Written Evidence from Professor David Gunnell (SPR0179)

At the meeting I mentioned a couple of concerns with suicide statistics. You asked me to forward information relevant to your meeting with the Chief Coroner next week. I've listed a few key issues below, but please can i also take this opportunity to re-emphasise two issues i mentioned in my written evidence (attached for info). My submission was not referred to in the Interim Report, but i'm pleased to hear that all submissions have been read.

Suicide Statistics

I've been very concerned about the deteriorating quality of suicide statistics in recent years. In my written evidence i noted the following:

"7.1 Good quality suicide mortality data are essential to inform and evaluate suicide prevention strategies. In England and Wales, hard to code narrative verdicts are once more increasing (from 6% in 2011 to 8% in 2014), compromising suicide prevention activity and leading to significant under-estimation of suicide rates and trends [http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations].

7.2 As the use of narrative verdicts varies tremendously from coroner to coroner, over time this may have distorted the assessment of suicide prevention activities in some areas. We have shown that some of the areas in England & Wales that experienced the largest apparent declines in suicide between 2001/2 and 2008/9 were the very same areas that experienced the greatest increased use of narrative verdicts (see Carroll et al http://jpubhealth.oxfordjournals.org/content/34/3/447.long)."

Whilst the Chief Coroner's written evidence points to the local accountability of coroners, i do think the LARGE variation between coroners in their recording practices is a cause for concern. The table below taken from one of one of our recent studies of "clinically defined suicides" (attached) shows that between 28% (coroner 4) and 84% (coroner 5) of clinically defined suicides received a decision (verdict) of suicide, and even when we combined suicide and open verdicts (as is usual when ONS report national suicide statistics), only between 73% (coroner 7) and 100% (coroner 3) of clinically defined suicides was given a decision of suicide/open. I've seen claims made for the success of local prevention programmes, where apparent suicide reductions have more likely reflected changes in local Coroner practice (increased use of narrative verdicts)

Coroners' district	Verdict				Total (100%)	Suicide and open combined (%)[b]
	Suicide[a]	Open	Accident or misadventure	Narrative		
1	71 (67.0)	10 (9.4)	24 (22.6)	1 (0.9)	106	81 (76.4)
2	40 (60.6)	19 (28.8)	2 (3.0)	5 (7.6)	66	59 (89.4)
3	15 (83.3)	3 (16.7)	0 (0.0)	0 (0.0)	18	18 (100.0)
4	6 (28.6)	11 (52.4)	3 (14.3)	1 (4.8)	21	17 (81.0)
5	21 (84.0)	2 (8.0)	2 (8.0)	0 (0.0)	25	23 (92.0)
6	15 (78.9)	2 (10.5)	2 (10.5)	0 (0.0)	19	17 (89.5)
7	26 (39.4)	22 (33.3)	3 (4.5)	15 (22.7)	66	48 (72.7)
8	32 (69.6)	12 (26.1)	1 (2.2)	1 (2.2)	46	44 (95.7)
9	32 (72.7)	8 (18.2)	4 (9.1)	0 (0.0)	44	40 (90.9)
10	42 (75.0)	10 (17.9)	3 (5.4)	1 (1.8)	56	52 (92.9)
11	45 (83.3)	7 (13.0)	2 (3.7)	0 (0.0)	54	52 (96.3)
12	43 (59.7)	20 (27.8)	8 (11.1)	1 (1.4)	72	63 (87.5)
Total	388 (65.4)	126 (21.2)	54 (9.1)	25 (4.2)	593 (100)	–

[a]Test of heterogeneity between coroners' districts in the proportion of researcher-defined suicides given a coroners' verdict of suicide: $\chi^2 = 53.48$, P-value ≤ 0.0001.

[b]Test of heterogeneity between coroners' districts in the proportion of researcher-defined suicides given an open or suicide verdict: $\chi^2 = 31.82$, P-value < 0.0001.

Between coroner variations in the use of different verdicts and trends in use of particular verdicts (as seen recently with the growth of narrative verdicts) could form the basis of misleading public health advice.

If possible it would be extremely useful if coroners could be required to :

1. Give a short form verdict (suicide / open / accident etc.) as well as a narrative for all deaths.

2. Receive mandatory training in use of short form verdicts as accident and open verdicts for probable suicides are used extensively (and to differing degrees, see above)

3. Asked to record details of the method of suicide systematically and consistently. There is clear evidence that restricting access to high-lethality methods of suicide saves lives. As indicated in my written evidence, there are current public health concerns around rises in suicide using helium gas and carbon monoxide from burning barbecue charcoal, but the source of the gas is recorded in <50% of the suicide deaths reported to ONS. This means, for example, that rises in barbecue charcoal poisoning cannot be distinguished from car exhaust gas (the two necessitate different public health actions).

4. Give all bereaved relatives Help is at Hand and contacts for local suicide bereavement support groups.

I strongly feel the standard of proof required to reach a suicide verdict should no longer be the criminal standard. This reflects back to a time when suicide was illegal. I imagine this required an act of parliament rather than input from the Chief Coroner.

General observations

I'm jointly trained in Primary Care and Public Health and have spent a considerable amount of time reading many hundreds of inquest reports of people who've died by suicide for research and practice purposes. Based on my reading of these I'd like to strongly echo the point made at yesterday's meeting about suicide being a Public Health issue. Only 40% of people who die by suicide are in contact with health services (GP/psychiatry etc) in the month before their death. Time and again when reviewing inquest reports, I've been struck by deaths occurring more or less out of the blue, with the level of an individual's acute distress often being unknown to those around them. It is important to raise awareness in the wider population that depression / suicidal thoughts are common and preventable, encourage help-seeking and help those around people going through difficult periods of their lives to recognise and respond to distress. I referred to evidence of the effectiveness of 'gatekeeper' training in my written evidence.

Media reporting is a really challenging issue. Reporting can be important not only in terms of informing public views and attitudes towards suicide but also in terms of propagating the spread of novel methods of suicide in populations. Research with colleagues from Taiwan, Hong Kong and Korea shows just how quickly new, highly lethal methods of suicide can be taken up by populations following high profile reporting. This can lead to rises in both method-specific and overall suicide. It is increasingly clear that internet sites, such as Wikipedia, that describe methods of suicide in detail can contribute to risk (see attached paper). I do think it's time to tighten up some of the existing guidelines and regulation aimed at reporters, editors and film makers.

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