1. Purpose of report

1.1 The Public Health & Prevention Cabinet Panel is asked to note and consider the key findings from the Suicide Audit for Hertfordshire 2017 (as attached at appendix A).

2. Summary

2.1 Suicide audits are no longer a statutory requirement. National guidance recommends that local authorities carry out a suicide audit every year. Suicide audits identify the context in which suicides occur, the local groups potentially most at risk, and how the picture changes over time.

2.2 The suicide rate for Hertfordshire is significantly lower than the rate for England and has remained lower over time.

2.3 The Suicide Audit for Hertfordshire 2017 has been carried out through a multi-agency group, working to a more robust, consistent and objective process. The suicide audit for 2018 is following this process as well.

2.4 This audit provides an overview of suicides in Hertfordshire given a Coroner’s conclusion following an inquest held in 2017. 74 deaths were included in the audit.

2.5 Information within the audit is drawn from relatively small numbers. Other local and national data sources should also be taken into account by agencies working to reduce and prevent suicide.
3. **Recommendations**

3.1 Panel is asked to consider and comment on this report.

3.2 Once the suicide audits for Hertfordshire for 2017, 2018 and 2019 have been completed, Panel is asked to consider receiving an update report on key findings, including local trend data.

4. **Background**

4.1 [National Guidance](#) recommends that every local authority carries out an annual suicide audit, though these audits are no longer a statutory requirement. Suicide audits identify the context in which suicides occur, the local groups potentially most at risk, and how the picture changes over time. The Guidance also recommends that a suicide prevention action plan is developed, with a multi-agency group established to co-ordinate effective action within the local area.

4.2 Hertfordshire responded to this Guidance in 2016 by developing a [multi-agency suicide prevention strategy](#). This strategy was influenced by the most recent suicide audit at that time (for 2015/16). Reviewing and improving the suicide audit process was identified as a key action.

4.3 Work on the 2017 suicide audit was carried out by a multi-agency group with representatives from Hertfordshire County Council (Public Health, Coroner Service, Integrated Health and Care Commissioning), Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire Police Constabulary and British Transport Police. This audit provides an overview of suicides in Hertfordshire using information from files held by the coroner service.

4.4 The group agreed what information to capture from the coroner’s files on each individual, and a more robust, consistent and objective process was developed. The 74 deaths included were given a Coroner’s conclusion between 1 Jan and 31 Dec 2017, with the majority of deaths occurring in 2016.

4.5 The report includes recommendations for improving the process but does not include specific recommendations for action. This is because the information is from relatively small numbers and other data sources such as ONS death registrations, police, NHS and other service data should also be taken into account by agencies working to reduce and prevent suicide.

4.6 The number of suicides in this audit is an increase from the 56 included in the 2015/16 audit. As the numbers of suicides at local authority level are relatively small, changes between years are best reviewed by using three year age standardised rates. The suicide rate in Hertfordshire is significantly lower than the rate for England and has remained lower.
over time. There has been no significant change in the rate for Hertfordshire over time.

4.7 Key findings from the 2017 Audit:

4.7.1 In line with national findings, men aged 40-59 years old made up the highest proportions of people dying by suicide in the 2017 Hertfordshire Suicide Audit

4.7.2 Mental health issues were the most common risk factor mentioned in coroner’s files

4.7.3 Over a third of people included in the audit were known to a mental health service at the time of death, whilst almost a quarter discussed mental health issues with a member of their GP practice in the four weeks leading up to their death.

4.7.4 A third of people who died by suicide were known to have made a previous suicide attempt.

4.7.5 More than one in ten suicides took place on the railway, higher than nationally.

4.8 Analysis for the Suicide Audit 2018 is underway and findings will be reported this year

Recommendations arising from the 2017 Audit

4.9 The following recommendations arise from the audit:

- While no longer a statutory requirement, suicide audits should continue to be carried out every year for Hertfordshire.
- Hertfordshire’s suicide prevention strategy should be refreshed drawing on data from this audit, and the forthcoming 2018 audit.
- Trends should be reviewed once the 2019 audit has been completed.
- The next audit (for 2018) should:
  o report the number of deceased people known to the local mental health trust separately from those known to trusts out of area
  o collect postcode data for the location of each suicide, to identify potential hotspots
  o review the list of risk factors, to ensure categories are meaningful and significant.
- The findings of this and future audits should be communicated in order to inform and support the work of partners.

4.10 The Review of the coroner’s records undertaken for the Audit showed, with hindsight, that there remain opportunities to identify and support people at risk of suicide. The continued challenge is to spot and act on these signs, for individuals, for communities, and for services across Hertfordshire.

5. Equality Impact Assessment
5.1 When considering proposals placed before Members it is important that they are fully aware of, and have themselves rigorously considered the equalities implications of the decision that they are taking.

5.2 Rigorous consideration will ensure that proper appreciation of any potential impact of that decision on the County Council’s statutory obligations under the Public Sector Equality Duty. As a minimum this requires decision makers to read and carefully consider the content of any Equalities Impact Assessment (EqIA) produced by officers.

5.3 The Equality Act 2010 requires the Council when exercising its functions to have due regard to the need to (a) eliminate discrimination, harassment, victimisation and other conduct prohibited under the Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The protected characteristics under the Equality Act 2010 are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief, sex and sexual orientation.

5.4 No EqIA was undertaken in relation to this matter as this Suicide Audit is one of several data sources that agencies working to reduce and prevent suicide need to consider.

6. Financial Implications

6.1 This suicide audit was carried out by staff in Hertfordshire’s Public Health service. Although there was no direct expenditure on the audit, review of the notes, collation of the information, and linked analysis took up a significant amount of staff time.

6.2 A separate case has been made to the NHS to help resource delivery of this work and the wider suicide prevention programme from 2019/20. This is currently being considered.

Background Information