
| Intentional self-harm by rifle, shotgun and larger firearm discharge | 2 |
| Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system | 1 |

## Deaths from Injury of Undetermined Intent.

For deaths from injury of undetermined intent hanging, strangulation and suffocation and poisoning by and exposure to narcotics and psychodysleptics are the most common causes of death accounting for 50% of deaths.

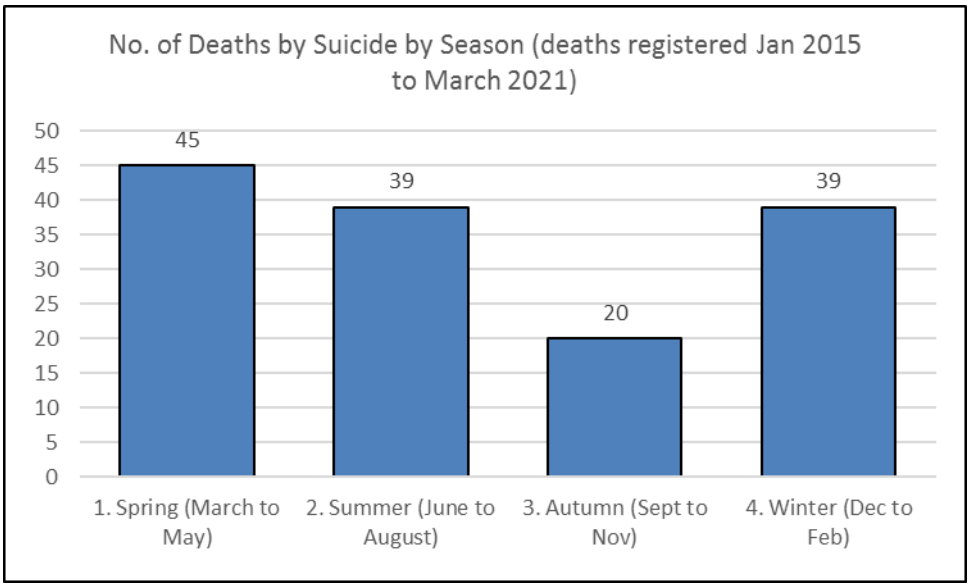
**Table 2: Method of suicide: injury of undetermined intent.**

| Cause of Death | No. |
|---|---|
| Hanging, strangulation and suffocation, undetermined intent | 9 |
| Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent | 6 |
| Drowning and submersion, undetermined intent | 4 |
| Unspecified event, undetermined intent | 3 |
| Other specified events, undetermined intent | 2 |
| Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent | 2 |
| Falling, jumping or pushed from a high place, undetermined intent | 1 |
| Poisoning by and exposure to alcohol, undetermined intent | 1 |
| Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent | 1 |
| Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent | 1 |

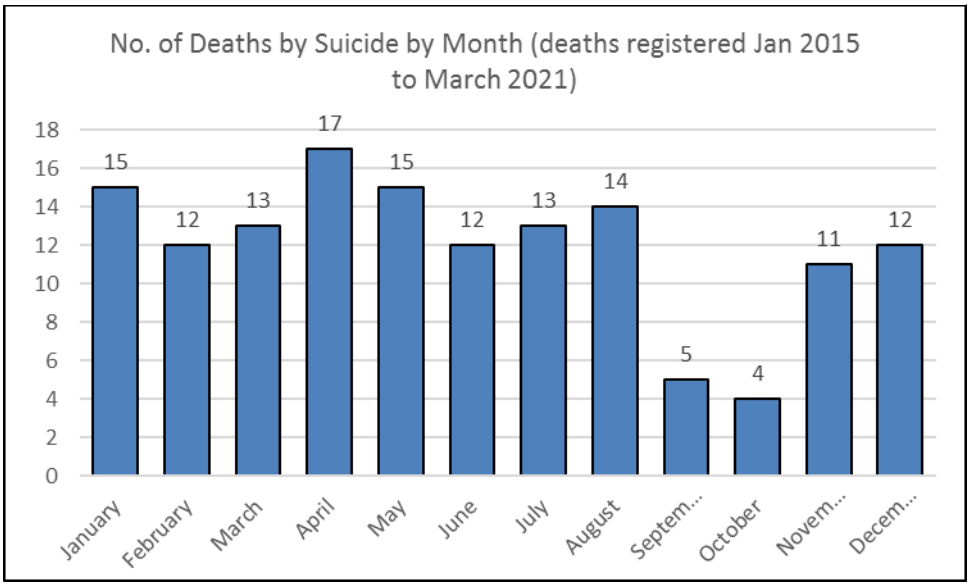
## Season / Month / Day of suicide event

It is of interest to analyse whether suicides are more likely to occur at certain times of the year or on particular days of the week. Deaths by suicide took place throughout the year but the highest number occurred in the spring months (March to May). By calender month the highest number of suicides occurred in April (17 deaths) followed by January and May (15 deaths).

## Figure 12: Season of Suicide Event

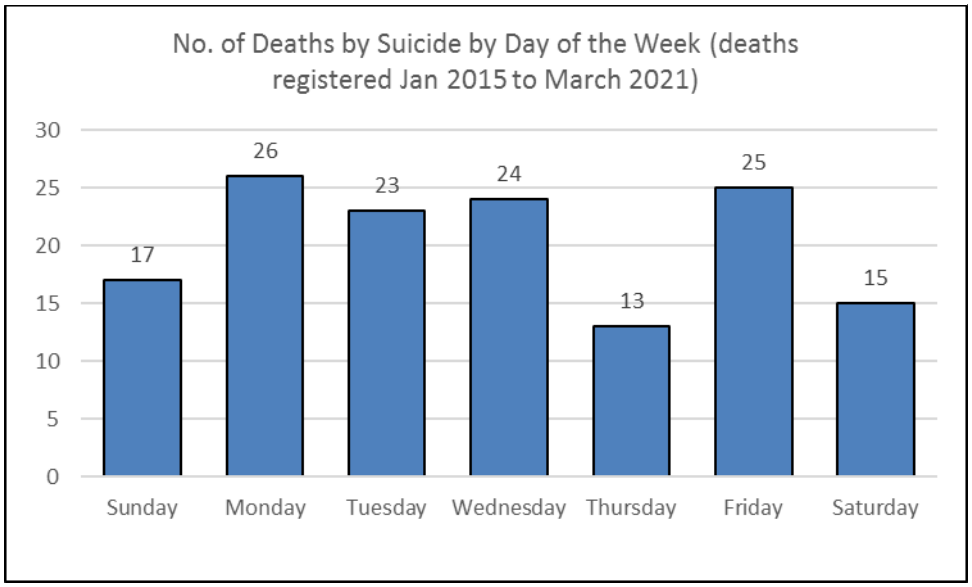



## Figure 13: Month of Suicide Event




The most common days of the week where people in the York sample took their own lives were Monday and Friday.

**Figure 14: Day of the week when suicide event took place**



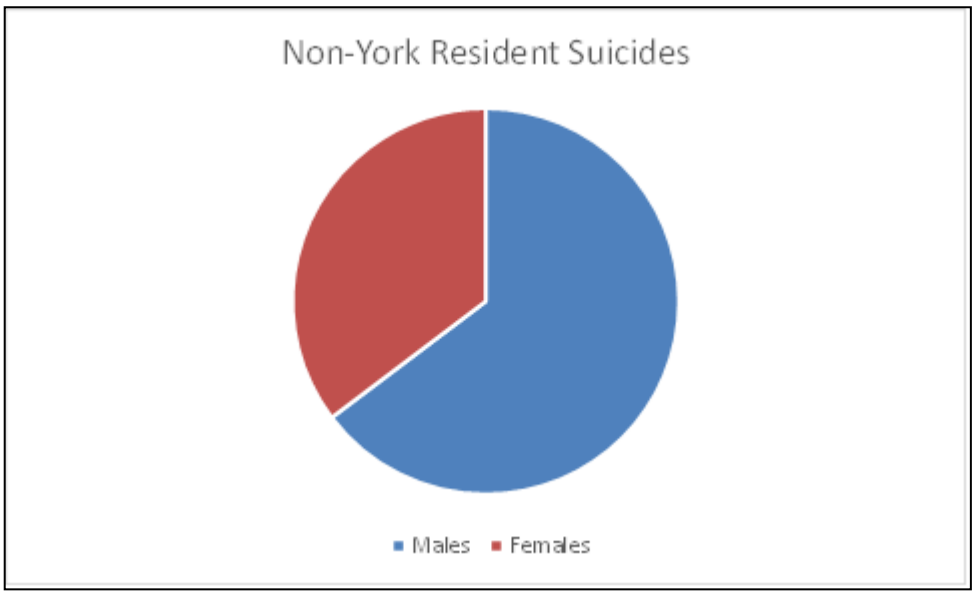

**Repeat Locations.**

Of the 143 deaths of York residents, 7 occurred in rivers (5 times in the Ouse and twice in the Foss). The deaths did not necessarily occur in the same parts of the river. A further river death occurred in York for a person who was not a York resident
Other repeat locations are Clifton Backies, and railway locations, which contributed to 6 more deaths (3 occurances each).

## Deaths by suicide of non-York residents which occurred in York.

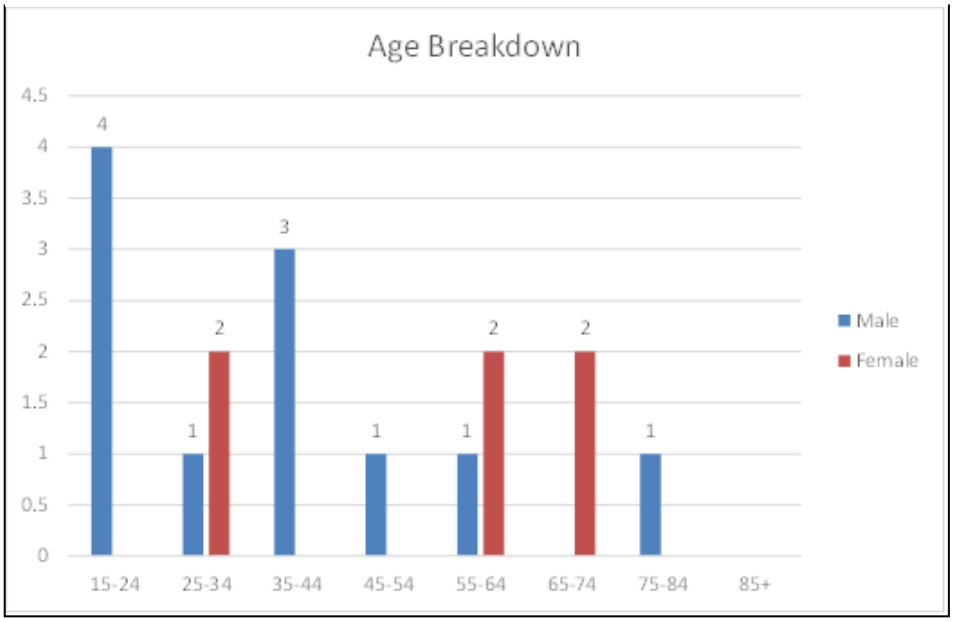
Between 1.1.2015 and 31.3.2021 there were 17 deaths by suicide registered for non York residents where the death occurred in York. 11 of these were male, 6 were female.

### Figure 15: Gender Breakdown of deaths of non-York residents occurring in York



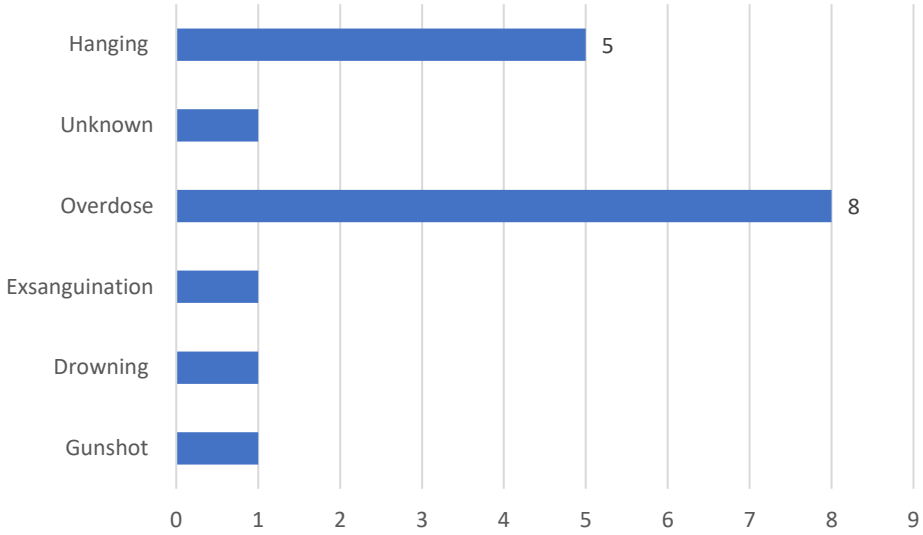

The average age of those who died was 42 years. The average age at death for males was slightly lower at 36 years. The age band with the highest number of suicides was 15–24-year-olds, which were predominantly males.

### Figure 16: Age / Gender Breakdown of deaths of non-York residents occurring in York




The most common method of suicide was by substance overdose, with 8 deaths, followed by hanging. The rest of the methods have less than 3 deaths.

**Figure 17: : Method of suicide for deaths of non-York residents occurring in York**




There are some apparent differences between this group of non York residents and the group of York residents e.g. they were younger and the most common method used was overdose, rather than hanging. The numbers of non York residents is much smaller however, so it is difficult to draw any firm conclusions from this brief analysis.

# Audit of Coroners Files

## Methodology

Coroners files were obtained for 51 York Residents who had died by suicide. All the deaths were registered between 1.4.18 and 31.3.21 which was the chosen period for the audit. Information was extracted from the files onto a template for analysis.

Based on PCMD data there had been 65 deaths by suicide of York residents registered between 1.4.18 and 31.3.21. 54 of these were deaths from intentional self harm and 11 were from injury of undetermined intent.

14 of the files were unavailable to view from the North Yorkshire Coroners Office. 5 of these 14 deaths had taken place away from York which may explain why the files were not available locally.

Viewing 51 files out of 65 deaths means that 78% of all deaths in the selected period were included in the audit of Coroner's files.

Of the 51 files viewed, 50 were people who had died from intentional self harm and the other was a person who had died from injury of undetermined intent.

Prior to the audit a proforma was developed in consultation with the public health team with advice from suicide prevention leads from other areas to standardise the data extraction. The coroners files were reviewed by three members of the public health team

# Suicide Event

## Location of Death

The majority of deaths occurred in the person's own home (35 incidents, 69%) which is similar to the 2016 audit (68%). A smaller percentage of deaths occurred on the railway (2%) compared with 12% in the 2016 audit.

### Table 3: Location of Death

| Location of Death | 2023 Audit (No.) | 2023 Audit (%) | 2016 Audit (%) |
|---|---|---|---|
| Home | 35 | 69% | 68% |
| Hospital | 6 | 12% | 0% |
| River | 3 | 6% | 0% |
| Road / Street | 2 | 4% | 3% |
| Woodland / Park | 2 | 4% | 7% |
| Field | 1 | 2% | 0% |
| Railway | 1 | 2% | 12% |
| Workplace / Office | 1 | 2% | 2% |
| Bridge | | 0% | 2% |
| Other | | 0% | 7% |
| **Total** | 51 | 100% | 100% |

## Suicide Note

23 out of 51 people (45%) left a suicide note. In the 2016 audit 53% of people left a note.

## Warning Signs / Evidence of Risk

For 27 of the 51 people (53%) there were warning signs or evidence of risk prior to death by suicide.

# Person's status at time of death.

## Living arrangements

The majority of people (55%) were living alone at the time of death which is a higher percentage compared with the 2016 audit (42%).

### Table 4: Living Arrangements

| Living arrangements | 2023 Audit (No.) | 2023 Audit % | 2016 audit % |
|---|---|---|---|
| Alone | 28 | 55% | 42% |
| With close family | 17 | 33% | 42% |
| Not known | 2 | 4% | 5% |
| Shared house | 2 | 4% | 12% |
| With extended family | 1 | 2% | |
| Rough sleeping | 1 | 2% | |
| **Total** | **51** | **100%** | **100%** |

## Relationship status

Three quarters of people in the York sample were either single, divorced, widowed or separated (38 out of 51 people, 75%). The detailed breakdown by relationship status is shown the the chart below.

### Table 5: Relationship status

| Relationship status | 2023 Audit (No.) | 2023 Audit (%) | 2016 Audit % |
|---|---|---|---|
| Single | 22 | 43% | 52% |
| Married | 10 | 20% | 17% |
| Widowed | 7 | 14% | |
| Divorced | 6 | 12% | 12% |
| Seperated | 3 | 6% | 10% |
| Not known | 2 | 4% | |
| In a relationship | 1 | 2% | |
| Co-habiting | | | 10% |
| **Total** | **51** | **100%** | **100%** |

## Employment status

Employment status at the time of death is shown in the chart below. 27 people (53%) were in employment at the time of death, 12 (24%) were unemployed and 9 (18%) were retired. Compared with the 2016 audit there are a higher proportion of retired people (18% v 12%) and a lower proportion of students (2% v 10%).

### Table 6: Employment Status

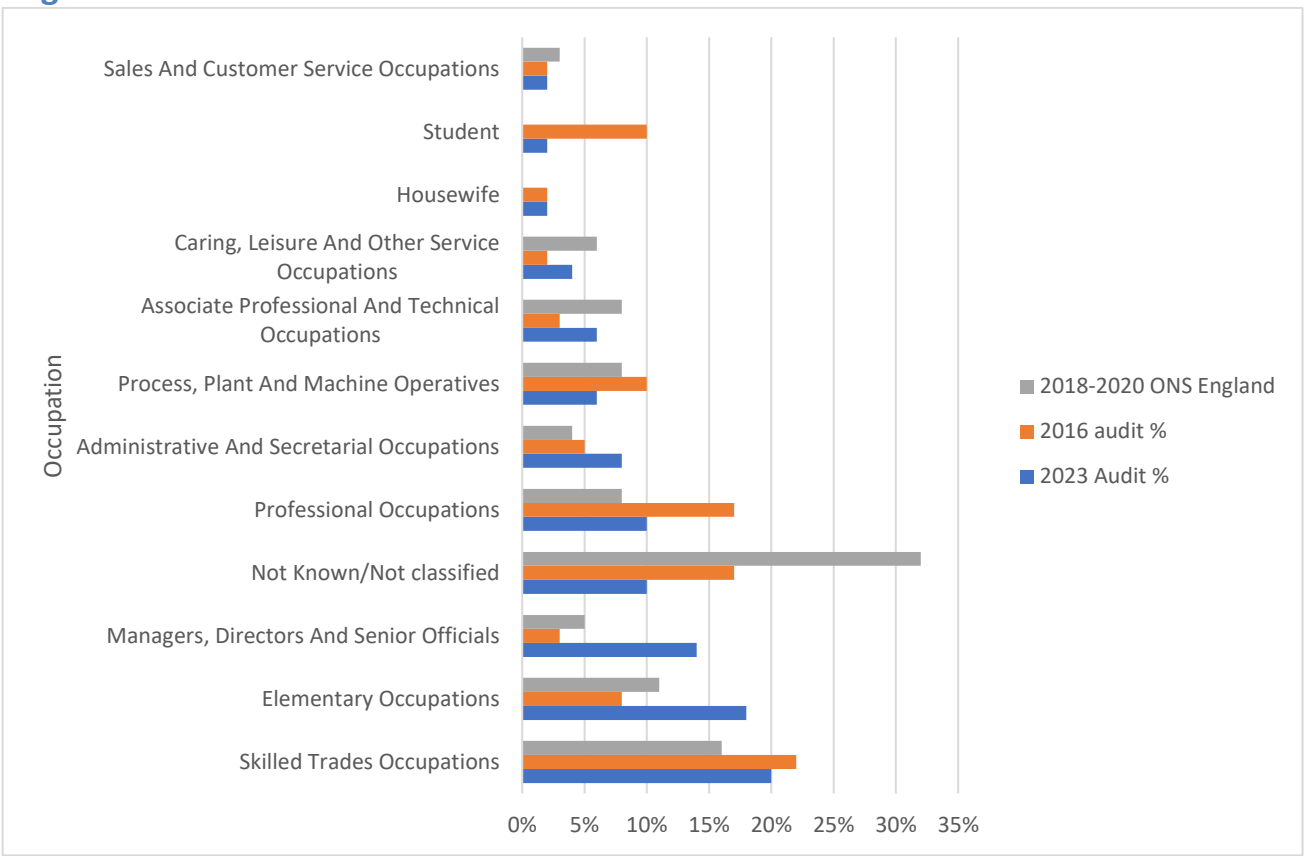
| Employed | 2023 Audit (No.) | 2023 Audit (%) | 2016 Audit (%) |
|---|---|---|---|
| Employed / Self Employed | 27 | 53% | 43% |
| Not Employed | 12 | 24% | 22% |
| Retired | 9 | 18% | 12% |
| Sickness | 2 | 4% | 8% |
| Student | 1 | 2% | 10% |
| Not Known | | | 5% |
| **Total** | **51** | **100%** | **100%** |

## Occupation

Occupation is reported at the time of death registration by the informant. The recorded occupation likely reflects the deceased's main lifetime occupation at the time of death. It is also possible that, when they died, the deceased was retired, unemployed, or in a different job altogether. Numbers of deaths alone cannot be used to ascertain the risk of suicide among occupation groups. Year-to-year differences in numbers of deaths may merely reflect differences in the population of a given occupation as opposed to changes in the risk of suicide.

These occupations were clustered into groups using the ONS Occupation Coding Tool. The largest occupational groups were 'Skilled Trades' (20%) and 'Elementary' (18%). Compared with the 2016 audit, there were more Elementary Occupations (18% v 8%) and more Managers, Directors and Senior Officials (14% v 3%) and fewer Professional Occupations (10% v 17%) and fewer people who's occupation was unknown (10% v 17%). The analysis by occupation does need to be interpreted with some caution however, as the job titles are self reported by the person registering the death and may not always be the most recent job undertaken.

## Figure 18: Occupation York Audit 2023 compared to York Audit 2016 compared to England 2018-20




| Occupational Status | 2023 Audit (No.) | 2023 Audit (%) | 2016 Audit (%) | 2018-2020 ONS England |
|---|---|---|---|---|
| Skilled Trades Occupations | 10 | 20% | 22% | 16% |
| Elementary Occupations | 9 | 18% | 8% | 11% |
| Managers, Directors And Senior Officials | 7 | 14% | 3% | 5% |
| Not Known/Not classified | 5 | 10% | 17% | 32% |
| Professional Occupations | 5 | 10% | 17% | 8% |
| Administrative And Secretarial Occupations | 4 | 8% | 5% | 4% |
| Process, Plant And Machine Operatives | 3 | 6% | 10% | 8% |
| Associate Professional And Technical Occupations | 3 | 6% | 3% | 8% |
| Caring, Leisure And Other Service Occupations | 2 | 4% | 2% | 6% |
| Housewife | 1 | 2% | 2% | - |
| Student | 1 | 2% | 10% | - |
| Sales And Customer Service Occupations | 1 | 2% | 2% | 3% |
| **All** | **51** | **100%** | **100%** | **100%** |

***'Not classified' mainly includes 'inadequately described occupations' and 'occupation not stated' but also includes 'retired', 'students', 'independent means', 'permanently sick', 'full-time care of the home and/or dependent relatives, voluntary workers' and 'unemployed persons with no other information'.***

# Drugs and Alcohol

## Alcohol

For 14 of the 51 people (27%) alcohol was present at the time of death based on information in the coroners file. This is lower than the figure of 37% from the 2016 audit.

14 of the 51 people (27%) had a history of alcohol misuse (and alcohol was present at the time of death for 8 of these people).

## Drugs

For 19 of the 51 people (37%) drugs were present at the time of death based on information in the coroners file. The most frequently recorded drugs were: Cocaine (5 people); Paracetamol (5 people); Venlaflaxine (2 people); Sertraline (2 people); Diazepam (2 people) and Cannabis (2 people).

10 of the 51 people (20%) had a history of drug misuse (and drugs were present at the time of death for 5 of these people).

# Prior contact with services

## Substance Misuse Services

18 out of 51 people (35%) had a history of either drug or alcohol misuse (or both). This is a lower figure than the 2016 audit (47%). For only 4 of these 18 people was involvement with drug and alcohol treatment agencies recorded on the coroner's file suggesting a possible lack of engagement with treatment services amongst the York cohort.

## Other Services

Based on information recorded on the Coroner's file, 7 out of 51 people had contact with one or more other agencies. These agencies were: Community Mental Health Team (2 people); Citizen's Advice; Samaritans; Private Counselling; Psychologist; Housing Services; Safeguarding; Hospice and Bereavement Services.

## Known to City of York Council

The names of the 51 people were checked against the City of York Council 'Single View' database to see how many were known to the Council and in what capacity.

- 20 people (39%) were known to the City of York Council.
- 15 people were currently or had previously known to adult social care services.
- 5 people had received Housing Services.
- 3 people were parents of children who had been in receipt of Children's Social Care services
- 2 people had been involved with the Youth Justice services.

## Most recent contact with GP

21 people out of 51 (41%) had seen their GP in the month prior to their death. This is a higher percentage compared with the 2016 audit (28%).

### Table 7: Most recent contact with GP prior to death

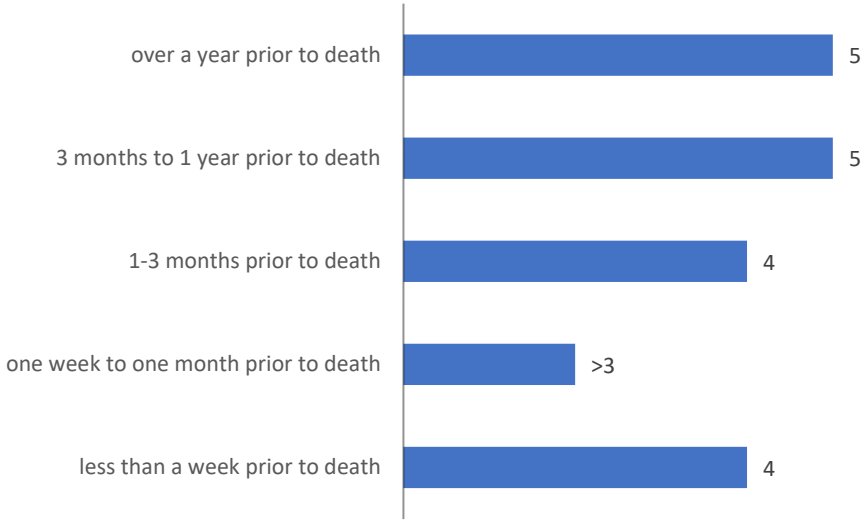
| Most recent contact with GP | 2023 Audit (No.) | 2023 Audit (%) | 2016 Audit (%) |
|---|---|---|---|
| Less a week prior to death | 14 | 27% | 15% |
| One week to one month prior | 7 | 14% | 13% |
| 1-3 months prior | 9 | 18% | 13% |
| 3 months to 1 year prior | 9 | 18% | 22% |
| Over a year prior | 7 | 14% | 22% |
| None / Unknown | 5 | 10% | 15% |
| **Total** | **51** | **100%** | **100%** |

Of the 21 people who saw their GP in the month prior to death, 14 had attended for reasons to do with their mental health (including reviews or specific concerns). The other 7 had attended for other medical (non mental health) reviews or specific concerns.

## Accident and Emergency

Previous attendance at an Accident and Emergency Department had been recorded for 20 people (39%).

**Figure 19: Number of people attended A&E prior to death**




Of the 6 people to attend A&E in the month prior to death, 5 were for reasons relating to mental health (e.g. attempted suicide, overdose, self harm, acute mental health symptoms) and one was for medical (non mental health) reasons.

**Elective Admissions in last 12 months.**

Only one person had an elective admission in the last 12 months for a medical procedure.

**Previous Involvement with the Criminal Justice System**

6 of the 51 people (12%) had previous involvement with the Criminal Justice System. The most recent date of involvement was recorded for three of the people. In two cases the contact was 6+ years prior to death and in one case the contact was only days before death.

# Mental Health

**Diagnosis**

35 people (69%) had a mental health diagnosis. 19 of these people had depression, 8 had anxiety and 5 were diagnosed with mood disorder or low mood.

**Treatment**

30 people (59%) had received mental health treatment in the last 12 months.

**Risk of Harm / History of Self Harm**

7 people (14%) had a risk of harm recorded on the GP records.

12 people (24%) had a history of self harm, a lower propotion compared to the 24 out of 60 people (40%) reported in 2016 audit. The self harm occurred:

- less than a week prior to death (3 people)
- one week to one month prior to death (1 person)
- 1-3 months prior to death (1 person)
- 3 months to a year prior to death (4 people)
- Over a year prior to death (1 person)
- For 2 people, the timing of the self harm had not been recorded.

**Previous suicide attempts**

23 people (45%) had made at least one suicide attempt in the 12 months prior to death. The number of suicide attempts ranged from 1-9 per person. 6 people had made more than one attempt in the last 12 months. 16 people had attempted an overdose and 6 people had attempted hanging.

## Other Factors

The Coroner's file audit template included a free text space for recording any other significant factors in relation to the suicide which may not have been picked up in the previous structured questions.

These factors were identified for the following numbers of people.

- Perceived financial issues and concerns (n=10)
- Relationship breakdown (n=5)
- COVID pandemic (n=4)
- Bereaved (n=3)

A caveat of this analysis is that just because a factor was not mentioned in the coroner's file it does not mean it was not relevant for the suicide. For example financial

issues may possibly have been a factor in more than ten instances, but it was only explicitly recorded in the coroners files for these ten people.

## Next steps

This report deliberately does not set out recommendations. This is because an action plan will be formulated in 2024, using the findings and concentrating on two specific work streams:

1. The real time surveillance response across the North Yorkshire and York Police/Corononial geographic area.
2. The York community prevention response, aligned to the national suicide prevention strategy.

# Acknowledgements

We would like to thank the following:

Rachel Davies, the coroner for the City of York and her team for support in granting access to files; The York Suicide Prevention Delivery Group for their continued committemnt to the suicide prevention in York; Sally Ballow (Hull City Council) for knowledge sharing and Heather Baker (City of York Council) for supporting with infographics.

The report team would like to express their deep condolences to all those affected by the deaths covered in this document, and have carried out this work in the hope that it will contribute to our shared goal of making York a suicide-safer community, and deaths by suicide in our city less common.

# Report Authors

| | |
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# Appendices

**Appendix 1: Glossary of Terms**

**Rate** a measure of the frequency with which an event occurs in a defined population over a specified period of time.
**Alcohol dependence** is a previous psychiatric diagnosis in which an individual is physically or psychologically dependent upon drinking alcohol. In 2013 it was reclassified as alcohol use disorder (alcoholism) along with alcohol abuse in DSM-5.

**OHID** Office of Health and Improvement Department

**Office of National Statistics** is the UK's largest independent producer of official statistics and is the recognised national statistical institute for the UK.

**Protective factors** lifestyle influences which serve to improve an individual's resilience and thereby make them less susceptible to suicide such as good mental health, supportive family and friends, stable employment or accommodation.

**Risk Factors** lifestyle influences which increase an individual's vulnerability to suicide such as poor mental health, lack of support or close relationships, bereavement through suicide, drug and alcohol dependency, unstable employment, housing or financial position. These should not be considered suicide indicators, however

**Self-Harm** The National Institute for Health and Care Excellence (NICE) Guidance definition is used in this report: any act of self poisoning or self injury carried out by a person, irrespective of their motivation. This commonly involves self poisoning with medication or self injury by cutting. Self harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

**Suicide** is the act of intentionally causing one's own death.

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