BROMLEY SUICIDE AUDIT
2014

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Summary Facts

In Bromley 2013:

- The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women although significantly lower than males seem to be reducing.

- Local data shows that there were more deaths (69%) in people from routine and manual employment.

- For those deaths where a record was obtained, hanging or strangulation was the most common method used, followed by self-poisoning.

- The lack of access to coroner’s records has meant that it is not possible to report trends around social circumstances. However, GP records show depression and mental ill health and substance misuse are the most common contributing factors recorded in these deaths.

- In 2000 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2013 this number had increased to 318.

- 78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.

- In Bromley there are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women.

- In 2013 in Bromley, there was a suicide rate of 7.5 per 100,000, population 15+, lower than the 2012 rate of 9.9 per 100,000 population aged 15+.

- 61% of deaths were males aged 50 years and over.
  Although small numbers, the majority of deaths within this age group had a history of poor physical health and a mental illness diagnosis.

- 77% of deaths had no documented suicide risk recorded.
- 36% of all the deaths had a recorded health condition such as heart disease or COPD.

- 54% had contact with Primary Care in the 12 months prior to death.

- 38% of all deaths had a previous contact with mental health services.

- 38% had a diagnosis of mental illness 12 months prior to the death.
Introduction

Suicide is one of the leading causes of death for all ages worldwide with more than one million deaths per year globally\(^1\). Suicide is an act of deliberate self-harm that results in death. The Office for National Statistics defines suicide as deaths with an underlying cause of self-harm or an injury/poisoning of undetermined intent.

It is customary in the UK to count open verdict deaths resulting from injuries and poisoning of undetermined intent in people aged 15 years and over as suicides. This is because there is insufficient evidence to prove deliberate intent to kill oneself however, the harm was self-inflicted.

Purpose

The London Borough of Bromley has a statutory responsibility for the health surveillance of the population of Bromley. Monitoring through clinical audit all those who have died by suicide is part of a work programme on suicide prevention.

This report has used the National suicide prevention strategy framework to ensure a best practice approach in developing local suicide prevention strategies.

This report compares local and national rates in order to identify Bromley trends and therefore enabling recommendations for further system and service change in the prevention of suicide in Bromley.

Context of suicide statistics

Suicide is a major public health issue that has devastating effects on families and society. Recently, suicide has been acknowledged as a priority in public health policy and has been addressed through national strategic documents. In 2012 the Department of Health launched a new cross-government strategy, *Preventing suicide in England*\(^2\), which supported action in bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available.

The 2012 all age suicide prevention strategy builds on the successes of the 2002 *Suicide Prevention Strategy*\(^3\), recognising that real progress has been made in reducing suicide rates in England to record low levels.
The Government’s white paper *Saving Lives-Our Healthier Nation* (DH 1999)\(^4\) sets reducing the death rate from suicide and undetermined injury by at least a fifth by the year 2010 as one of its four targets.

**Preventing Suicide in England Strategy Objectives:**

- A reduction in the suicide rate in the general population in England ; and
- Better support for those bereaved or affected by suicide.

In addition to national strategic documents there are other evidence based reports on suicide. ‘No health without mental health’ (2011)\(^5\) discusses suicide in its ambition to work towards six objectives for better mental health for the population. The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (University of Manchester, 2012)*\(^6\); provides health professionals, policymakers, and service managers with the evidence and practical suggestions necessary to implement change (*See box below*).

**Key areas to support delivery of the strategy objectives:**

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive reporting of suicidal behaviour
6. Support research, data collection and monitoring

Suicides statistics provide an indicator of mental health in the population and are important for monitoring trends in deaths resulting from intentional (and probable) self-harm. The Bromley Suicide Audit report and previous audits are presented, discussed and used for both mental health planning and suicide prevention approaches within the following groups:

- CCG Quality Improvement
- Mental Health Strategic Programme Board
- Mental Health Strategic Quality Improvement Group
- Oxleas Foundation Trust’s Patient Safety Group
- Drug Death Review Panel
- Substance Misuse Board
- Bromley Safeguarding Boards (Adult and Children)
Methodology

Data sources and definitions

In order to understand suicide figures for Bromley, a comprehensive monitoring system has been set up using the Suicide Audit Tool. This tool interrogates mortality data from the Primary Care Mortality Database, General Practice Medical notes and history of hospital admission.

Coroner Information

Information on cause of death is collected via the death registration system which is undertaken by the Local Registration Services and the General Register Office (part of the Office for National Statistics, ONS)

Suicide is reported as a cause of death on death certificates in England and Wales using ICD10 codes. Around 30,000 Coroner’s inquests are held each year in England and Wales following any unnatural or unexpected deaths. Verdicts are commonly recorded as;

- accidental,
- natural causes,
- suicide,
- industrial disease or
- ‘open’ where there is doubt about the intentions of the deceased.

Many open verdicts are likely to be suicides. For these reasons, the Office of National Statistics (ONS) combines official suicides and open verdicts to give the overall suicide statistics for England and Wales.

Primary Care Mortality Database PCMD

The Primary Care Mortality Database (PCMD) provides a list of all deaths recorded as suicides or open verdicts. PCMD collates deaths by place of death, CCG of residence and date of death. The underlying cause of death is recorded for all deaths in the PCMD using the World Health Organisation’s (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in Table 2 in the appendix.
The definition of suicides in this report includes deaths from undetermined injury, also known as open verdicts, as evidence suggests that the majority of open verdicts are a result of suicide.  

**GP Clinical notes**

To complement the PCMD extract, corresponding GP clinical notes are accessed for qualitative data in relation to each death. This information is collated and inputted to the Suicide Audit Tool and used to assist in obtaining the ‘social story’ and context in which the death occurred.

The complete picture helps identify trends and hotspots thus permitting a more thoughtful and knowledge based approach to suicide reduction interventions in Bromley.

Obtaining this qualitative data has become increasingly difficult as changes with legislation and access to patient identification information has impacted on access to this information. This has meant that the social history information available is often patchy. The access to the Coroner’s records, which was available for the last 10 years, has now been rescinded due to these changes in legislation and practice. We have taken this issue up with Public Health England and await their guidance on this.

**Comparator data**

Comparator data is used to look at how Bromley compares to the UK, England and London and also identify trends. The data is derived from releases from the Office for National Statistics and the Health and Social Care Information Centre Indicator Portal for national and local comparison.

**Suicide Audit Tool**

The Suicide Audit Tool created by the National Institute of Mental Health in England offers a ready-made database for conducting suicide audits at local level. This database has been adapted for our use locally.

The database collates information on:

- Coroner related information e.g. substances specified with self-poisoning deaths
- Contact with Primary Care Services e.g. physically disabled/ distressing conditions, diagnosis of mental illness, number of consultations with GP, etc.
• Demographic details e.g. age, gender, ethnicity
• Acute hospital services e.g. number of times patients seen in A&E or psychological assessment details.
• Psychiatric history

A full list of the metadata of the toolkit can be found in the attached Appendix1.

**Data caveats for consideration**

1. It is worth noting that all age-standardised rates presented in this report differ from previous publications due to the Office for National Statistics (ONS) recalculating rates using the 2013 European Standardised Population (ESP). Previous publications used the 1976 ESP and so revisions have been provided back to 1981. Therefore figures in this report will differ to those published in previous reports. It is important to understand that any differences are purely methodological and do not indicate an actual change in the previously published observed number of deaths or death rates.

2. The Health and Social Care Information Centre publishes suicide rates in persons aged 15 years and over while the Public Health Outcomes Framework publishes rates for all ages. The three year average morality trend dataset previously published on the Indicator Portal is no longer available. The differences in definitions inhibit reporting some historic trends or triangulating the two datasets at the moment. However for the purposes of completeness we do count and report suicides in under 15’s in this report if they occur in Bromley but they are not included in the trends.

3. Recording of ethnicity data is not complete on all the data sources used in this report. PCMD reports place of birth, General Practice reports ethnicity but not comprehensively and the coroner records ethnicity or place of birth where available. Caution should be exercised when drawing any conclusions as place of birth is being used as a rough proxy indicator of ethnicity where no ethnicity data is available.

4. Due to the nature of coding such sensitive deaths as suicides and open verdicts, there can be a significant delay in obtaining figures. The data presented in the England and UK statistics is two to three years old due to the impact of death registration delays. Suicides in England are certified by a coroner following an inquest and then registered. In keeping with most other UK mortality statistics, suicide figures are presented based on deaths registered in a calendar year. Therefore UK suicide figures for deaths registered in 2013 will comprise deaths occurring in different time periods for different countries of the UK. However, as
suicide trends tend to change relatively slowly over time, this is unlikely to have a
great impact on the usability of UK suicide statistics.\textsuperscript{11}

**Burden of Suicide**

Years of life lost is a measure of premature mortality, estimating the length of time a
person would have lived had they not died prematurely. Years of life lost due to
mortality from suicide and injury of undetermined intent is an attempt to better
quantify the burden or impact suicide and injury of undetermined intent has on a
population.

Figure 1: Years of life lost due to mortality from suicide and injury of undetermined intent, 2015

*Figure 1* above shows that generally women are experiencing significantly lower
premature mortality from suicides and injury of undetermined intent than men. The
rate of years of life lost is increasing in Bromley year on year, particularly driven up by
loss of life in men.

When Bromley is compared to England and London, there is a mixed picture. The rate
of life lost is lower than England but not London. But significance of difference seen
cannot be defined statistically because of small numbers in Bromley deaths.

**Age-standardised rates**

In London, there were 516 deaths attributed to suicide and undetermined injury in
2013, which equates to a rate of 7.9 per 100,000 people (15+ years) which is lower
than the England rate (10.7 per 100,000) and national rate (11.9 per 100,000). In 2013
In Bromley, there was a rate of 7.5 per 100,000, population 15+, lower than the 2012 rate of 9.9 per 100,000 population aged 15+. The local data should be treated with caution as it is subject to random variation attributed to the small number of observed deaths.

In figure 2, the mortality rates have been aggregated over three years to increase the number of events to levels which are more statistically meaningful. Due to several changes including methodological reasons previously discussed this data is currently only available from 2008.

The mortality rates from suicide and undetermined injury in Bromley have been consistently lower than the London and England rates.

Figure 2: Three year average mortality rates: England, London and Bromley (2008-2013)

The 2010 target for Bromley was set at 6.3 per 100,000. Despite the fluctuations due to small numbers, Figure 3 shows that Bromley has not yet achieved the target but fluctuates around it. It is worth pointing out that the rates in figure 3 may not be comparable to rates previously published in Bromley Suicide Audit reports due to population denominator revisions discussed in the methodology section.
National Patterns by age and gender

The latest suicide prevention strategy for England [DH, 2012] reiterates the message that suicides are three times more common in males with middle-aged men continuing to be one of the high-risk groups. A report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, greater solo living) that have particularly impacted on the lives of this cohort of men who are now 35-59 years [Samaritans, 2012].

Men

- Men continue to be more than three times at greater risk of suicide than women. Most suicides are among men aged under 59. Men aged 35-49 are now the group with the highest suicide rate.
- Older men (over 75) also have higher rates of death by suicide and injury of undetermined intent, which may reflect the impact of depression, social isolation, bereavement or physical illness.

Figure 4 shows the age standardised mortality rate for males and females in England. The majority of suicides continue to occur in young adult males, that is, those under 50 years. In comparison to women of the same age, younger men are more likely to take their own lives. The peak difference is the 35-50 age group as there are four
male suicides to each female. The average ratio between men and women of all ages is almost three male suicides to each female. Once people pass 50 years of age, the ratio gradually reduces, to around 2.1 male suicides to each female suicide in the 80 and over age group.

Local Patterns by Age and Gender

In Bromley there are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women.

Figure 5 shows the age standardised mortality rate for males and females in Bromley compared to London and England. The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women although significantly lower than males seem to be reducing. The difference seen in Bromley and London or England in both genders is not statistically significant due to the wide confidence intervals in Bromley.
According to the HSCIC Indicator Portal, there were 19 deaths from suicides and injury of undetermined intent registered in 2013 in Bromley. However locally, we are only able to discuss 13 possible suicides and injury of undetermined intent in 2013, of which 7 were open verdicts (PCMD, 2014). The difference in observed numbers is possibly a result of:

a) deaths coded with narrative verdicts where narrative verdicts are not accessible on the PCMD or,

b) reporting deaths by date of occurrence as opposed to date of registration which means that some deaths which occurred in 2012 are being counted in 2013

However this difference does not affect trends and rates.

The majority of suicides in Bromley are aged 40 years and over and are mainly males. Although women are less likely to die from suicide and the numbers are small. In Bromley 2013, 89% of all people dying by suicide were men, of which the majority of deaths were in males aged 35-64.

**Ethnicity**

Data on ethnicity is limited; it is not fully available from death certificates or general practice records. Place or country of birth is being used as a proxy indicator for ethnicity, however it doesn’t take into account the relatively large number of people from Black and other minority ethnic groups who are born in the UK. This situation is
Now changing since the 2011 census where ethnicity is being recorded on all birth and death records. This will facilitate more effective monitoring in the future.

Less than half of the local deaths from suicides and undetermined injury in 2013 had a recorded ethnicity. Deaths where ethnicity was recorded were from the White and White British ethnic group. In addition, recorded place of birth on the Primary Care Mortality database shows that 85% of deaths were born in the UK.

The picture on ethnicity is more complex and needs further investigation. Bromley is predominantly white, coupled with incomplete recording of ethnicity. Comparing prevalence in the White population against the BME population would not unpick the underlying issues in BME communities. There may be a need for a deep dive investigation of the BME community to understand prevalence of suicide within these communities.

**Other information**

**Marital status**

There is evidence suggesting that marital status, especially divorce has a strong net effect on mortality from suicide particularly in men. Divorced and separated persons are over twice as likely to commit suicide as married persons\(^{14}\). Due to the small number of suicides and data incompleteness further analysis and interpretation of the distribution of suicides by marital status has not been possible. This highlights a need to have access to Coroner records to facilitate a better understanding of local patterns in Bromley.

**Occupation**

National Evidence has shown that there is an increased rate of suicide among the unemployed\(^ {15-16}\) and that certain occupation groups can have an elevated risk of suicide\(^ {17}\).

Local data shows that there were more deaths (69%) in people from routine and manual employment. This is the first time that the suicide audit has reported on suicide by occupation. It is hoped that over time trends can be identified within Bromley and lead to better targeted prevention approaches.

Recorded living status and employment were incomplete from the records on the Primary Care Mortality Database and a lack of access to coroner’s records has prevented further analysis.
Coroner Information

Method of suicide

National data in Figure 7 shows that suffocation is now by far the most common method used in suicide deaths. Suffocation accounts for more than half of all male suicide deaths and a considerable proportion of female deaths too.

Nationally, in women, drug-related poisoning was the second most common method, accounting for 38% of all female suicide deaths, closely following hanging and suffocation at 40% of all female deaths in 2013.

In Bromley, method of suicide was not recorded on the Primary Care Mortality Database in 30% of deaths. These deaths may have been the ‘open verdict’ deaths and therefore it was not possible to supplement this information with Coroner’s records. However for those deaths where a record was obtained, hanging or strangulation was the most common method used, followed by self-poisoning.

Registration delays

Deaths should be registered within 5 days of the death occurring. Deaths considered unexpected, accidental or suspicious will be referred to a coroner. Due to the nature of recording such sensitive deaths as suicides and open verdicts, there can be a significant delay in obtaining figures caused by delayed coroner’s inquests which exacerbate death registration delays.
In 2013 the average (median) registration delay for suicides in England was 168 days. Of the 4,722 suicides in England registered in 2013, 51% occurred before 2013. In England the average registration delay has gradually increased over time.

In Bromley all the suicide deaths presented in this report were registered in 2013, which was the year they occurred. The average (median) registration delay was 57 working days.

Although there are no significant differences in suicide rates when calculated based on date of death occurrence rather than date of death registration, it is recommended that successive suicide audit reports will be presented based on the latter. This will contribute significantly to local data alignment with national statistics.

**Place of suicide**

In 2013, 85% of suicides were recorded as having taken place in the person’s own home. Only a small proportion died in hospital and there were no deaths recorded outside of Bromley.

In general, suicides are more common in areas of high deprivation. However this general pattern is complicated by the easier access to means by people in professions such as doctors, nurses, vets, dentists and farmers. Analysis examining the association between suicide and area-based deprivation and social fragmentation has shown that suicide mortality is more strongly associated with social fragmentation than deprivation, whereas deaths from other causes were more closely related to deprivation\(^18\).

**Contributory factors**

The lack of access to coroner’s records has meant that it is not possible to report trends around social circumstances. However GP records show depression and mental ill health and substance misuse are the most common contributing factors recorded for these deaths.

**Contact with Primary Care**

The National Confidential inquiry into Suicide and Homicide by Mental Illness (NCISH) states that most people who die by suicide have seen their general practitioner (GP) in the previous 12 months before death. The NCISH notes that although this may provide an opportunity for prevention, identifying patients who are at particular risk is challenging\(^19\).
In Bromley, 54% of suicides had contact with primary care within 12 months prior to death. Of those accessing primary care within 12 months prior to death, the numbers were evenly distributed between physical health and mental health reasons for contact with their GP.

In Bromley, 38% of suicides had a diagnosis of mental ill health 12 months prior to death including depression.

Depressive illness accounts for the vast majority of mental illness in patients who commit suicide in Bromley. It is present in 80% of all mental illness diagnoses in 2013, seconded by mental ill health consequences of substance misuse.

Treatment for those diagnosed with mental illness included pharmacological medication, talking therapies and social interventions. However only half adhered to the treatment plan prescribed.

**Deliberate Self Harm**

Deliberate self-harm is a way of coping with life and most commonly starts in teenage years. There is a link between self-harm and completed suicide reported by the Samaritans (1998), one out of every 100 attempts will result in death within one year. Also known is that one of the most important risk factors for suicide is having a history of self-harm. The Samaritans (1998) state that the more a person self-harms the greater the risk that they will eventually die by suicide. Around half of all people who die by suicide have a history of self-harm and self-harm is a sign of serious emotional distress in its own right (HM Government 2014). Reducing and preventing self-harm is thought to have a preventive measure in reducing suicides. Identifying local trends can lead to targeted approaches. Bromley Public Health Department has carried out a clinical audit of self-harm in A and E and the recommendations from this report have been used to design new approaches in prevention.

National figures show Deliberate Self Harm (DSH) methods as including overdose, electrocution and wounding, although the most commonly used is self-poisoning, by both men and women. This picture is reflected in Bromley where self-poisoning continues to be the most common method of self-harm.

In 2000 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2013 this number had increased to 318. Analysis shows an upward trend in the
number of emergency admissions for deliberate self-harm in Bromley as shown in figure 8 below.

![Number of emergency admission trends for deliberate self-harm](image)

**Figure 7: Emergency Hospital admissions for Deliberate self-harm**

**Deliberate Self Harm in Bromley**

There is age and gender differences in hospital admissions for deliberate self-harm. Deliberate self-harm is more prevalent (70%) in women especially younger women as shown in figure 9. The 15 -19 year old age band have the highest number of hospital admission following self-harm, numbers remain high and throughout life up to the age of 54 for women.

Evidence\(^{21}\) suggests that;

a) older adults who self- harm are known to have high suicide rates.  
b) older adults presenting to hospital with self-harm are at higher risk for subsequent suicide, especially men
Self-harm hospital admissions by ethnicity

Most information about self-harm is based on data showing that proportions are greater in white populations. In Bromley, 84% of those who attended as emergency hospital admissions for self-harm were from a White background. 11% had no recorded ethnicity.

Although only 16% of the admissions for self-harm were in Black and minority ethnic groups as shown in figure 10, there is national evidence to suggest that this group especially women are less likely to receive psychiatric assessment and often present with self-harm.

Figure 9: Hospital admissions by ethnicity in Bromley, 2013

Source: NHS Bromley CCG-CSU, 2015
78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.

Figure 10: Percentage of emergency admissions for DSH by method: Bromley, 2013

Source: NHS Bromley CCG- CSU, 2015

Duration of spell in hospital

Age, severity of injury and underlying conditions are important contributors to length of stay in hospital. Most (78%) of the admissions in 2013 lasted between 0-1 days and only a small proportion (6%) lasted longer than 5 days.

Geographical distribution of self- harm

Deliberate Self-Harm acts seem to be concentrated around deprived areas within Bromley. However, since deliberate self-harm is also most concentrated in young people, these deprived wards also have higher numbers of young people.
It is interesting to see the pattern of people self-harming shown in map 1 above on the left is similar to the pattern of people in treatment for substance misuse known in Bromley (shown in the blue map).

Observing the patterns alongside each other (people in treatment and self-harm), raises the question whether there is a relationship between substance misuse and self-harm in Bromley in these areas. This needs further investigation.
Local Service Developments

There is a number of National and Local Strategies aimed at preventing suicides. The following describes developments of good practice and review as well as measuring progress against national targets.

Post-discharge policy

a) CPA information is faxed to the Initial Assessment and Duty Team of the appropriate Community Mental Health Team and to the GP surgery. Electronic Exchange of information has been developed through Oxleas Foundation Trust’s system and includes a facility for highlighting those patients at greatest risk who need to be followed up within seven days for people who have a current or recent history of severe mental illness, and/or a history of self-harm or have been detained under the Mental Health Act because of the risk of suicide.

There is an expectation that anyone who has been admitted to hospital following a self-harm attempt or who is considered a high risk to themselves is followed up within 48 hours of discharge. This is monitored by exception at Executive and Board level.

b) There is a structured action check-list developed within time frames.

c) There is a Home Treatment Team and a Crisis Service.

Out of Hours

a) There is a psychiatric liaison service which operates 24 hour access to treatment and assessment.

b) An out of hours service has also been developed for CAMHS for any child presenting to Accident and Emergency. There is an on call system so that CAMHS can give immediate advice or assessment within 24 Hours. This was set up in response to the number of under 18s presenting to A and E.

c) There is also an emergency duty team run by LBB and an Oxleas Home Treatment Team which is accessible up to 10pm.
Information Sharing

a) NHS 111 has developed joint protocols with Oxleas NHS Foundation Trust and refer direct to GPs, EmDoc or Home Treatment Service/crisis service for high risk patients.
b) Multi-agency Public Protection Panels- information sharing takes place between the police and other agencies. MAPPA usually deal with sex offenders and those who present extreme violence usually before legal action.
c) There is a Multi Professional and Multiagency high risk panel who meet on a regular basis to discuss those considered vulnerable or high risk to self or others.
d) The Bromley Central AMHP team undertakes Mental Health Assessments for those at highest risk.

Audit

A Trust wide Patient Safety Group has been set up by Oxleas NHS Foundation Trust. A trust-wide critical incident management group has also been set up. These groups assist in learning lessons and taking necessary action to reduce suicide.

To improve governance in the area of suicide prevention the Associate Director of Public Health, Quality Team from the CCG and the safeguarding team from Bromley Borough are now represented on the patients’ safety group or the Quality Improvement Group. Discussions have taken place in Clinical Quality meetings and new protocols have been put in place around adult safeguarding.

The Preventing suicide in Community Mental Health Audit 2013 carried out by Oxleas made the following recommendations.

- Community mental health teams to use the standard CPA letter template and review any adaptation of this to ensure it includes an assessment of risk/risk factors

- Ensure clinicians carrying out risk assessments include an assessment of physical health, medication, social circumstances, recent loss/separation, risk of accidents, family issues and condition related behaviours, insight and family history of suicide/suicide attempts and their potential to contribute to suicide risk. This information should be reflected in the risk assessment. Since the current form does not explicitly prompt for all of these factors, services may wish to consider/agree a where/how to document this consistently.
- Ensure clinicians are aware of current evidence of known suicide risk factors (static and dynamic)

- Ensure clinicians continue to review risk of suicide/self-harm with patients between CPA/medical reviews including dynamic which may affect risk

- Consider training (and/or experts within teams) to address assessment of suicide risk, risk factors and confidence to discuss suicide/self-harm sensitively with patients

- Ensure clinicians continue to keep risk assessments current and up to date and this should be closely aligned with CPA reviews.

- Maintain current good practice in CPA

- Directorates to consider action plans for their service areas and audit is underway following embedded change. The re-audit should incorporate changes to the risk assessment in addition to observation mentioned above. Results of the audit will be disseminated in the next iteration.

**Preventing suicide in prisons**

There is not a prison in Bromley Borough but risk assessments are carried out as part of the cell interviews prior to transfer to prison and as part of the work of the ‘Through Care Team’ of the Probation Service. Details of suicide prevention in prisons are presented in the Themed Report for the South London prisons of HMP Belmarsh and HMP Brixton. There is a Drug and Alcohol worker in CRI in Bromley who works with prisoners who were Bromley residents.

Oxleas NHS Trust has a court diversion service which covers the custody suite at the Police station and the Magistrates court. This service assesses self-harm risk and notifies the AMHP if a Mental Health Assessment is required.

**Risk assessment/management**

- There is a training programme by Bromley Mental Health Services on risk assessment together with the review of the risk assessment guidelines.

- Junior doctors in Accident and Emergency have training in management of deliberate self-harm as part of their orientation training.
• A Royal College of Psychiatry programme has been implemented using NICE guidance on managing Self-Harm a number of years ago. An audit of self-harm services and practices was completed at that time. This needs to be revisited in light of the changes in Management of the PRUH by Kings.

• The community teams manage risk using ‘zoning’ methodology. The Borough wide High Risk Panel will consider vulnerable and high risk individuals.

• A Psychiatric Liaison Team has been set up at the PRUH.

• See also out of hours section.

**Deliberate Self-Harm**

a) Follow-up from A&E / policy  
b) Investigation of serious incidents  
c) The new monitoring system in Public Health has recorded history of deliberate self-harm preceding suicide. The information collected from the Critical Event Sheet has enabled further investigation into each suicide and highlighted those who had a history of deliberate self-harm.

d) Implementation of NICE self-harm guidance through the Royal College of Psychiatry Programme has been completed. This now needs reviewing.

e) A detailed analysis of self-harm was carried out by Public Health in 2012 and 2014.

f) A number of initiatives involving the prevention of suicide in Children has been developed which includes a new Bromley Community Wellbeing Service for Children and Young People.

**Partnership Working**

• Representation and approach is multidisciplinary and multiagency.  
• Suicide audits discussed at MH Strategic Groups, MH Quality Improvement Groups, Oxleas Patient Safety Group and BCCG Adult safeguarding.  
• Discussion in Clinical Quality Groups

**Mental Health Promotion**

The Mental Health Promotion Strategy 2007-2010 has been implemented and was followed by the Bromley Mental Health and Wellbeing Strategy which includes mental
health promotion objectives. The present strategy is aimed at improving the mental and physical well-being of the people of Bromley. A number of initiatives such as the five ways to wellbeing were commissioned through Bromley Healthcare.

Mindfulness programmes have also been developed for Bromley schools and teachers. Bromley CCG has further developed the IAPT programme for Depression and Anxiety and there has been a suicide awareness course for teachers in Bromley secondary schools.

**Twelve Points to a Safer Service**

*(National confidential inquiry suicides and homicides)*

<table>
<thead>
<tr>
<th>No.</th>
<th>Target</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Staff training in the management of risk every 3 years</td>
<td>Bromley Mental Health Services has designed and implemented programme on suicide prevention and risk assessment.</td>
</tr>
<tr>
<td>2.</td>
<td>All patients with SMI and history of self-harm and violence to receive the most intensive level of care under the care programme approach</td>
<td>All patients with history of self-harm and violence on enhanced CPA. SMI registers developed in primary care.</td>
</tr>
<tr>
<td>3</td>
<td>Individual care plans to specify actions to be taken if patient is non-compliant or fails to attend</td>
<td>Part of CPA</td>
</tr>
<tr>
<td>4.</td>
<td>Prompt access to services for people in crisis and for their families</td>
<td>Assessment available through EmDoc or Green Parks House. Crisis and home treatment team. Samaritans telephone cover. Access to 24 hour assessment through Psychiatric Liaison Team set up in PRUH. LBB emergency duty and assessment team. New Community Wellbeing Service for Children and young people available</td>
</tr>
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<tr>
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</tr>
<tr>
<td>5.</td>
<td>The Assertive Outreach Team to prevent loss of contact with vulnerable and high risk patients.</td>
<td>24 hours for advice or assessment within 24 hours.</td>
</tr>
<tr>
<td>6.</td>
<td>Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with ‘typical’ drugs because of side effects.</td>
<td>Atypical medication is available for all patients with Severe Mental Illness who are non-compliant with typical drugs due to side effects. NICE guidelines implemented.</td>
</tr>
<tr>
<td>7.</td>
<td>Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service.</td>
<td>Substance misuse is assessed on admission to Green Parks House ACT Teams have 2 nurses trained in dual diagnosis. A dual diagnosis clinical care pathway has been developed and all substance misuse deaths are discussed at the Drug Death Review Panel. Bromley working for wellbeing have introduced some initiatives on suicide assessment and prevention.</td>
</tr>
<tr>
<td>8.</td>
<td>In-patient wards to remove or cover all likely ligature points. By March 2002 reduce to zero the number of suicides by mental health inpatients as a result of hanging from non-collapsible bed railings.</td>
<td>New hospital–collapsible equipment and ligature points covered. There were no deaths from this in Bromley. National Audit recently carried out on further possible ligature points.</td>
</tr>
<tr>
<td>9.</td>
<td>Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months.</td>
<td>Part of enhanced CPA for people with SMI or history of self-harm in previous 3 months</td>
</tr>
<tr>
<td>10.</td>
<td>Patients with a history of self-harm in</td>
<td>Medication limited to 2 weeks on</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>the last 3 months to receive supplies of medication covering no more than 2 weeks</td>
<td>discharge. There is an effective pharmacy system, which permits patients with a history of self-harm to receive supplies of medication on a daily basis if needed.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Local arrangements for information-sharing with criminal justice agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>System is in place in Trust for critical events analysis Routine information exchange between health, coroner and appropriate agencies. MAPPA panel. Court Diversion Team.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Policy ensuring post-incident multi-disciplinary case review and information to be given to families of involved patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follows suicides within secondary care. Not routine for suicides not known to secondary care. System established within Public Health to analyse mortality files and patient GP records. Assistant Director of Public Health reviews all RCA’s and serious incidents with BCCG. Information about self-help groups e.g. Papyrus, St. Christopher’s Candle Project for bereaved children, Bereavement Services in Bromley. Bibliotherapy Service. Bromley working for wellbeing service are signposting to self-help groups. IAPT programme implemented with additional capacity agreed for future years.</td>
<td></td>
</tr>
</tbody>
</table>
Summary of Developments in 2014/15

Changes in suicide rates reflect the mental health of the community and every action to improve mental health may contribute to suicide prevention. Over the last year the following areas have been developed or implemented:

- Suicide Prevention is embedded in the Bromley Mental Health Strategy 2012-2015.
- Notification of all deaths in Bromley Mental Health Services to Commissioning, Public Health and LBB. This has led to improved governance and improved assurance for safeguarding purposes. The suicide incidents are recorded on STEIS and all RCAs are reviewed by the assistant Director of Public Health.
- A Root Cause Analysis investigation for each death in Mental Health Services was carried out.
- Further development of the Bromley Working for Well-being service including substantial increase in funding for 2013/14, 2014/15 and 2015/16.
- Mind Computerised CBT courses and Coping with Life Programme established and extended with MIND.
- Mind Employment focussed work as part of IAPT programme.
- Community Mental Health teams manage risk using ‘zoning’ methodology.
- Further developed the Drug Related Death Panel with analysis of links with suicide.
- Mindfulness programme for children established by Bromley and Lewisham Mind.
- Suicide awareness training developed and provided for Secondary School Teachers in Bromley.
- The high risk panel takes referrals and discusses highly vulnerable individuals.
- There is a Court Diversion Team in custody Suites and the Magistrate’s Court.
- Clinical Audit of self-harm completed with recommendations on prevention. These prevention plans will now be implemented and with Leadership from Public Health.

Proposed Development Work for 2015/16

This suicide audit has highlighted areas of need and development for further prevention work. The following suggested developments are linked to National and Local Research, best evidence approaches and National Targets.

Strategy development

- Further development of prevention methods linked to National and Local Mental Health Strategies.
Data and intelligence

- Use the analysis from Oxleas’s investigation of all suicides across three boroughs to reduce suicides of patients known to or receiving services from Oxleas NHS Foundation Trust. In particular monitor the implementation of the recent suicide prevention audit carried out by Oxleas.
- Continue to develop the Bromley Suicide Database to look at long term trends and ‘Hot Spots’ longitudinally.
- Lobby Public Health England to regain access to coroner’s records.
- Bromley Community Wellbeing Service for Children and Young People will analyse all referrals in relation to self-harm.
- Continued development of Governance arrangements between Public Health, Safeguarding Team and Oxleas NHS Foundation Trust.
- Link the development of the Drug Death Related Death Panel to the Suicide Audit and vice versa and report both to Adult Safeguarding and Substance misuse Board.
- In 2015 report on the last ten years of local information to further identify trends.

Service development

- Develop child suicide prevention training for schools in Bromley.
- Further development of the Bromley Community Wellbeing Service for children and young people in relation to prevention of suicide and self-harm.
- Implement the Bromley Working for Wellbeing Service part of the National roll out of the Improving Access to Psychological Therapies programme.
- Commission and develop teachable moment concept with Alcohol brief intervention through Bromley Healthcare.
- Public Health has commissioned through London GLA a web based system to help Londoners deal with Mental Health issues.
- Promote the NHS endorsed digital mental health services Mental Health Apps library.
- A specialist perinatal Mental Health Service will be developed in 2015.
- Further develop the Over the Counter/Prescription medication service by Drug and Alcohol Services.
### Appendix

**Suicide related ICD10 codes**

**Table 1: ICD-10 codes used for identifying suicides and injury of undetermined intent**

<table>
<thead>
<tr>
<th>Suicide Verdict</th>
<th>Open Verdict</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicide</strong></td>
<td>X60-X84</td>
</tr>
<tr>
<td><strong>Poisoning</strong></td>
<td>X60-X69</td>
</tr>
<tr>
<td>Drug-related poisoning</td>
<td>X60-X64</td>
</tr>
<tr>
<td>‘Other’ poisoning</td>
<td>X65-X69</td>
</tr>
<tr>
<td><strong>Hanging, strangulation and suffocation</strong></td>
<td>X70</td>
</tr>
<tr>
<td><strong>Drowning</strong></td>
<td>X71</td>
</tr>
<tr>
<td><strong>Firearms and explosives</strong></td>
<td>X72-X75</td>
</tr>
<tr>
<td>Sharp objects</td>
<td>X78</td>
</tr>
<tr>
<td><strong>Jumping/falling from a high place</strong></td>
<td>X80</td>
</tr>
<tr>
<td><strong>Jumping/lying/falling before a moving object</strong></td>
<td>X81</td>
</tr>
<tr>
<td><strong>Crashing of a motor vehicle</strong></td>
<td>X82</td>
</tr>
<tr>
<td>Intentional self-harm by other specified means</td>
<td>X83</td>
</tr>
<tr>
<td>Intentional self-harm by unspecified means</td>
<td>X84</td>
</tr>
</tbody>
</table>
Suicide Audit Toolkit Metadata

<table>
<thead>
<tr>
<th>PERSONAL DETAILS</th>
<th>Drop down items (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Date of death</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Male, Female</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
</tr>
<tr>
<td>Forename</td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>GP Practice</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British, White Irish, Other White, White &amp; Black Caribbean, White &amp; Black Africa, White &amp; Black Asian, Any Other Mixed Background, Indian, Pakistani, Bangladeshi, Any Other Asian Background, Caribbean, African, Any Other Black Background, Chinese, Any Other Ethnicity, Not Known</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single, Married, Divorced, Widowed, Separated, Co-habiting, Unknown</td>
</tr>
<tr>
<td>Living situation</td>
<td>Alone, Spouse / Partner, Spouse / Partner &amp; Children &lt;18yrs, Spouse/Partner &amp; Children &gt;18 yrs, Child(ren) Under 18, Child(ren) Over 18, Parents, Other Family, Adults (non-family), Other (shared), Other (Specify), Unknown</td>
</tr>
<tr>
<td>If other - specify</td>
<td></td>
</tr>
<tr>
<td>Housing status at time of death</td>
<td>Council/Housing Assoc, Owner Occupier, Privately Renting, B&amp;B/Lodgings, Homeless/No Fixed Abode, NHS/SSD/Voluntary/Independent Care Provider, Supervised Hostel, Unsupervised Hostel, Prison or Young Offenders Institution, Other, Unknown</td>
</tr>
<tr>
<td>Occupation at time of death</td>
<td></td>
</tr>
<tr>
<td>Employment Status at time of death</td>
<td>Full time, Part time, Sheltered, Unemployed, Long Term Sick or disabled, Caring for home/family, Student (full time), Student (part time), Retired, Housewife/Husband, Unknown</td>
</tr>
<tr>
<td>History of being in prison or Young Offenders Institution at any time on the 12 month before death (including being a remand prisoner)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>History of being involved with the probation service at any time in the 12 months before death</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Field Name</td>
<td>Drop down items (if applicable)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Underlying cause of death</td>
<td></td>
</tr>
<tr>
<td>Was there a suicide note</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>What was the verdict?</td>
<td>Suicide, Open Verdict, Other Verdict</td>
</tr>
<tr>
<td>Incident Description</td>
<td></td>
</tr>
<tr>
<td>Has the person been reported missing?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>If yes, when was the last date they were last seen?</td>
<td></td>
</tr>
<tr>
<td>Place of death</td>
<td></td>
</tr>
<tr>
<td>Place of death postcode</td>
<td></td>
</tr>
<tr>
<td>Method of death</td>
<td>Self-poisoning, carbon monoxide poisoning, hanging/strangulation, drowning, firearms, cutting or stabbing, jumping from a height, jumping before a train, jumping before a road vehicle, suffocation, burning, electrocution, other (specify), not known</td>
</tr>
<tr>
<td>If other – specify</td>
<td></td>
</tr>
<tr>
<td>If self-poisoning, please indicate the substance used</td>
<td></td>
</tr>
<tr>
<td>Substance source</td>
<td>Not self-poisoning, prescribed for the subject, prescribed for someone else, a combination of substances prescribed for more than one person, not prescribed, not known</td>
</tr>
<tr>
<td>Was alcohol taken at the time of death?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Were other non-prescribed drugs taken at the time of death?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>In the opinion of the Coroner are there lessons to be learned from this case that might help prevent suicides in the future?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>If yes, please detail</td>
<td></td>
</tr>
<tr>
<td>Date of Inquest</td>
<td></td>
</tr>
<tr>
<td>Further details recorded by the Coroner</td>
<td></td>
</tr>
<tr>
<td>Field Name</td>
<td>Drop down items (if applicable)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GP Practice</td>
<td></td>
</tr>
<tr>
<td>Please list any other physically disabling or distressing conditions</td>
<td>(non-psychiatric) at the time of death</td>
</tr>
<tr>
<td>Date of last contact primary health care team</td>
<td></td>
</tr>
<tr>
<td>Reason for contact</td>
<td>Mental health, physical health, both</td>
</tr>
<tr>
<td>Please give more details</td>
<td></td>
</tr>
<tr>
<td>Number of consultations with the GP for mental health problems during the</td>
<td></td>
</tr>
<tr>
<td>previous 12 months</td>
<td></td>
</tr>
<tr>
<td>Was there a diagnosis of a Mental Illness 12 months prior to the death?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Please list any current and/or ongoing psychological conditions (max 3)</td>
<td></td>
</tr>
<tr>
<td>Mental state assessment date</td>
<td></td>
</tr>
<tr>
<td>Type of Mental State Assessment carried out</td>
<td>No mental state assessment documented, Some level of mental health assessment documented, Assessment tool (e.g. Beck’s depression inventor), Some level of mental health assessment documented, Other form of mental state assessment, Not known</td>
</tr>
<tr>
<td>Documentation of suicide risk</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Please list any treatments taken up in the last 12 months (max 4 including</td>
<td></td>
</tr>
<tr>
<td>other)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Did the patient adhere to their medication/treatment plan?</td>
<td>Yes, No, Partially, Not Known</td>
</tr>
<tr>
<td>Please list all medications prescribed irrespective of purpose (max 6)</td>
<td></td>
</tr>
<tr>
<td>History of self harm?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Number of known previous suicide attempts</td>
<td></td>
</tr>
<tr>
<td>Other agencies involved in the 12 months prior to death</td>
<td>Substance misuse services, Alcohol services, Probation service/Youth justice, Social services, Voluntary sector services, Accommodation services, Occupational health, Faith community, Employment service, Other, Not known</td>
</tr>
<tr>
<td>Date of last contact with specialist mental health services (excluding any</td>
<td></td>
</tr>
<tr>
<td>primary care e.g. practice based counsellors)</td>
<td></td>
</tr>
<tr>
<td>Nature of last contact</td>
<td>No contact, Assessment but not taken on caseload, Discharge from inpatient care, Discharge from caseload, Contact while on caseload, Not known</td>
</tr>
<tr>
<td>Has this case led to a practice based Significant Event Audit (SEA)?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Has the Primary Care Trust been informed of any practice-based learning</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>from the Significant Event Audit?</td>
<td></td>
</tr>
</tbody>
</table>
Did the significant event audit involve consideration of any secondary health care service involvement?

Yes, No, Unknown

In the opinion of the primary care team are there lessons to be learned from this case that might help prevent suicides in the future?

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**PSYCHIATRIC HISTORY**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Drop down items (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Psychiatric Status</td>
<td>No known previous contact with mental health service, One or more previous contacts with mental health services (Community only services) within a psychiatric specialty but not subject to CPA, One or more previous contacts involving a consultant episode (community only services) within a psychiatric specialty and subject to CPA, One or more previous contacts involving a consultant episode (hospital in-patient services) within a psychiatric specialty, Not known</td>
</tr>
<tr>
<td>Additional comments associated with psychiatric services contact</td>
<td></td>
</tr>
<tr>
<td>Date of last psychiatric contact</td>
<td></td>
</tr>
<tr>
<td>Nature of last contact</td>
<td>No contact, Assessment but not taken on caseload, Discharge from inpatient care, Discharge from caseload, Contact while on caseload, Follow-up post discharge, Not known</td>
</tr>
<tr>
<td>Number of admissions to psychiatric inpatient ward in the past 5 years (including any admission at time of death)</td>
<td></td>
</tr>
<tr>
<td>If applicable, admission date</td>
<td></td>
</tr>
<tr>
<td>If applicable, discharge date</td>
<td></td>
</tr>
<tr>
<td>Had there been face to face contact with the patient by a Mental Health Provider within 7 days of discharge from inpatient care?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Psychiatric Learning Disability Diagnosis</td>
<td>Schizophrenia and other delusional disorder, Bipolar affective disorder, Depressive illness, Anxiety/Phobia/Panic Disorder/OCD, Eating disorder, Dementia, Alcohol dependence, Drug dependence, Personality disorder, Adjustment disorder/reaction, Learning disability, No mental disorder, Other, Not known</td>
</tr>
<tr>
<td>History of violence (i.e. serious threat or assault causing significant physical harm, including sexual assault)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>History of alcohol misuse</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>History of drug misuse</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>In the opinion of the Mental Health Trust are there lessons to be learned that might prevent suicides in the future?</td>
<td></td>
</tr>
<tr>
<td>Field Name</td>
<td>Drop down items (if applicable)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Number of times patient seen in A&amp;E / hospital in 12 months prior to suicide</td>
<td></td>
</tr>
<tr>
<td>Date of admission #1</td>
<td></td>
</tr>
<tr>
<td>Date of discharge #1</td>
<td></td>
</tr>
<tr>
<td>Reason for attendance #1</td>
<td></td>
</tr>
<tr>
<td>Date of admission #2</td>
<td></td>
</tr>
<tr>
<td>Date of discharge #2</td>
<td></td>
</tr>
<tr>
<td>Reason for attendance #2</td>
<td></td>
</tr>
<tr>
<td>Was a psychosocial assessment carried out prior to discharge?</td>
<td>Yes, No, Unknown</td>
</tr>
</tbody>
</table>
References


4. Saving Lives: Our Healthier Nation, Department of Health, 1999

5. No health without mental health: A cross-government mental health outcomes strategy for people of all ages, Department of Health, 2011

6. The National Confidential Inquiry into Suicide and Homicide by people with mental illness; Annual Report for England, Wales, Scotland and Northern Ireland, University of Manchester, July 2012


10. HSCIC Indicator Portal: The Health and Social Care Information Centre Indicator Portal. NHS Information Centre


Whitley M, Gunnell D, Dorling D and Davey Smith G *Ecological study of social fragmentation, poverty and suicide* British Medical Journal 319 (1999), 1034-1037


Samaritans [www.samaritans.org](http://www.samaritans.org)

Murphy, E et al. Multicentre cohort study of older adults who have harmed themselves: risk factors for repetition and suicide. British Journal of Psychiatry, 2012;200: 399-404