Wirral Suicide & Open Verdict Audit 2017-19

Wirral Intelligence Service

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Wirral Suicide & Open Verdict Audit 2017-19

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Key Findings

- There were 75 cases included in this 2017-19 audit; 55 of which were assigned as suicide verdicts (72%); the remaining 20 cases (28%) were assigned other verdicts (e.g., open, narrative, misadventure)
- Wirral had a lower suicide rate than England overall (8.7 per 100,000 in Wirral compared to 10.1 per 100,000 in England) in 2017-19 (according to ONS data, which includes only those cases classified as suicide). This is the first time Wirral has had a lower rate than England since 2011-13
- Of the 75 suicide cases during this period, nearly half (49%) were among individuals living in the most deprived areas of Wirral; compared to 36% of the overall population of Wirral who live in areas classed as the most deprived
- Men were over-represented in this audit; 79% of cases were male and 21% were female. This is consistent with the national picture (male/female ratio of 75/25)
- Average age at the time of death was 47 years; the peak 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 conclusions however, especially as there were 4% of cases with no recorded ethnicity, despite recent improvements in recording
- The most common cause of deaths included in this audit (overall and in men) was hanging/strangulation (45%), which, historically, has always been the most common method (both locally and nationally); in females however, the most common method was self-poisoning
- Almost half of both male and female suicide cases were most likely to be living alone (48%) and in terms of marital status, be single (53%)
- Sexuality is still poorly recorded, despite LGBT young people having a significantly higher risk of suicide (and self-harm); 47% of Wirral cases made no mention of sexuality
- In terms of employment status, males and females were both most likely to be unemployed (39%); when those not working due to disability or long-term sickness are included, this increases to 43%
- February and May appeared to be the peak months for suicide in Wirral in 2017-19; December did not appear to mark a particular peak in cases
- Over half of cases were recorded as being known to mental health services (56%); around 1 in 12 (or 8%) had previously been detained under the Mental Health Act
- Females were more likely to have previously attempted suicide than males (44% vs 37%), and have recorded instances of self-harm than males (44% vs 41% of males)
- Current or historic substance misuse was recorded in 43% of cases; current or previous alcohol misuse was recorded in 41%
- Relationship issues (39%), physical health issues (35%) and bereavement (21%) were the most commonly recorded antecedents in Wirral suicides between 2017-19 (consistent with previous audits)
- Mental health medications were the most commonly found prescribed drug at post-mortem (45% of cases)
- Alcohol was detected in 35% of cases at post-mortem, with illicit drugs found in 29% of cases. The most common illicit substance recorded at post-mortem was cocaine (19% of 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 contain data from three pooled years (in the case of this audit 2017, 2018 and 2019). 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 (possibly due to the need to collect sometimes complex evidence relating to the case).

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 which are presented 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).

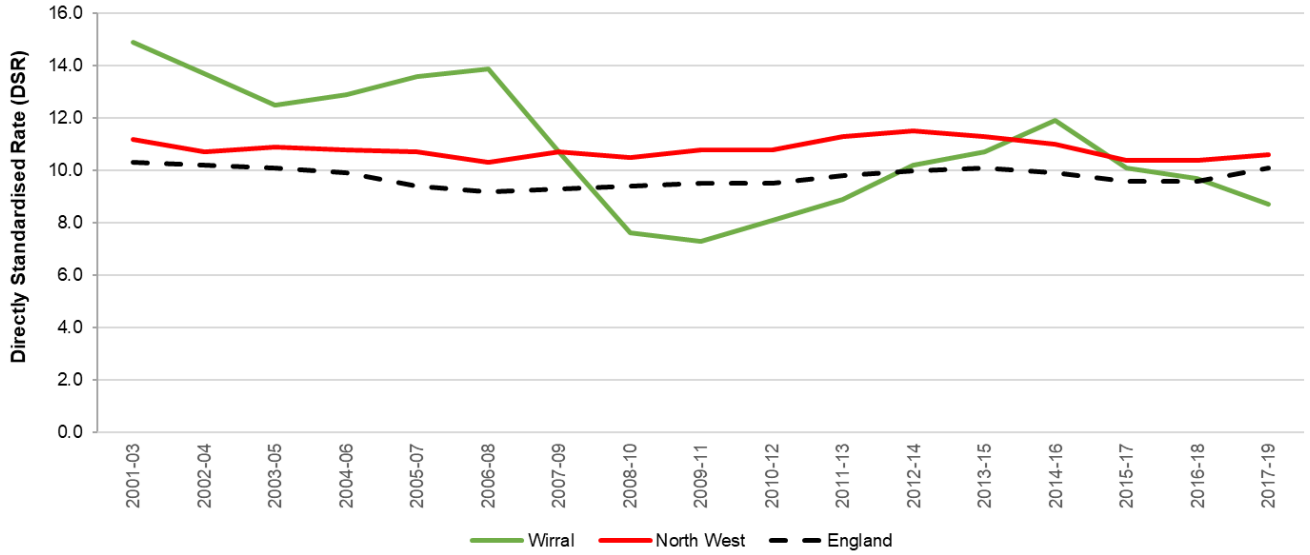
Suicide Cases

Trend in suicide rates

Figure 1 shows the trend in suicide rates locally, regionally and nationally using ONS data. It should be noted that the information in **Figure 1** 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.

Figure 1 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 regional and national rates for the latest period (2017-19). Over the same period, Wirral (8.7 per 100,000) has shown a decrease and is now lower than England for the first time since 2011-13.

Figure 1: Trend in suicide rate in Wirral, North West and England, 2001-03 to 2017-19

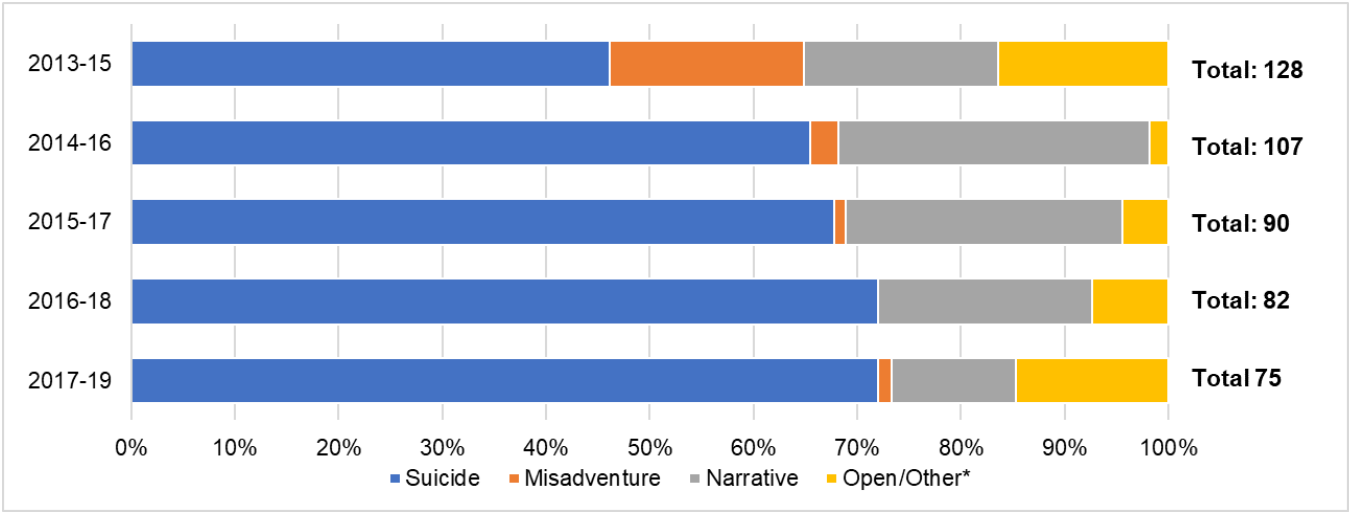


Source: Public Health Outcomes Framework, OHID (2022)
Note: More information can be found here - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

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, in 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 2: Proportion of cases included in the Wirral Suicide audits by assigned verdicts, 2013-15 to 2017-19



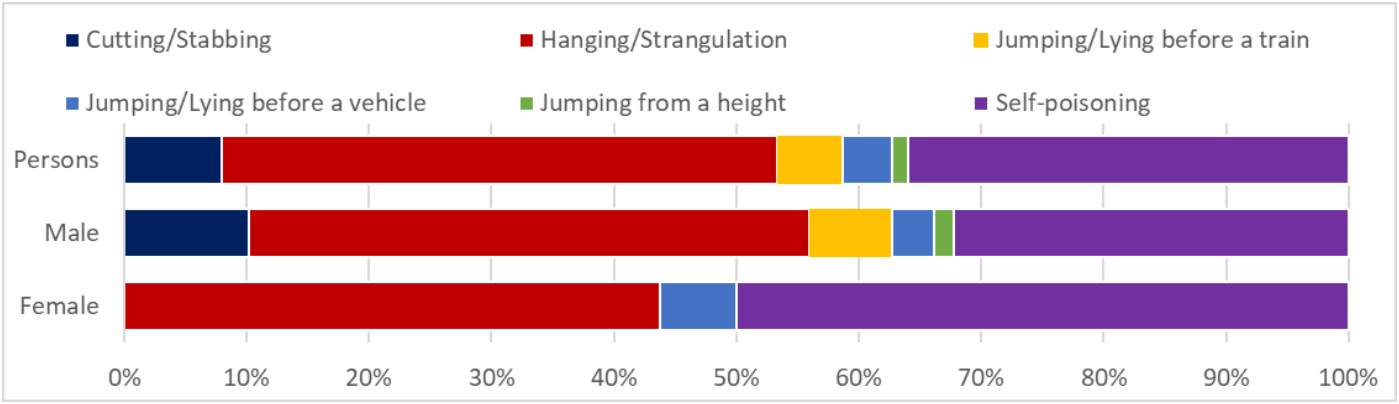
Source: Merseyside Coroner records (data collected specifically for this audit)
***Note:** Some of the cases with verdicts as "other" include Accidental and Drug Related Death (i.e., individuals used self-poisoning as their method)

As **Figure 2** shows, the 2017-19 reflects the largest proportion of Open/Other verdicts (14.7%) since 2013-15 (16.4%). However, the number of cases included within each period continues to decrease, which will lead to smaller numbers causing larger fluctuations.

Method

The most common suicide method for males in Wirral between 2017-19 was hanging or strangulation (47% of cases). Self-poisoning was the most common method for females (50% of cases), but due to the smaller number of female cases, hanging remained the most common method overall. Hanging or strangulation was also the most common method for both males and females nationally, followed by self-poisoning. Males in Wirral appear to have used a greater variety of methods than females over the 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 3**.

Figure 3: Proportion of suicides in Wirral, by method and gender, 2017-19



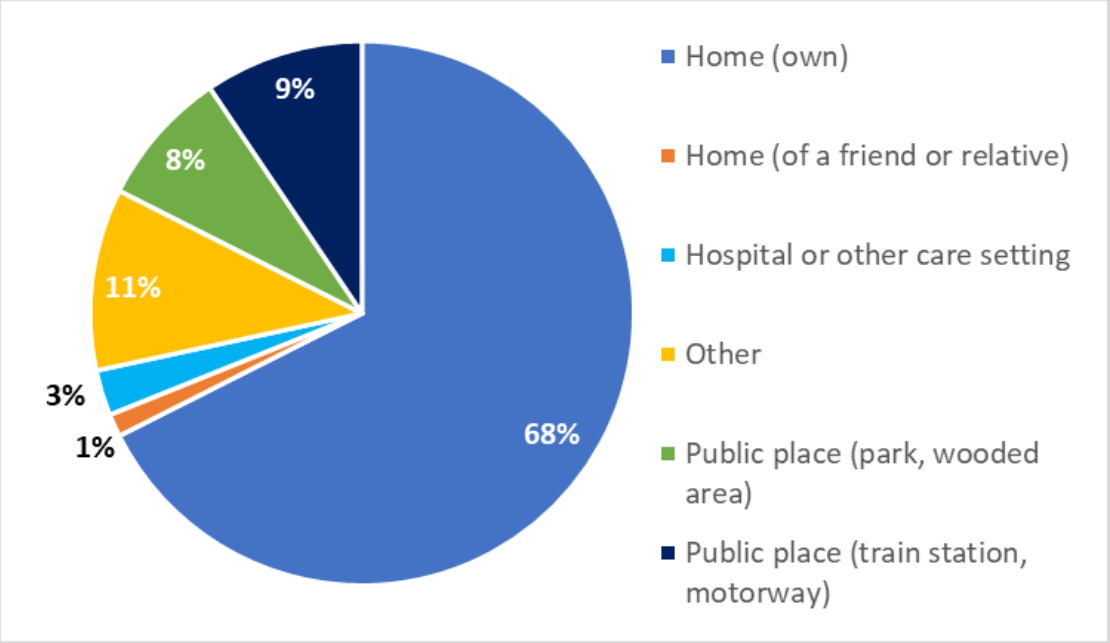
Source: Merseyside Coroner records (data collected specifically for this audit)
Note: ONS use a different categorisation of suicide methods compared to the Cheshire and Merseyside Suicide Audit Template. ONS only use 5 broad categories: 'drowning', 'fall and fracture', 'poisoning', 'hanging, suffocation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

Location of event

As **Figure 4** 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 2017-19. This is a consistent trend over many years in Wirral[8].

Places such as wooded public places, railway stations/ motorways and hospitals or other care settings make up some of the remaining locations. “Other” may include locations such as being abroad, in a hotel or where records have not been clear about the specific location.

Figure 4: Location of death of Wirral suicide cases in 2017-19



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

Demographics

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.

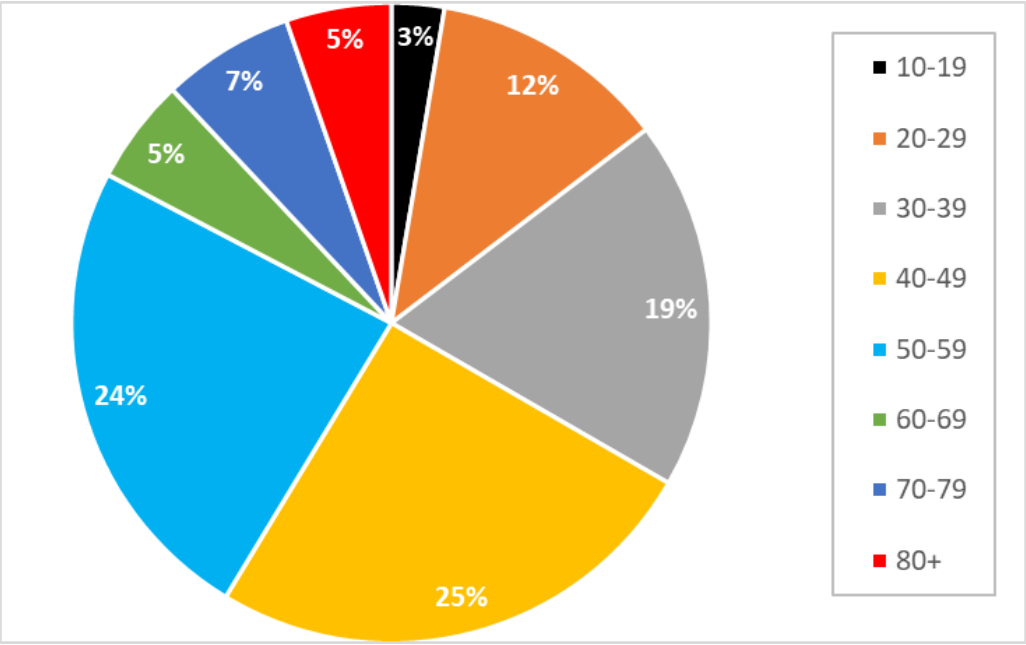
Nationally, suicide cases were 76% males and 24% female in 2019 and, in previous years, Wirral has shown a very similar trend. For 2017-19 the proportion of suicides in Wirral were split 79% male whilst 21% were female – so in line with the national ratio.

Age

Another important factor in suicide is age. Nationally, people aged between 45-64 years were most likely to take their own life (29% of all suicide cases)[4]. In Wirral in 2017-19, this was also true, with those aged 45-64 comprising 39% of all suicide cases.

The analysis in **Figure 5** 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 years (25% or 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 5: Age breakdown of Wirral suicide cases in 2017-19 (proportions)



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

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

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 2017-19 is less than might be expected, although, overall figures are too small to draw firm conclusions.

There were also 4% 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.

Potential Contributory Factors

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 (63%) cases had Wirral as their place of birth. A further 16% of cases had the Cheshire or Merseyside area as their place of birth, meaning that 21% (or just over 1 in 5) cases included in this audit were likely to be living some distance from where they were born. See **Table 1**.

Table 1: Place of birth of Wirral suicide cases in 2017-19, numbers and proportions

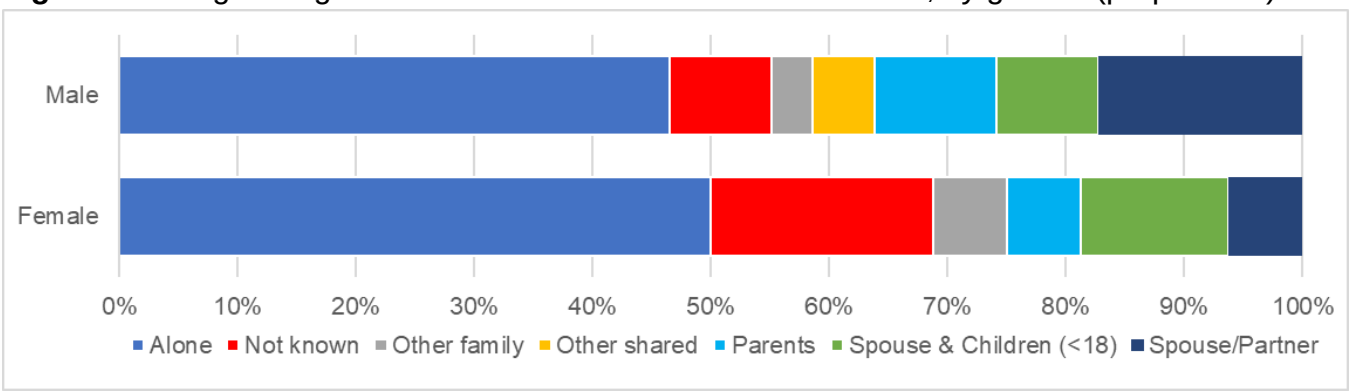
Place of birth	Number	%
Wirral	46	62.7%
Cheshire & Merseyside (excl. Wirral)	12	16.2%
Rest of UK	9	12.2%
Europe	<5	<5%
Rest of world	<5	<5%
Unknown	<5	<5%
Total	**75**	**100.0**

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 (47% overall); this is a long-standing trend in Wirral.

Males were then next likely to live with a spouse/partner, females with a spouse/partner and children (<18yrs). 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 2017-19, 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 married people comprising a lower proportion of cases 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 suicide cases in 2017-19, by gender (proportions)

Marital Status	Female	Male	Persons	*Persons in Wirral overall*
Married/Civil Partnership	12.5%	18.6%	17.3%	45%
Not known	<5%	<5%	<5%	N/A
Separated/divorced	31.3%	18.6%	21.3%	13%
Single	43.8%	56.0%	52.3%	34%
Widowed	12.5%	<5%	5.3%	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

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, data on marital status from the 2022 Census is not yet available and so 2011 data is still the most reliable indicator of marital status available. The data shows that there are some considerable differences between the Wirral population overall and those included in this audit in terms of marital status. For example, those included in this audit were more likely to be single (53% of suicide audit cases vs 34% of the Wirral population), less likely to be married or in a civil partnership (17% of audit cases vs 45% of the Wirral population) and more than twice as likely to be divorced or separated (21% of audit cases vs 13% of Wirral population).

For more information, please see "Who is most at risk of suicide?" article from ONS using death registration data alongside various research undertaken by Samaritans.

Sexuality

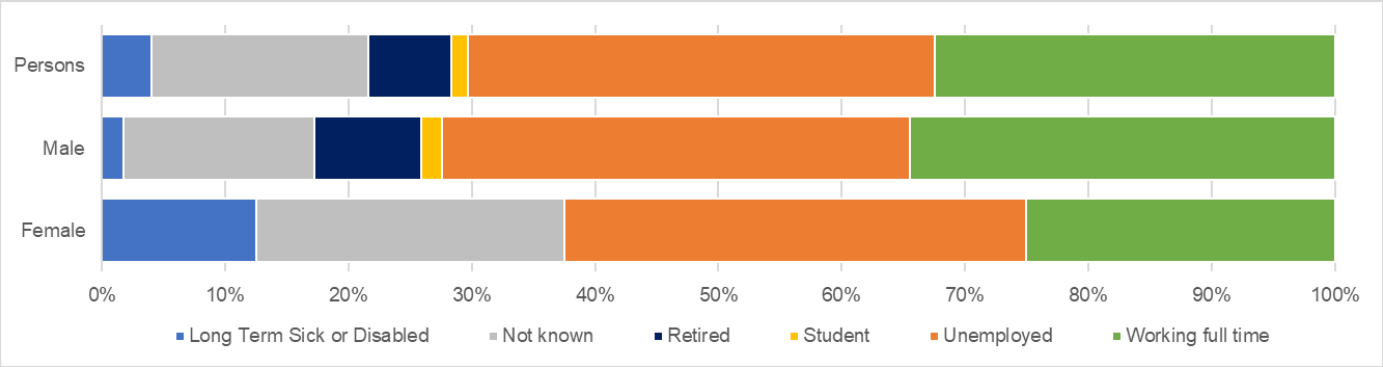
Data recording around sexuality is poor. It is only through anecdotal reports from family and/or friends that sexual preference is identified. Detailed results have therefore been omitted from this audit based on limited recording and poor data (although this indicator is included on the regional Suicide Audit data collection template); 47% 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 (33% 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: Employment status of Wirral suicide cases in 2017-19, by gender (proportions)



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

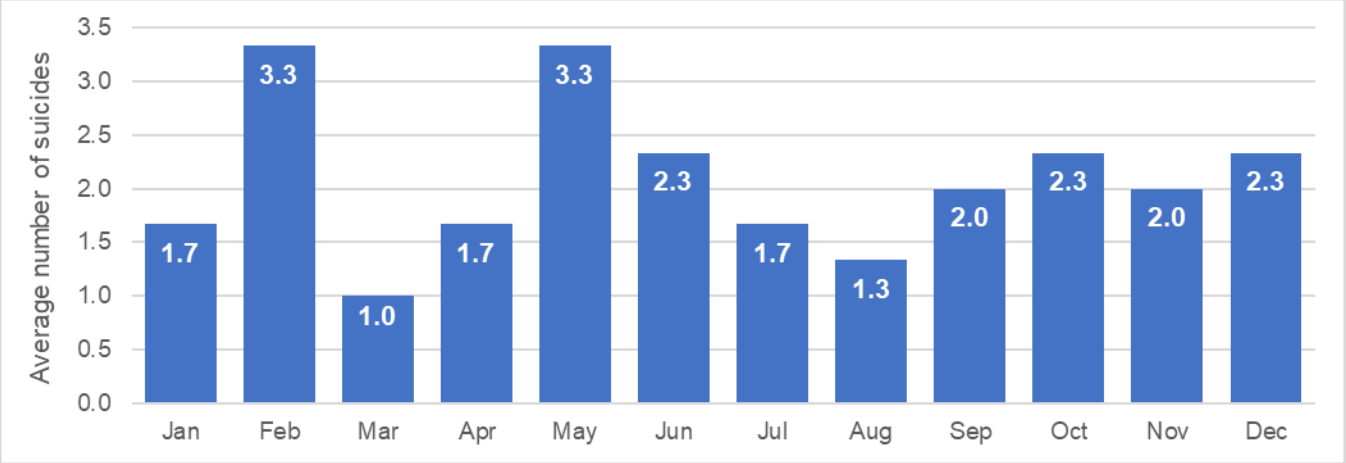
The findings of an international study looking at World Health Organisation (WHO) data from 63 countries found unemployment elevated suicide risk[12].

This is reflected in the 2017-19 Wirral suicide cases, with the most common employment status for both males and females being unemployed (39% of cases overall); when including those who did not work due to disability or long-term sickness, this increases to 43%.

Seasonality / time of year

Figure 8 shows that March and August had the lowest average number of suicide cases between 2017-19. Contrary to popular expectation, December and Christmas/New Year 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 October and June; February and May had the highest average number of cases (3.3 per year) - **see Figure 8**.

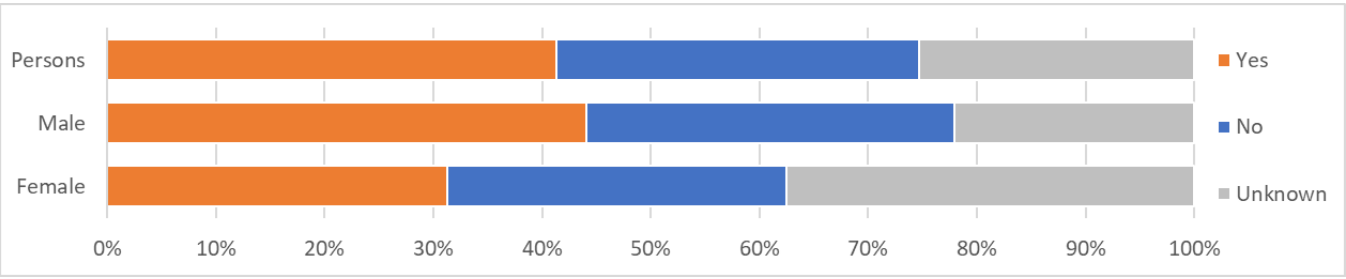
Figure 8: Average number of Wirral suicide audit cases, by month of occurrence, 2017-19



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: Wirral suicide cases recording a history of alcohol misuse, by gender, 2017-19



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

Figure 9 shows that there appears to be around 4 in 10 cases included in this audit who have a noted history of alcohol misuse and there was a substantial difference between males (44%) and females (31%).

As with all the issues noted in the Coroner's records, reporting relies on accurate and/or up to date medical records, and or relatives disclosing a full history to the Coroner. It is possible therefore, that the figures above for confirmed issues with drugs or alcohol may understate both issues. In more than a third of cases (27 of 75 cases or 35%), individuals were noted as having alcohol present at the time of the post-mortem (detected from either blood or stomach contents).

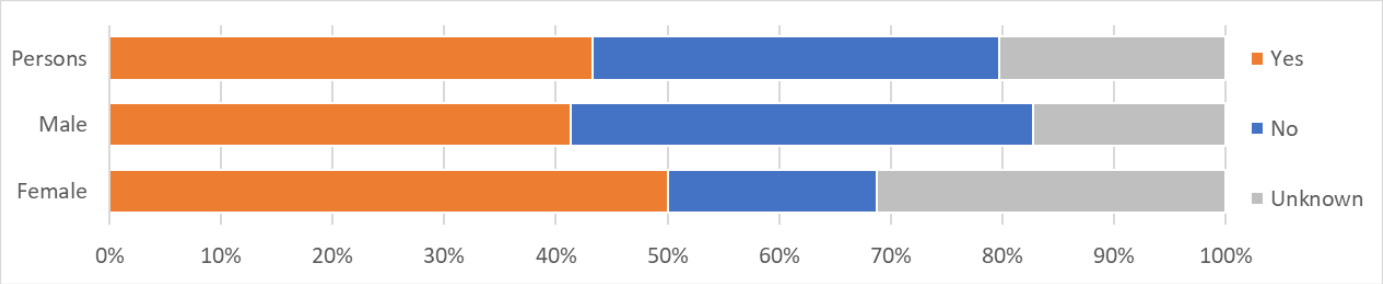
History of substance misuse

Substance (or drug) misuse is a risk factor for suicide[14] and, as such, is recorded on the local suicide data collection template. **Figure 10** shows the proportion of Wirral cases, by gender, which recorded substance misuse in the case records between 2017 and 2019.

Figure 10 shows that just over 4 in 10 cases included in this audit had a history of drug misuse noted on the case records. It should be noted however, that there were 20% of cases which did not clearly indicate whether the person had a history of substance misuse, 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 drug misuse compared to males, but this is against a backdrop of a

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

Figure 10: Wirral suicide cases recording a history of drug misuse, by gender, 2017-19



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

Illicit drugs were reported in 29% of toxicology reports (22 of 75 cases). The most commonly detected illicit substances at post-mortem were cocaine (19% or almost 1 in 5 cases) and cannabinoids (14% of cases). Other illicit drugs mentioned in case notes were MDMA, amphetamines and heroin.

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 – over half of both males and females (56% and 55% respectively), shown in **Figure 11**.

Furthermore, **Figure 11** shows that just under one in ten (8%) of both females and males (19% and 5% respectively) had previously been detained under the Mental Health Act. It also shows that in Wirral between 2017-19, 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, however Wirral data shows that a similar proportion of males/females had a history of self-harm (41% and 44% respectively).

Figure 11: Wirral suicide cases recording a history of mental health issues, by gender, 2017-19

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

Prescribed medications

In 41 of 75 cases (or 55%), individuals had active prescriptions for any medication. Of these, mental health medications were prescribed to 33 cases (or 44%), sertraline was the most prescribed medication, closely followed by citalopram. This figure (44%) may be lower than expected given that over half of all cases were recorded as being known to mental health services. Other mental health medications recorded included mirtazapine, fluoxetine, diazepam, venlafaxine and propranolol.

In addition to mental health medications, drugs used for pain management were also prescribed in 9 cases (or 12%), with paracetamol being the most prescribed medication.

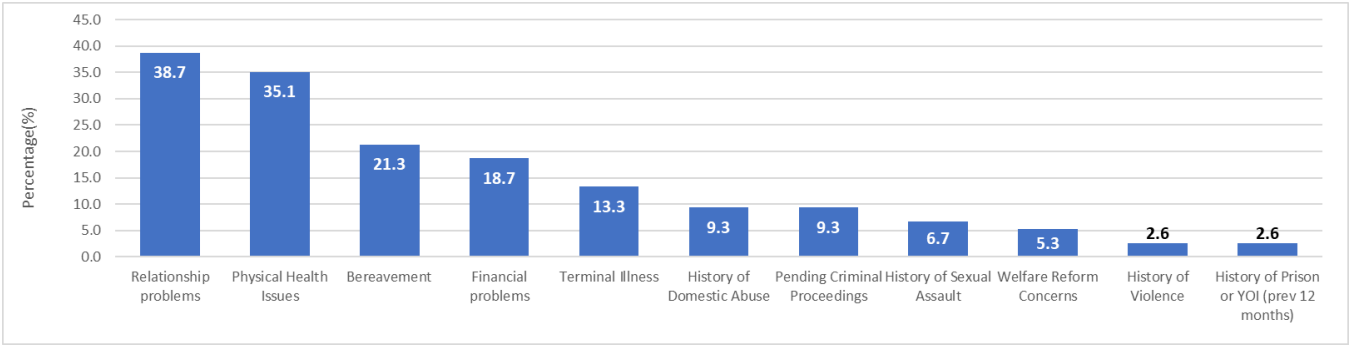
Other potential contributory factors

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) or disclosure from friends and relatives. **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) in Wirral cases between 2017-19 were relationship problems (39%), followed by physical health issues (35%). More than one in five (21%) had experienced a notable bereavement (a small proportion being bereaved by suicide) and nearly one in five individuals (19%) were noted as experiencing financial difficulties. The presence of these factors, does not of course, necessarily mean these were the cause of the suicide. 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 than that of males in the general population. It is important to note, that the increased risk of suicide may not be caused by the prison environment alone but may be influenced by the increased prevalence of substance misuse and mental health problems in the prison population[17]. In Wirral, 3% cases recorded a history of being in prison or a youth offenders institute; in 9% of Wirral cases, there were pending criminal proceedings noted in the records.

Figure 12: Wirral suicide cases where various potential contributory antecedents (known to be linked to suicide) were recorded by the coroner, 2017-19



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

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Appendix One

Figure 13: Cheshire & Merseyside Suicide Audit template, 2017-19

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/GSD/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

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