Wirral Suicide & Open Verdict Audit 2018-20

Wirral Intelligence Service

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Wirral Suicide & Open Verdict Audit 2018-20

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Key Findings

- There were 78 cases included in this 2018-20 audit; 63 of which were assigned as suicide verdicts (81%); the remaining 15 cases (19%) were assigned other verdicts (e.g., open, narrative, misadventure)
- Wirral had a broadly similar suicide rate to England overall (10.5 per 100,000 in Wirral compared to 10.4 per 100,000 in England) in 2018-20 (according to ONS data, which includes only those cases classified as suicide)
- Suicide notes were present in 31 in 78 of Wirral cases (40%)
- Men were over-represented in this audit; 78% of cases were male and 22% were female. This is consistent with the national male/female ratio (75/25)
- Average age at the time of death was 47 years; the peak 10 year age band was 40-49
- The proportion of Wirral suicide cases who were BAME was lower compared to the proportion of Wirral's population who are BAME; 1% compared to 5% respectively. Numbers are too small to draw any firm conclusions however, as there were 10% of cases with no recorded ethnicity, despite recent improvements in recording
- The most common cause of death among cases included in this audit was hanging (59%); historically, this has been the most common method used (both locally and nationally)
- The most common living situation was to be living alone (45%) and in terms of marital status, to be single (44%)
- Sexuality is still poorly recorded, despite LGBT young people having a significantly higher risk of suicide (and self-harm); 76% of Wirral cases had made no mention of sexuality
- Employment status was poorly recorded, particularly among females. Where employment status *was* recorded, being unemployed due to being long term sick or disabled and/or being unemployed for any reason was the most likely situation of cases in Wirral
- June appeared to be the peak months for suicide in Wirral during this 3 year period. Locally, December did not appear to mark a particular peak in cases in 2018-20
- Over half of cases were recorded as being known to mental health services (54%); around 1 in 10 (or 9%) were recorded as having ever been detained under the Mental Health Act
- Current or historical issues with drugs and/or alcohol were not always definitively recorded, with 42% of cases having no mention of whether drug use had ever been an issue and 47% of cases with no mention of whether alcohol use was, or had ever been problematic
- Where drug or alcohol misuse was mentioned, 36% of cases (just over 1 in 3) had had previous or current drug misuse issues; 28% had (or had previously had) alcohol issues
- Females were more likely to have previously attempted suicide than males (59% versus 38% of males), and have recorded instances of self-harm than males (59% versus 43% of males)
- Physical health issues (49%), relationship issues (35%) and bereavement (22%) were the most commonly recorded antecedents in Wirral suicides between 2018-20 (this was consistent with previous audits)
- Mental health medications were the most commonly found prescribed drug at post-mortem (45% of cases); Sertraline being the most commonly detected prescribed drug
- Alcohol was detected in 1 in 3 cases (33%) of cases at post-mortem
- The most commonly found illicit substance at post-mortem was cocaine (19% or 1 in 5 cases)

Introduction

Suicide cases for single calendar years have decreased in recent years making it difficult to establish any conclusions about trends. It has therefore been decided for the Wirral Suicide & Open Verdict Audit to include data from three pooled years (in the case of this audit 2018, 2019 and 2020). The date of death may not necessarily have been during those years however, as some cases take time for an official verdict to be reached (due to the need to collect sometimes complex evidence relating to cases).

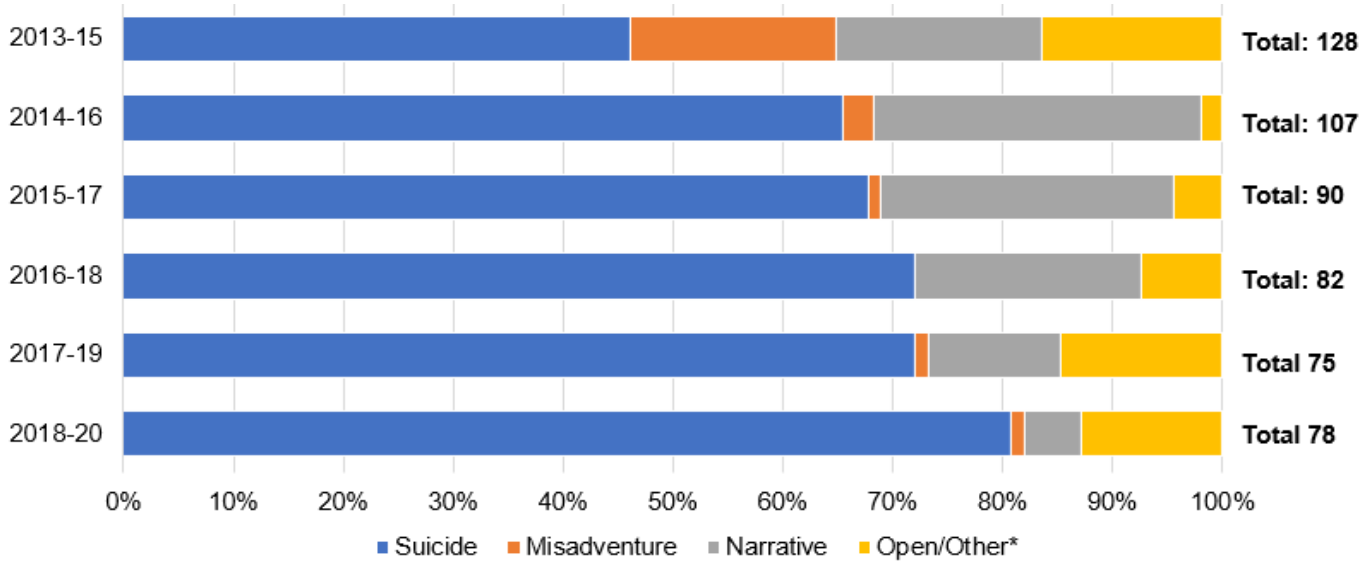
Office for National Statistics (ONS) suicide figures are also presented for the year that deaths are registered (e.g. around half of the suicides in England registered in one year will actually occur in the year before), but use the ICD-10[1] cause of death codes rather than the coroners verdict (used in this audit). This discrepancy can explain differences between the figures that are presented in this audit for Wirral and the national figures produced by ONS for Wirral - along with the fact that this audit also includes cases of potential or possible suicide, see next section.

Wirral uses the standardised Cheshire and Merseyside Suicide Audit Template when collecting the data for this audit (see Appendix One/Figure 13 for Audit Template). This regular audit is used to inform and shape the multi-agency response to suicide in Wirral.

Verdicts

Unlike ONS suicide statistics, which are restricted to cases assigned as suicide, this audit considers cases of *potential* or *possible* suicide where there appears to have been intent on behalf of the deceased person to end their life. Since 2018, Coroners assign suicide verdicts in cases where suicidal intention is a 'reasonable probability'. Sometimes however, cases that may appear to be apparent suicide, other verdicts may still be assigned if the Coroner cannot be certain that suicide was the deceased person's intention. Therefore, other verdicts such as open, misadventure, accidental death, drug related death and narrative (see Appendix Two for more details on verdicts) are sometimes included in this audit, particularly so prior to 2018.

Figure 1: Proportion of cases included in the Wirral Suicide audits by assigned verdicts and total number of cases included (right of chart), 2013-15 to 2018-20



Source: Merseyside Coroner records (data collected specifically for this audit)
***Note:** "Other" can include Accidental and Drug Related Death (e.g. individuals used self-poisoning as the method)

There was a significant change in categorisation after 2013**.** For example, in 2013-15, just under half (46%) of cases were classified as suicide, compared to 16% Open or other verdicts and 19% Misadventure. In 2018-20, however, 81% of cases were assigned as suicide and just 1% as Misadventure and 13% as Open or other verdicts **(Figure 1)**.

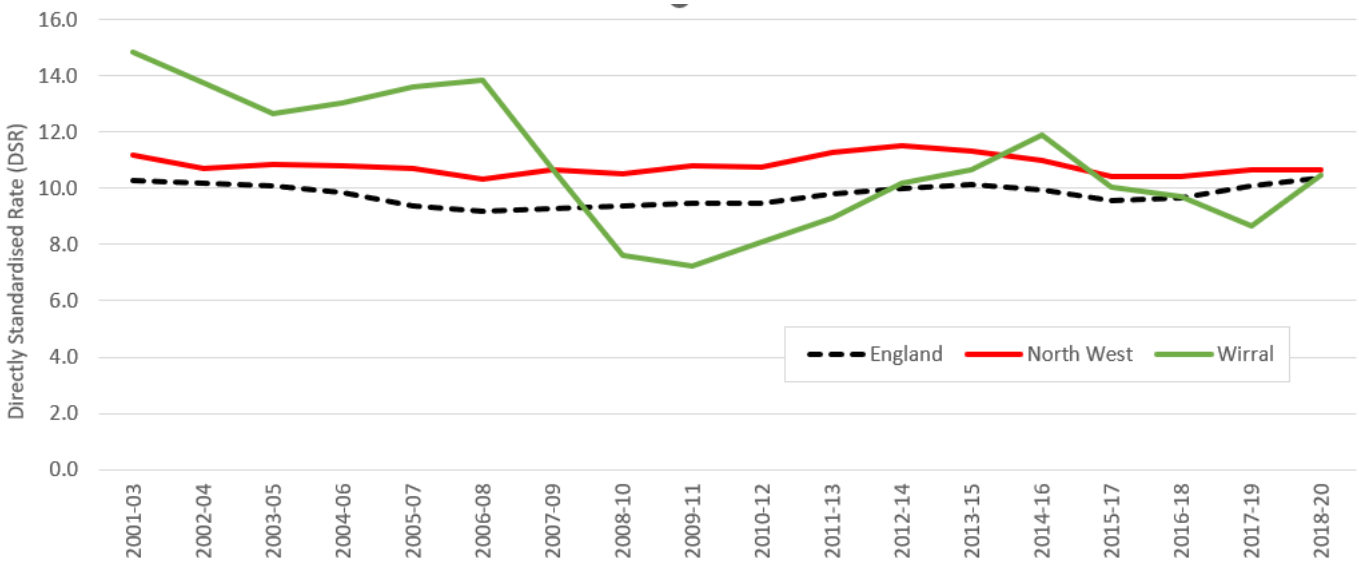
Possible contributory factors to this change may be improvements and standardisation in the recording of information enabling a more concise verdict to be reached; the change in jurisdiction (to the Liverpool Coroner); and/or less stigmatising attitudes towards mental health and suicide.

Trend in suicide rates

Figure 2 shows the 20-year trend in suicide rates locally, regionally and nationally using ONS data. It should be noted that the information in Figure 2 is NOT based on numbers collected in this audit. It is based on national data that are restricted to ICD-10 coded causes of death.

It shows that suicide rates in Wirral have fluctuated more than England and the North-West, which is typical of smaller datasets. Nationally and regionally, the trend in suicide appears broadly stable, with a very slight increase in the England and North-West rates over the last 3 time periods. In the most recent time period (2018-20), Wirral (10.5 per 100,000) showed a steeper rise and current rates are very similar to England (10.4 per 100,000) and the North-West (10.7 per 100,000).

Figure 2: Trend in suicide rate in England and Wirral, 2001-03 to 2018-20



Source: Public Health Outcomes Framework, OHID (2022)
Note: This chart uses national data and is restricted to ICD-10 coded cause of death only. More information can be found here: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

Gender

Gender is an important factor in suicide, with national and international data indicating that men are significantly more likely than women to take their own life and this has also been the case locally since recording began[2].

Despite men being more likely than women to take their own life, the recent UK Adult Psychiatric Morbidity Survey reported that women were more likely to make an attempt (5.4% of men,

compared with 8.0% of women[3]). For more information about suicide attempts please see the 'History of mental health issues' section here.

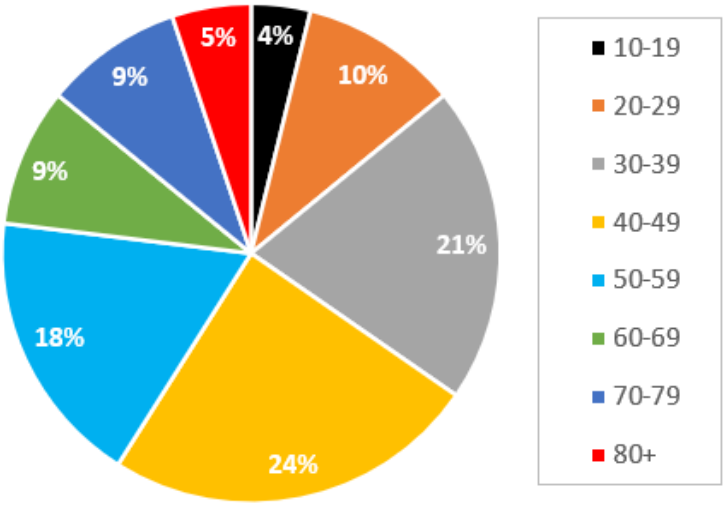
Nationally, suicide cases were 75% males and 25% female in 2020 and, in previous years, Wirral has shown a very similar trend. For 2018-20, the proportion of suicides in Wirral were split 78% male whilst 22% were female – so very similar to the national ratio.

Age

Another important factor in suicide is age. Nationally, people aged between 45-64 years were most likely to take their own life (38% of all suicide cases)[4]. In Wirral in 2018-20, those aged 45-64 comprised 34% of all suicide cases. The largest percentage of cases were in 25-44 age band, which comprised 40% of all suicide cases in Wirral.

The analysis in **Figure 3** below shows the age of Wirral cases split by smaller (10 year) age bands for additional insight and shows that the largest proportion of suicide cases occurring in those aged 40-49 (24% or almost 1 in 4). Both males and females saw the highest number of suicide cases within the 40-49 age group. The average age of suicide cases in this audit was 47 years overall.

Figure 3: Age breakdown of Wirral cases (2018-20)



Source: Merseyside Coroner records (data collected specifically for this audit)

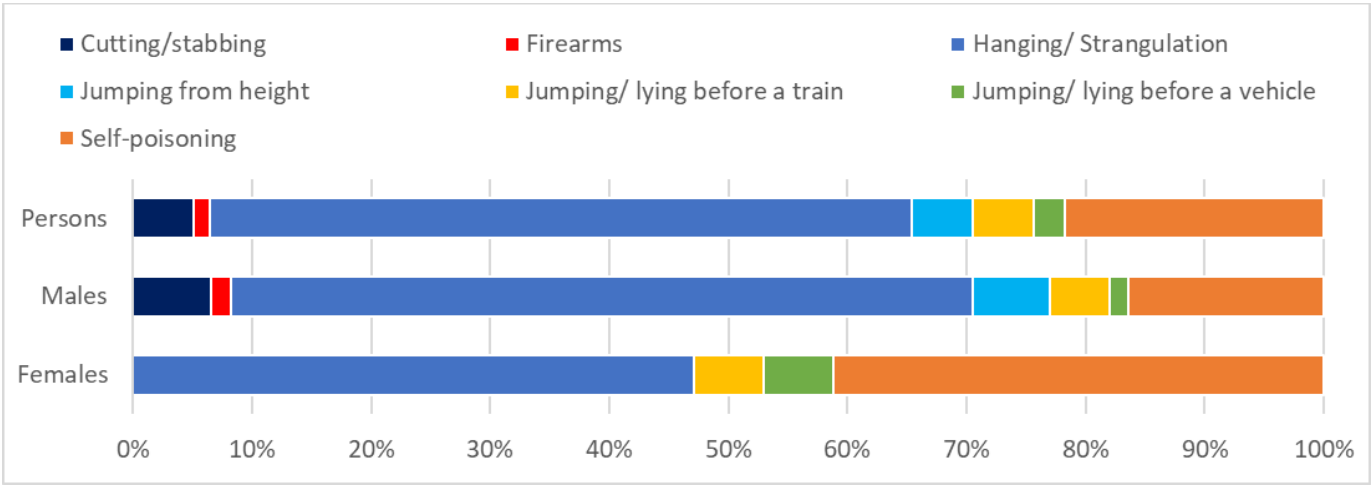
There were 6 suicide cases included in this audit among people aged 0-24. All were male. In addition, in those aged 65+, the overwhelming majority were also male (over 90%).

Method

The most common suicide method for both males and females in Wirral between 2018-20 was hanging/strangulation (59% of all cases). Self-poisoning was the second most common method for both genders and this was true both nationally and in Wirral.

Males in Wirral appear to have used a greater variety of methods than females over the time period shown (true in previous time periods also), although this may just be a function of a greater number of male suicides overall, see **Figure 4**.

Figure 4: Proportion of suicides in Wirral, by method and gender, 2018-20



Source: Merseyside Coroner records (data collected specifically for this audit)
Note: ONS use a different categorisation of suicide methods compared to the Cheshire and Merseyside Suicide Audit Template. ONS only use 5 broad categories: 'drowning', 'fall and fracture', 'poisoning', 'hanging, suffocation and strangulation' and 'other' whereas the Cheshire and Merseyside Suicide Audit Template contains a greater number of methods (see Appendix One/Figure 13 for Audit Template).

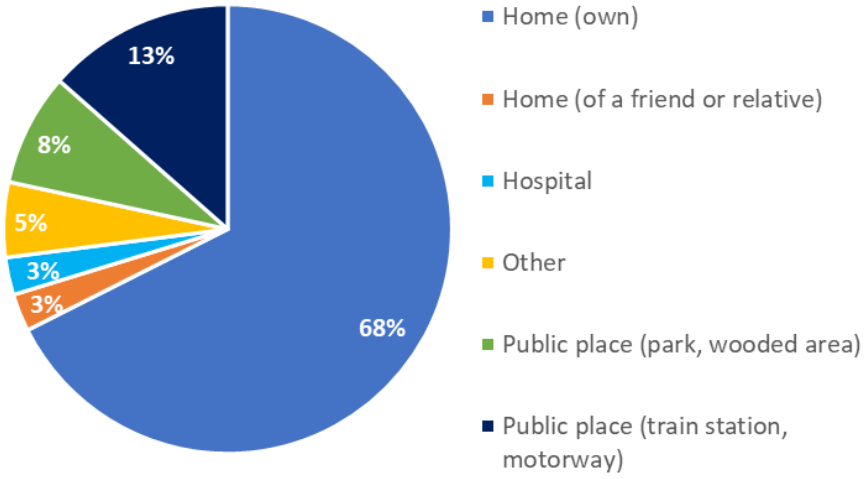
Ethnicity

Wirral is estimated to have a Black, Asian and Minority Ethnic (BAME) population of 5.5%[7], so 1% of suicide cases in BAME groups in 2018-20 is less than might be expected although overall figures are too small to draw firm conclusions. There were also 10% of cases where ethnicity was unrecorded, so this also hinders drawing any conclusions. The ethnicity of the BAME cases has not been published for confidentiality reasons. It is not possible to compare Wirral data to a national picture, as ethnicity is not reported on national death registrations.

Location of event

As **Figure 5** shows, the most likely place people took their own life was in their own home; just over 2 in 3 cases took place in the persons own home between 2018-20. This is a consistent trend over many years in Wirral[8]. Places such as wooded public places and railway stations/ motorways make up some of the remaining locations. "Other" may include locations such as being abroad, in a hotel or where the records have not been clear about the specific location.

Figure 5: Location of death of Wirral Suicide cases in 2018-20



Source: Merseyside Coroner records (data collected specifically for this audit)
Note: Cases with 'hospital' as their place of death are generally those who have been conveyed from a place they were discovered, but who were unable to be resuscitated in hospital for example

Place of birth

Place of birth may be a relevant factor for suicide because it can affect social support and mental health in general. People who are living far from their place of birth, may be more likely to lack a network of friends and family to whom they can turn in times of need. This is not just true for those born outside of the UK, but also of people born in other parts of the UK who are living far from friends and relatives.

Over half (59%) cases had Wirral as their place of birth. A further 15% of cases had the Cheshire or Merseyside area as their place of birth, meaning that around 1 in 4 (where a place of birth was recorded), were living some distance from where they were born. See **Table 1**.

Table 1: Place of birth of Wirral suicide cases in 2018-20, number and proportion

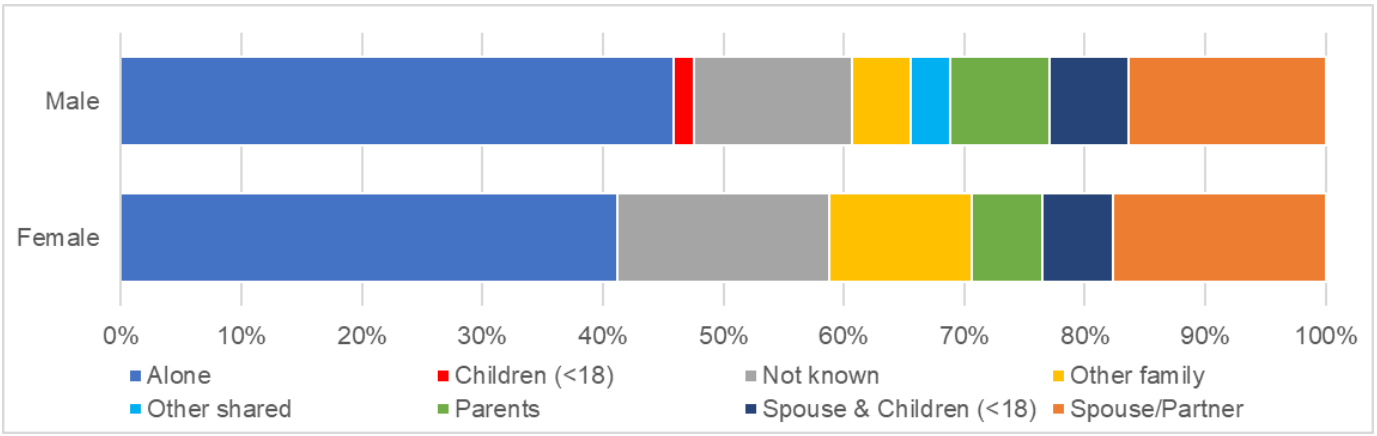
Place of birth	Number	%
Wirral	46	59.0
Cheshire & Merseyside (excl. Wirral)	12	15.4
Rest of UK	9	11.5
Europe	<5	<5%
Rest of world	<5	<5%
Unknown	7	9.0
Total	**78**	**100.0**

Living Arrangements

Figure 6 appears to show that living alone was the most common living arrangement for both males and females included in this audit (45% overall); this is a long standing trend in Wirral.

Both males and females were then next likely to live with a spouse/partner. Males appear more likely than females to live with their parents or in shared accommodation; females appear more likely than males to live with other members of their family.

Figure 6: Living arrangements of Wirral suicide cases in 2018-20, by gender (proportions)



Source: Merseyside Coroner records (data collected specifically for this audit)
Note: Cases are classed as unknown when the individuals' living situation is not directly mentioned in the Coroner's report

Marital Status

Marital status is evidenced as being related to the risk of suicide with marriage appearing to have a protective effect on individuals compared to separated/divorced people[9]. **Table 2** shows the breakdown of suicide and related verdicts by both gender and marital status at the time of death, plus a comparison with the marital status of the overall population of Wirral.

Table 2: Marital status of Wirral cases of suicide and related verdicts in 2018-20, by gender

Marital Status	Male	Female	Persons	Persons in Wirral overall
Married/Civil Partnership	20%	24%	21%	45%
Not known	<5%	<5%	<5%	N/A
Separated/divorced	26%	29%	27%	13%
Single	44%	41%	44%	34%
Widowed	<5%	6%	5%	8%
Total	**100%**	**100%**	**100%**	**100%**

Source: Merseyside Coroner records (data collected specifically for this audit) and NOMIS for Census, 2011 data (for marital status of the general population of Wirral)
Note: Figures may not sum due to rounding

Males and females who were single accounted for the largest proportion of suicide and related verdicts in Wirral between 2018-20 (44%). The next most common status was to be Separated or divorced, again this was true of both males and females (27% of cases overall). National data show that women who were divorced had higher suicide mortality rates than married women[9].

Table 2 also shows a comparison with the marital status of the general population of Wirral (aged 16+) according to the last Census in 2011. Although this is some time ago and the next Census is due in 2022, it is still the most reliable indicator of marital status available. It shows that there are some considerable differences between the Wirral population overall and those those included in this audit in terms of marital status.

For example, those included in this audit were more likely to be single (44% of suicide audit cases vs 34% of the Wirral population), less likely to be married or in a civil partnership (21% of audit cases vs 45% of the Wirral population) and more than twice as likely to be divorced or separated (27% of audit cases vs 13% of Wirral population).

Sexuality

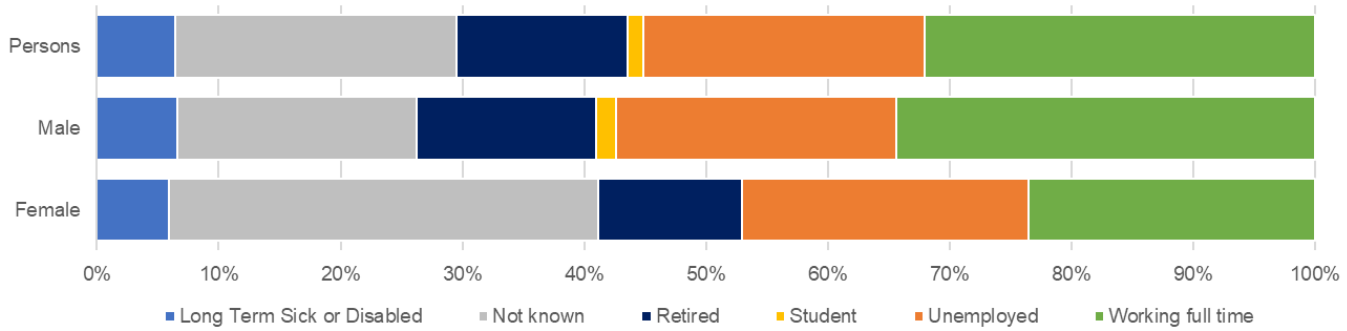
Data recording around sexuality is poor. It is only through anecdotal reports from family and/or friends that sexual preference is identified. Detailed results have therefore been omitted from this audit based on limited recording and poor data (although this indicator is included on the regional Suicide Audit data collection template - (see Appendix One/Figure 13 for Audit Template); 76% of Wirral cases had no mention of sexuality.

This issue could perhaps be raised at various local and regional suicide forums. The RaRE Research Report (2015) has, however, estimated that young Lesbian, Gay, Bisexual & Trans (LGBT) people (those aged <26 years) are almost twice as likely to have attempted suicide at least once, compared to their heterosexual counterparts (34% versus 18%)[10].

Employment Status

Employment status is a well-evidenced risk factor for suicide, with unemployment and lower skilled roles usually associated with a higher risk of suicide[11]. The highest rates of suicide tend to be among workers with the lowest skilled jobs (for example, cleaners, low-skilled labourers), whereas the lowest rates of suicide were seen amongst those working in highly skilled occupations (for example, managers, chief executives, senior officials)[11]. It is important to note that it is not the actual occupation that puts individuals at risk, but features of that occupation such as low pay, job insecurity, lack of control over working environment and the wider socio-economic characteristics of individuals employed in a particular sector[12]. See **Figure 7**.

Figure 7: Suicide and related verdict cases in Wirral, 2018-20, by employment status and gender



Source: Merseyside Coroner records (data collected specifically for this audit)
Note: Student FT refers to individuals who were full time students. Student PT refers to individuals who were part time students

The findings of an international study looking at World Health Organisation (WHO) data from 63 countries found unemployment elevated suicide risk[12]. The proportion of the working age population of Wirral who are not in work (for any reason, including being long term sick or disabled according to Local Insight) was 17% in 2022.

If those who were unemployed (23% of all audit cases) and those not working due to being long term sick of disabled (also 23% of audit cases) are considered together, this means that 46% of cases were not in work. This emphasises that proportionately, the risk of suicide is much higher for those who are unemployed, including those who are unemployed due to being long term sick or disabled.

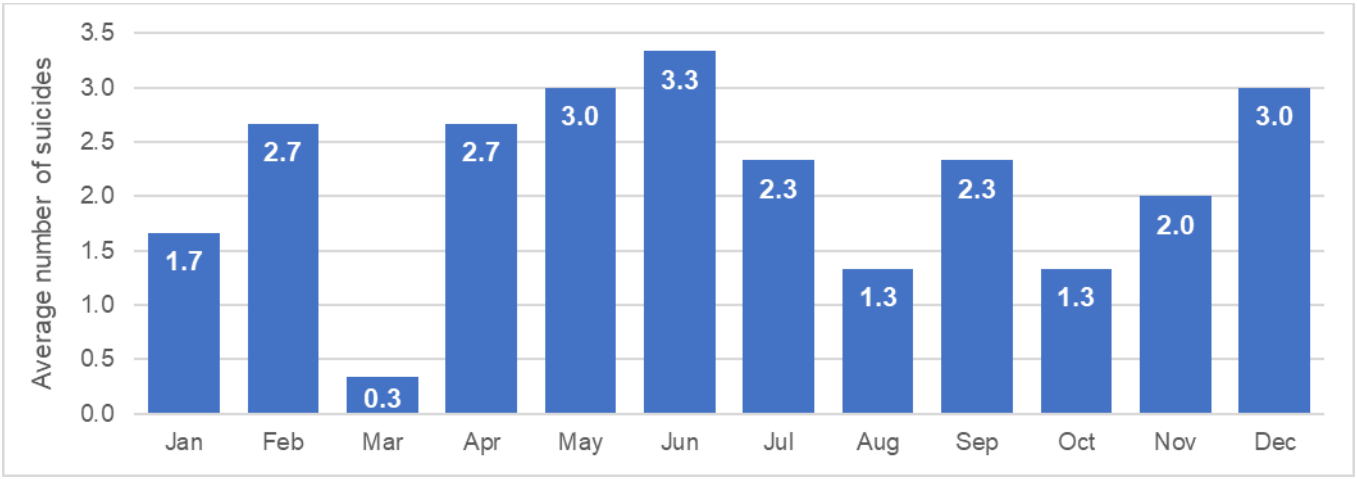
Among females, the most common option was for employment status to be unrecorded (35%), this was higher rate of non-recording than is the case for males; reasons for this are unclear.

Seasonality / time of year

Figure 8 shows that March, August and October had the lowest average number of suicide cases between 2018-20. Contrary to popular expectation, December did not mark a notable peak in suicides during the years covered by this audit (and this has also been true in previous years audits), although it was one of the higher months along with May and June (which had the highest average of all).

Reasons for this are unclear and cannot be compared to national figures as suicide cases are not presented by month nationally. **See Figure 8**.

Figure 8: Average number of Wirral suicide audit cases, by month of occurrence, 2018-20



Source: Merseyside Coroner records (data collected specifically for this audit). Date relates to when the death occurred, not when case was examined by the Coroner (which can occasionally be some time later)

History of alcohol misuse

Figure 9: Proportion of suicides in which alcohol misuse was recorded, Wirral, 2018-20

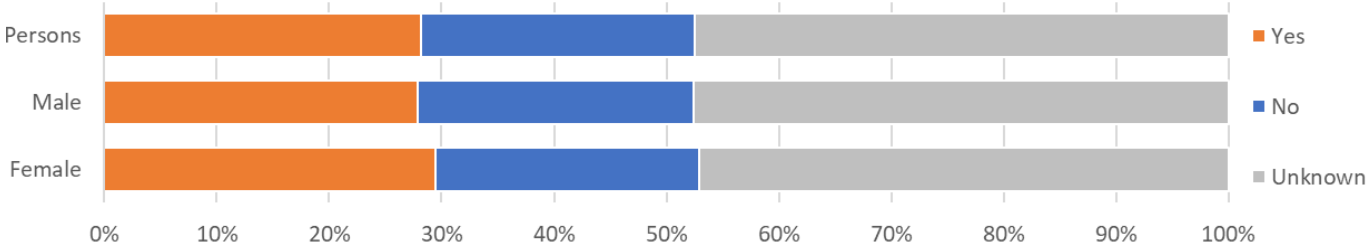


Figure 9 shows that similarly to drug misuse, there appears to be around 1 in 3 cases included in this audit who have a noted history of alcohol misuse and there was little difference between males and females. As with all the issues noted in the Coroners records, reporting relies on accurate and/or up to date medical records, and/or relatives disclosing a full and frank history to the coroner. It is possible therefore, that the figures above for confirmed issues with drugs or alcohol may understate both issues. In a third of cases (25 of 78 cases or 32%), individuals were noted as having alcohol present at the time of the post-mortem (detected from either blood or stomach contents).

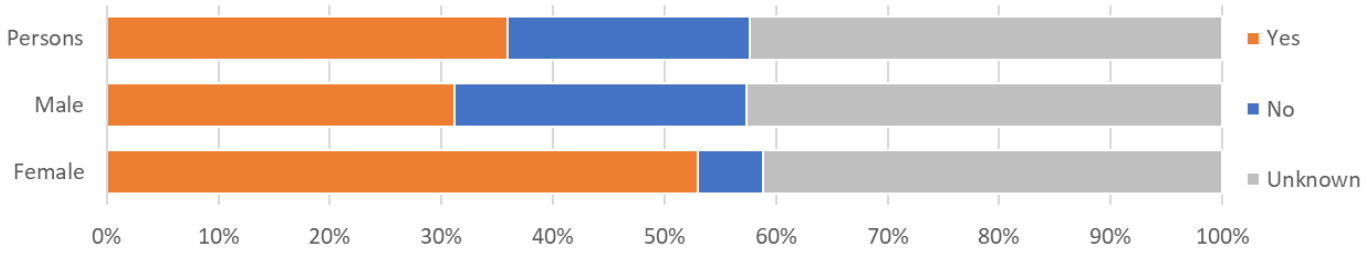
History of drug misuse

Drug misuse is a risk factor for suicide[14] and, as such, is recorded on the local suicide data collection template (see Appendix One/Figure 13 for Audit Template). **Figure 10** and **Figure 11** show the proportion of Wirral cases, by gender, where either drug or alcohol misuse was recorded in the case records as being a current or historic issue for the person.

As **Figure 10** shows, just over 1 in 3 cases included in this audit, had either a history or were currently noted as having drug misuse issues. It should be noted however, that there are a large proportion of unknowns (around 40% of cases), so this may be an under-representation of the true picture. There appeared in this audit, to be a higher likelihood of females having a history of substance misuse compared to males, but this is against a backdrop of a much smaller number

of overall suicide cases in females (small numbers can often result in large percentage differences).

Figure 10: Proportion of suicides in which drug misuse issues were recorded, by gender, Wirral, 2018-20



The most common illicit or non-prescribed drugs detected at post-mortem were cocaine (19% or almost 1 in 5 cases) and cannabinoids (16% of cases). Other illicit drugs mentioned in case notes were MDMA, amphetamines and butane (gas).

Prescribed medications

In 35 of 78 cases (or 45%), individuals had active prescriptions for mental health medications. Of these, Sertraline was the most commonly prescribed medication. This figure may be lower than might be expected, given that over half of all cases were recorded as being known to mental health services.

Other drugs (prescribed and/or non-illicit) listed as a cause or contributory factor in death (due to being above therapeutic levels) included methadone, dihydrocodeine, venlafaxine, paracetamol and tramadol.

History of mental health issues

As has been the case in previous Wirral audits**,** a large proportion of suicides were either currently or previously known to mental health services – around half of both males and females (54% and 53% respectively), shown in **Figure 11**.

As **Figure 11** also shows, just under one in ten (9%) of both females and males (12% and 8% respectively) had previously been detained under the Mental Health Act. It also shows that in Wirral between 2018-20, self-harm and previous suicide attempts were more prevalent in females than males. Self-harm is more common among young people than other age groups, particularly young women.

In England, the proportion of young women who said they had self-harmed increased by 13% between 2000 and 2014[15].

Certain learning disabilities (such as Autistic Spectrum Disorders) are linked to a higher risk of suicide[16]. Between 2016 and 2018, just 2% of all cases had a record as having a learning difficulty. In these cases, the coroner report noted that the learning difficulties had increased the vulnerability of the deceased.

Figure 11: Proportion of individuals with a history of mental health issues, 2018-20, by sex

Source: Merseyside Coroner records (data collected specifically for this audit)
Notes: 'Known to MH services' is every having a recorded instance of contact with mental health services

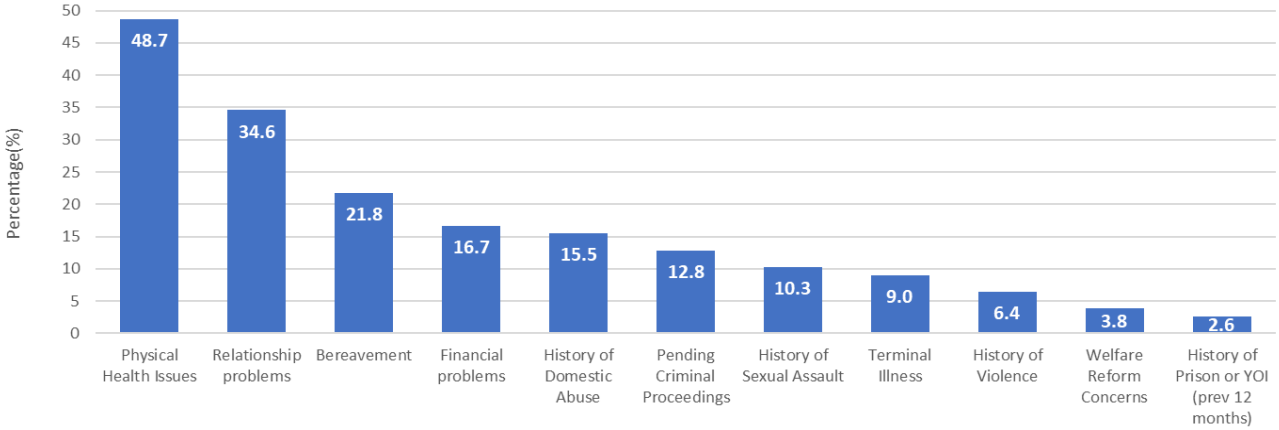
Other potential contributory factors

It is important to note that the information in this section and shown in **Figure 12** is not definitive, but rather *indicative* from the contents of a suicide notes (if they exist), disclosure from friends and relatives or accurate recording in health or other records. **True prevalence of these factors could be higher than that which is officially recorded**.

The most common factor (of those included on the Cheshire & Merseyside template - see Appendix One/Figure 13 for Audit Template) in Wirral cases in 2018-20 were physical health problems. This does not mean these were the cause of the suicide, but it is notable that almost half (49%) had at least one physical health issue. In almost 1 in 10 of cases (9%), the deceased person had some form of terminal illness. One in 3 (34.6%) had relationship problems and over 1 in 5 individuals (21.8%) were noted as having suffered a bereavement. See **Figure 12**.

National figures, provided by ONS, show that male prisoners in England and Wales were 3.7 times more likely to take their own life that men in the general population. It is important to note, that the increased risk of suicide may not be caused by the prison environment, but may be influenced by the increased prevalence of substance misuse and mental health problems in the prison population[17]. In Wirral, 2.6% of cases had a history of being in prison or a youth offenders institute; in 12.8% of Wirral cases, there were pending criminal proceedings noted in the records.

Figure 12: Proportion of Wirral suicide cases in 2018-20 where various potential contributory antecedents (known to be linked to suicide) were noted by the coroner



Source: Merseyside Coroner records (data collected specifically for this audit)

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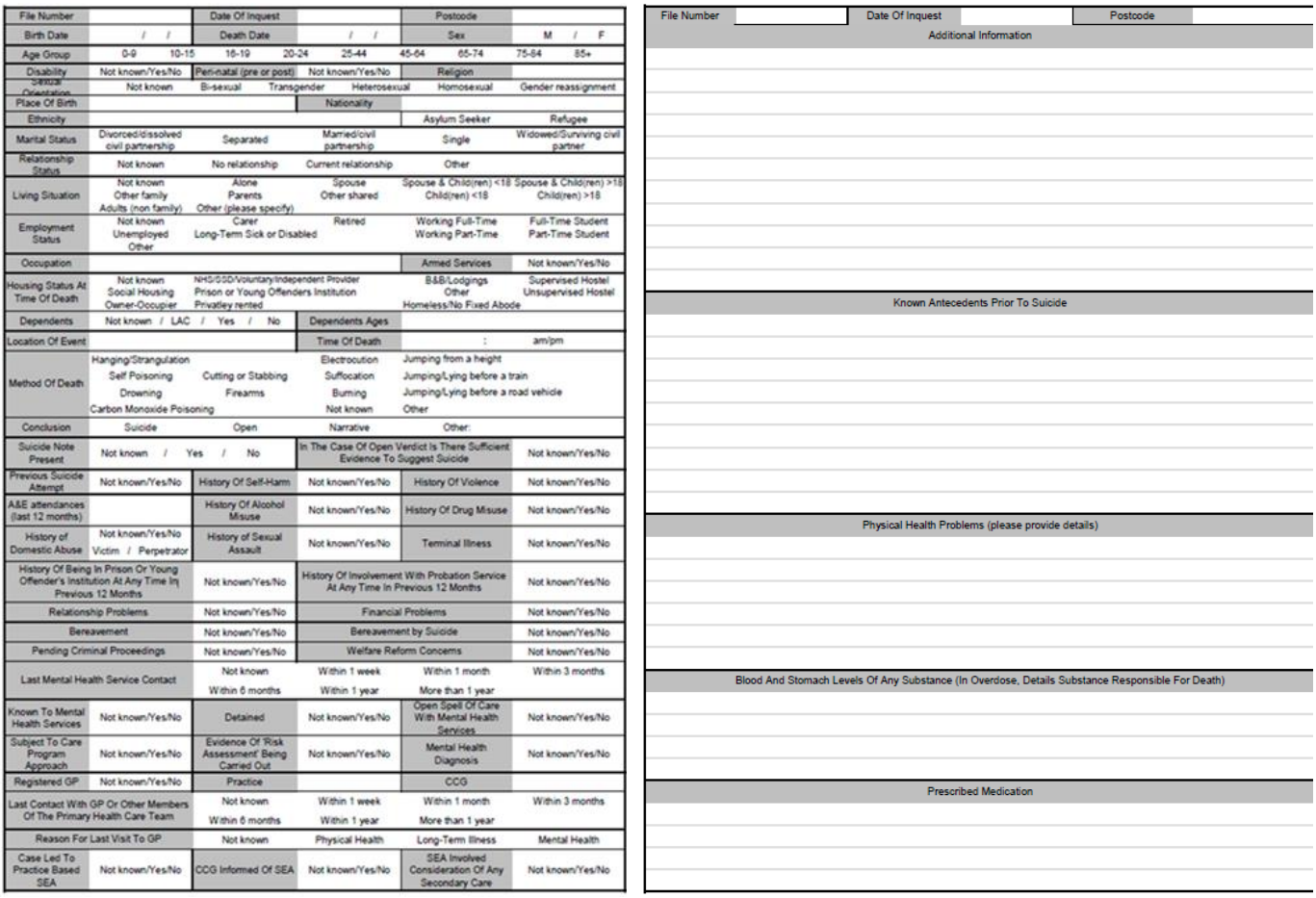
Appendix One

Figure 13: Cheshire & Merseyside Suicide Audit template, 2018-20



File Number		Date Of Inquest		Postcode	
Birth Date	/ /	Death Date	/ /	Sex	M / F
Age Group	0-9 10-15	16-19	20-24	25-44	45-64 65-74 75-84 85+
Disability	Not known/Yes/No	Peri-natal (pre or post)	Not known/Yes/No	Religion	
Sexual Orientation	Not known	Bi-sexual	Transgender	Heterosexual	Homosexual Gender reassignment
Place Of Birth			Nationality		
Ethnicity				Asylum Seeker	Refugee
Marital Status	Divorced/dissolved civil partnership	Separated	Married/civil partnership	Single	Widowed/Surviving civil partner
Relationship Status	Not known	No relationship	Current relationship	Other	
Living Situation	Not known Other family Adults (non family)	Alone Parents Other (please specify)	Spouse Other shared	Spouse & Child(ren) <18 Child(ren) <18	Spouse & Child(ren) >18 Child(ren) >18
Employment Status	Not known Unemployed Other	Carer Long-Term Sick or Disabled	Retired	Working Full-Time Working Part-Time	Full-Time Student Part-Time Student
Occupation				Armed Services	Not known/Yes/No
Housing Status At Time Of Death	Not known Social Housing Owner-Occupier	NHS/DSD/Voluntary/Independent Provider Prison or Young Offenders Institution Privatley rented		B&B/Lodgings Other Homeless/No Fixed Abode	Supervised Hostel Unsupervised Hostel
Dependents	Not known / LAC / Yes / No		Dependents Ages		
Location Of Event			Time Of Death	:	am/pm
Method Of Death	Hanging/Strangulation Self Poisoning Drowning Carbon Monoxide Poisoning	Cutting or Stabbing Firearms	Electrocution Suffocation Burning Not known	Jumping from a height Jumping/Lying before a train Jumping/Lying before a road vehicle Other	
Conclusion	Suicide	Open	Narrative	Other:	
Suicide Note Present	Not known / Yes / No		In The Case Of Open Verdict Is There Sufficient Evidence To Suggest Suicide		Not known/Yes/No
Previous Suicide Attempt	Not known/Yes/No	History Of Self-Harm	Not known/Yes/No	History Of Violence	Not known/Yes/No
A&E attendances (last 12 months)		History Of Alcohol Misuse	Not known/Yes/No	History Of Drug Misuse	Not known/Yes/No
History of Domestic Abuse	Not known/Yes/No Victim / Perpetrator	History of Sexual Assault	Not known/Yes/No	Terminal Illness	Not known/Yes/No
History Of Being In Prison Or Young Offender's Institution At Any Time In Previous 12 Months		Not known/Yes/No	History Of Involvement With Probation Service At Any Time In Previous 12 Months		Not known/Yes/No
Relationship Problems		Not known/Yes/No	Financial Problems		Not known/Yes/No
Bereavement		Not known/Yes/No	Bereavement by Suicide		Not known/Yes/No
Pending Criminal Proceedings		Not known/Yes/No	Welfare Reform Concerns		Not known/Yes/No
Last Mental Health Service Contact		Not known Within 6 months	Within 1 week Within 1 year	Within 1 month More than 1 year	Within 3 months
Known To Mental Health Services	Not known/Yes/No	Detained	Not known/Yes/No	Open Spell Of Care With Mental Health Services	Not known/Yes/No
Subject To Care Program Approach	Not known/Yes/No	Evidence Of 'Risk Assessment' Being Carried Out	Not known/Yes/No	Mental Health Diagnosis	Not known/Yes/No
Registered GP	Not known/Yes/No	Practice		CCG	
Last Contact With GP Or Other Members Of The Primary Health Care Team		Not known Within 6 months	Within 1 week Within 1 year	Within 1 month More than 1 year	Within 3 months
Reason For Last Visit To GP		Not known	Physical Health	Long-Term Illness	Mental Health
Case Led To Practice Based SEA	Not known/Yes/No	CCG Informed Of SEA	Not known/Yes/No	SEA Involved Consideration Of Any Secondary Care	Not known/Yes/No

File Number		Date Of Inquest		Postcode	

Additional Information

Known Antecedents Prior To Suicide

Physical Health Problems (please provide details)

Blood And Stomach Levels Of Any Substance (In Overdose, Details Substance Responsible For Death)

Prescribed Medication

Appendix Two

Coroners Verdicts Pre-2018

Most inquest verdicts must be decided on the balance of probability (in other words 'it is more likely than not' that the death of a person happened in a particular way). However, prior to 2018, inquest verdicts of suicide (and unlawful killing) were decided on the basis of being 'beyond reasonable doubt.' This was the reason that in some cases, what may have appeared to be an apparent suicide (e.g. a note which could be construed as a suicide note was present), alternative verdicts such as Narrative or Misadventure were given. The 'beyond reasonable doubt' requirement of a suicide verdict meant that Coroner believed that the deceased had acted in a *conscious* way; the presence of large concentrations of alcohol or drugs therefore often meant a suicide verdict would not be assigned, because alcohol and drugs are well evidenced to affect the ability of individuals to make conscious choices.

Coroners Verdicts Post-2018

On 26th July 2018, as a result of a case in the High Court, the standard of proof – the evidence threshold – used by coroners to determine whether a death was caused by suicide was changed from the criminal standard of "beyond reasonable doubt", to the civil standard of "on the balance of probabilities". The "standard of proof" refers to the level of evidence needed by coroners when determining whether a death was caused by suicide. This legal change appears not to have resulted in any significant change in the reported suicide rate in England and Wales.

‘Short form’ Inquest Verdicts

- **Suicide:** The Coroner has determined that the person has voluntarily acted to end his or her life in a conscious way
- **Misadventure:** implies that the deceased has taken a deliberate action that has then resulted in his or her death, i.e., an intended act but with unintended consequence; similar to Accidental death
- **Open verdict:** Used when there is not enough evidence to return a verdict. This is rare and generally only used as a verdict of ‘last resort’

Narrative verdict

The coroner is not obliged to use short form verdicts and can use ‘narrative verdicts’ which set out the circumstances of the death in a detailed way, based on the evidence heard. For those attending an inquest of a loved one, it can sometimes be helpful to hear the Coroner’s verdict in this form, as more of a detailed conclusion of events leading to the death is provided.

Contact details

For further details please contact: Wirral Intelligence Service at: wirralintelligenceservice@wirral.gov.uk

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