Haringey Suicide Audit 2013

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Executive summary

Suicide is one of the top twenty leading causes of death for all ages worldwide with more than one million deaths per year globally. Men are three times more likely to commit suicide than women. Nationally suicide rates are decreasing for men and women, other than 2011 which showed an increase in both men and women over 15.

While the rate of suicides in women is in line with the national and London average, suicides in men in Haringey have increased in recent years. According to the Coroner’s Report, in 2012, there were three deaths by suicides committed in Haringey compared to 15 open verdicts out of which five were undetermined. Over 74% of suicides were in those residing in the east of the borough. Data on ethnicity is unavailable however place of birth data shows that 62% of suicides occurred in people born in the UK compared to 34% born abroad. The most common method was hanging followed by poisoning. In line with national data, 47% who committed suicide were single and 17% were divorced. Data on whether people had had previous contact with their GP or secondary mental health services is relatively poorly recorded however it is likely that many people have had no contact with health services. In-patient suicides show a sustained fall across the UK.

Although the numbers are small on which to base firm conclusions, we are clear from the data that suicide prevention activities needs to be focussed on young men, particularly in the east of the borough. The worsening economic climate and the impact of housing reforms is likely adversely impact on those with already significant mental health problems.

Mental health is a key priority of Haringey’s Health and Wellbeing Strategy. There are an estimated 34,500 people with common mental problems and over 3000 people with a psychotic illness. Many people will have undiagnosed mental illness due to fear and the perceived stigma of a mental health condition. In the east of borough there are high rates of worklessness, overcrowding and domestic violence. These are all factors that are strongly associated with mental health problems and can be contributing factors in driving a person to suicide.

There is work going on in Haringey with both the statutory and voluntary sector to reduce the number of suicides but it takes a multi-agency, multi-faceted approach to have a significant impact on the local situation. The audit will help direct targeted work to those most at risk of suicide and suicidal intention.
1. Introduction

Suicide is one of the top twenty leading causes of death for all ages worldwide with more than one million deaths per year globally. Men are three times more likely to commit suicide than women. In the UK, there has been an overall decline in the numbers of suicides until 2011 which saw 6,045 suicides in people aged 15 and over, an increase of 437 compared with 2010. Roughly seventy five per cent of these suicides were committed by men. The highest suicide rate was in men aged 30 to 44 and, in women it was highest in 45 to 59 age group. In-patient suicides showed a sustained fall across the UK. This is most likely due to intense work by acute hospitals and mental health trusts to reduce access to ligature points and undertake staff training to reduce suicide. This report forms a suicide audit for Haringey to compare local and national rates, understand local trend and make recommendations to reduce the number of local suicides.

2. Purpose

Haringey is a borough with a diverse and fast changing population. It is the fourth most deprived borough in London and the thirteenth in England. The more deprived areas of the borough lie towards the east, where are greater rates of overcrowding, homelessness, unemployment as well as higher rates of mental illness. These risk factors, together with the current economic climate lead to an increase risk of suicide for susceptible individuals. This audit forms part of our work programme on suicide reduction in Haringey. It will help us understand our local picture compared to the situation in London and England. It will also facilitate our understanding of those most at risk and allow us to target suicide prevention strategies appropriately.

3. Context

Suicide is a major public health issue that has a devastating effect for families and society; as a result many national strategic documents have addressed it extensively. Saving Lives - Our Healthier Nation (DH 1999) lists reducing the death rate from suicide and undetermined injury by at least a fifth as one of its four targets. 'No health without mental health' (2011) discusses suicide in its ambition to work towards six objectives for better mental health for the population. Preventing suicide in England (DH 2012) outlines six areas for action, including a plan to reduce the risk of suicide in key high-risk groups, reducing access to the means of suicide, and supporting research, data collection and monitoring. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Inquiry (University of Manchester 2012) provides health professionals, policy makers, and service managers with the evidence and practical suggestions they need to effectively implement change. Barr et al (2012) found a link between recent increases in suicides in England and the financial crisis that began in 2008. The Samaritan’s Report 2012 found changes in: attitude from repressive pre-war to liberal post-war culture, the roles of men and women and the structure of families, economic restructuring and the decline of male industries as probable causes for men being more likely to commit suicide. Suicide by prisoners highlights the need to recognise the fluctuating and long-term nature of suicide risk in prisoners and recommends suicide prevention measures to be concentrated in the period immediately following reception into prison.
Regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men. A London Health Authority report (2009) looked at suicides in London from 2005 to 2007 and found large inequalities in suicide rates across London, with a higher concentration in inner London as opposed to outer London. 

Locally in Haringey, supporting people with severe and enduring mental health needs is one of the key priorities of Haringey’s Health and Wellbeing Strategy 2012-15 and is part of the overall aim to improve mental health and wellbeing of all the residents of Haringey. Many programmes and initiatives for suicide prevention are in place both in the community and secondary care.

4. Methodology

Suicide is reported as a cause of death on death certificates in England and Wales. Around 30,000 Coroner inquests are held each year 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. It is thought that some open verdicts are given to avoid adding to a family’s distress. 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.

ONS data from the Compendium of Population Health Indicators was used to collect suicide rates for national and local comparison, including those for comparator boroughs. Further information was sought from Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) for details on suicide rates in patients in touch with mental health services. As it was not possible to obtain a database of suicides known to the Trust, a report on inpatient suicides was provided.

A request to the local Coroner was made and access to the Coroner’s database was permitted. A template was drafted to collect relevant information prior to accessing the database (see Appendix 2). There was limited availability of all the required fields however new database was compiled from the available Coroner’s data on all suicides and open verdicts in the last ten years in Haringey. (see Appendix 3). Non-residents who committed suicide in Haringey were excluded, as were individuals with no fixed abode (unless the suicide was committed in Haringey). Residential addresses were then sorted into residential wards and the location of death was analysed into subgroups from the addresses given. Only suicides committed in those aged fifteen and over were included, as this is the standard definition used by ONS and the Public Health Outcomes Framework.

No ethnicity data was available on the Coroner’s database, however place of birth can give a rough proxy indicator of ethnicity. The coroner’s records had very incomplete information about contact with GPs or mental health services. Therefore it is important to exercise caution when drawing any firm conclusions from an incomplete dataset.

5. Suicide in Haringey

Data from ONS shows that Haringey has had a rate of suicide in men consistently higher than the national average and an increase in this rate from 2007-2010 (see fig 1 and fig 2). Figure 2 shows the
annual rate of suicides with large fluctuations due to the low numbers involved. Suicides in men were consistently higher than the England and London averages. Suicides in women showed similar trends to the London and England average.

Figure 1: Three year age standardised mortality rate from suicide in England and Wales from 2000 to 2009

![Figure 1: Three year age standardised mortality rate from suicide in England and Wales from 2000 to 2009](image1)

Source: ONS

Figure 2: Age standardised mortality rate from suicide for all ages (2000-2010)

![Figure 2: Age standardised mortality rate from suicide for all ages (2000-2010)](image2)

Source: ONS

Since 1981 there has been a decline in suicide rates in the UK from 14.9 per 100,000 population in 1981 to 11.1 per 100,000 population in 2010\(^{ii}\). However, 2011 saw a significant increase of 437 more suicides compared to 2010. This increase has been attributed to several coding changes to suicide
statistics namely, improvement in coding of narrative verdicts, improvements in better identification of narrative verdicts and introduction of a new version of ICD-10 (International Classification of Diseases) software that led to changes in coding of event of undetermined intent.

From 2009 – 2011, there were 66 deaths by suicide in Haringey which equates to an annual rate of 8.71 per 100,000 population compared to the national rate for the same year of 7.87 per 100,000. Haringey’s statistical neighbours are Hackney, Lambeth, Lewisham and Southwark. In comparison to Haringey, Hackney’s annual rate is 8.84, Lambeth 6.64, Lewisham 6.63 and Southwark 7.38. Haringey has a higher suicide rate than all its comparator boroughs except Hackney.

6. Coroner’s verdict

The following section provides an analysis of records of deaths by suicides from the Coroner’s office. It compares the recent data with the previous audit that was conducted in 2006 in Haringey.

In the 2006 audit of suicides in Haringey, the Coroners verdict (2001-2006) was shown to have 75% open verdicts and 25% suicide verdicts. This compared to the national levels of 33% open and 67% suicide verdicts. The data collected from the Coroner’s database over the recent 5 year period from 2008 to 2012 reveals a further larger proportion of verdicts being classed as open by Coroners (85% as open and 15% suicide).

In 2012, there were 3 deaths by suicides committed in Haringey compared to 15 open verdicts out of which five were undetermined. In the last ten years, there has been a consistent trend with the highest of 9 suicides committed in 2003 and in 2007 and the lowest of 2 in 2005, 2008 and in 2011 (see fig 3).

Figure 3: Trend in number of deaths by suicides from 2002 to 2012
Since 2001 there has been an increase in number of coroners summarising their inquest findings as narrative verdicts (factual record of how and in what circumstances a death occurred) rather than giving a short-form verdict (accident, misadventure, natural causes, suicide or homicide). In the UK out of the 30,000 coroners inquests held annually 90% conclude with a ‘short-form’ verdict. In 2011 out of 2966 narrative verdicts only 270 had intentional self harm or undetermined intent as underlying cause of death.

a. Age and gender

Nationally the rate of suicide has fallen overall in all age groups except for those aged 45-64 years, where it has remained stable. Recent data shows that the most commonly affected age group is 25-44 years followed by 45-64 years (figure 3). This does however vary on a year on year basis due to the relatively small numbers. The 2006 audit found the highest rates in men in the 25-34 age group and women in the 35-44 age group. This was consistent with national picture at this time.

Figure 4: Suicides by age-group in Haringey from 2002 to 2012

Figure 4 shows that in the last ten years there have been more male suicides in Haringey and this is consistent with national statistics. Although the numbers fluctuates, men have consistently had higher rates of suicide. Evidence shows women are more likely to self-harm than men and it is more pronounced in adolescence where girls are three times more likely to self-harm than boys. Men are more likely to use drugs or alcohol in response to distress.
b. Place of Birth and Ethnicity

The 2006 audit in Haringey noted that 44% of suicides in Haringey were born outside of the UK whereas only 37% of the general population of Haringey were born outside of the UK. Current data shows that 34% of Haringey residents were born abroad compared with 42% of suicides born abroad.

Data on ethnicity is limited as it is not available from death certificates, ONS or the Coroner. Place of birth can be used as a proxy indicator however it doesn’t take into account the relatively large number of people from Black and minority ethnic groups who were born in the UK. Interestingly, the 2006-2007 report by Barnet and Enfield Mental Health Trust\textsuperscript{viii} found the prevalence of suicides was highest in the “White British” ethnic group followed by “Black Caribbean” followed by “Other White”. This is anecdotal evidence from a small piece of detailed research and it may not be generalisable for the entire population of Haringey.

c. Marital Status

Similar to the findings from the 2006 audit, 47% of those who committed suicide were single compared to 43% in 2006 (figure 5). There was little difference in the figures for divorced and married people. The majority of those who committed suicide were found to be either single (43%) or divorced/separated (41%). Evidence shows relationship breakdown is more likely to lead men, rather than women, to suicide\textsuperscript{viii}.

Figure 6: Suicides by marital status from 2002 to 2012
d. Ward of residence

There is a volume of evidence to suggest that those in difficult socio-economic circumstances are at major risk for suicide. Figure 6 shows the number of suicide in each Haringey ward. Roughly 74% of suicides were in the east of the borough, which has the greatest level of deprivation. It is not possible to compare this to the information available in the 2006 audit due to previous missing postcode data.

Figure 7: Suicides by ward of residence in Haringey from 2002 to 2012

![Suicides by marital status (2002-12)](image)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widowed</td>
<td>4%</td>
</tr>
<tr>
<td>Single</td>
<td>15%</td>
</tr>
<tr>
<td>Not stated</td>
<td>17%</td>
</tr>
<tr>
<td>Divorced</td>
<td>17%</td>
</tr>
<tr>
<td>Separated</td>
<td>47%</td>
</tr>
<tr>
<td>Married</td>
<td>0%</td>
</tr>
</tbody>
</table>

e. Method of Suicide

Figure 7 below shows the commonest types of suicides in Haringey. In 39% of cases, no method of death was recorded. The most common method was hanging and strangulation (30%) followed by
poisoning (16%). Similar to the national figures and the findings of the 2006 audit, hanging was the most common mode of death for men in Haringey while poisoning was found to be more common in women. The relatively low number of suicides by poisoning reflects the lower levels of suicide in women.

Figure 8: Common modes of suicide (2002 to 2012)

<table>
<thead>
<tr>
<th>Method of Suicide</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>39%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>16%</td>
</tr>
<tr>
<td>Unknown</td>
<td>11%</td>
</tr>
<tr>
<td>Multiple Injuries</td>
<td>2%</td>
</tr>
<tr>
<td>Drowning</td>
<td>2%</td>
</tr>
<tr>
<td>Incised Wound</td>
<td>16%</td>
</tr>
</tbody>
</table>

f. **Employment**

A large proportion of the data on employment was not recorded by the coroner (38%) however out of those where employment was recorded (160 out of 258 cases), the proportion of those employed (81%) was greater than those who were not in employment or retired (19%). This finding is contrary to the national evidence that shows suicide is more likely to be committed in those not in full-time employment.

g. **Mental health services**

According to the recorded data (13.5%), around three quarters of people who committed suicide in Haringey had no contact with mental health services in the previous twelve months. There was poor recording of those who had access to mental health services however 13% were recorded to have a previous history of mental illness. This data is likely to be inaccurate so firm conclusion cannot be drawn. The 2006 audit found that compared to the 25% people nationally, 34% of Haringey residents who committed suicides were in touch with mental health services within one year of death.

h. **GP contact**

Data on contact with GP services is poorly recorded by Coroners, often due to lack of information as the time of the death. Only 9% of suicides and open verdicts recorded were known to a GP. It is
likely that this figure is higher but without future analysis by GP practice, it is impossible to give a more realistic figure. The 2006 audit did not look at data on contact with a GP and national comparators are unavailable.

7. Conclusion and Discussion

Nationally suicide rates are decreasing for men and women. While the rate of suicides in women is in line with the national and London average, suicides in men in Haringey have increased in recent years. Access to the local Coroner’s database has revealed that in men occurred suicide most frequently in the 25 to 34 age group. Those committing suicide were more likely to be single or divorced and live in wards in the east of the borough. Unfortunately data on access to primary care or specialist mental health services was incomplete however it is likely that many people were not known to services.

It is very difficult to draw key points from so few individuals but the emerging themes indicate that areas on which to focus prevention activities could include: young men, particularly those in the east of the borough. Although our data showed that they were more likely to be employed, however, there is much work to be done with job centres, the Citizen’s Advice Bureau, benefits and other agencies and organisations. For those employed it would seem logical to work with employers, certain occupations are at more risk with the worsening economic climate.

Mental health is a key priority of Haringey’s Health and Wellbeing Strategyxvii. We know there are an estimated 34,500 people with common mental problems and over 3000 people with a psychotic illness. Many people will have undiagnosed mental illness due to fear and the perceived stigma of a mental health condition. In the east of borough there are high rates of worklessness, overcrowding and domestic violence. These are all factors that are strongly associated with mental health problems and can be contributing factors in driving a person to suicide.

There is work going on in Haringey with both the statutory and voluntary sector to reduce the number of suicides but it takes a multi-agency, multi-faceted approach to have a significant impact on the local situation. The following recommendations come out of this audit and following local discussions with partner organisations.

8. Recommendations

1) Audit and analysis
   a. There needs to be data sharing agreements between coroners, primary and secondary care to enable each suicide and open verdict to be identified investigated and lessons learnt.
b. Better understand the recording of data by the coroner, how GP details are identified and how open verdicts are recorded

c. Secondary care services need to share data on those committing suicide with all agencies involved so that lessons can be learnt and more appropriate services planned

2) Learning lessons
   a. Data should be shared on a regular basis with the coroner, mental health trust and primary to identify whether there were any opportunities for early intervention in suicides and systems could change to accommodate these

3) Education and training
   a. The primary care workforce needs better training to ensure appropriate risk analysis of patients contemplating suicide
   b. Consider further training to employers and those working in job centres, the Citizen’s Advice Bureau, benefits and other agencies and organisations.
   c. Work with Credit Unions, betting and loan shops to target those most at risk of financial difficulties.
   d. Raise awareness of mental health problems through the Haringey stigma campaign and target schools and colleges in suicide awareness

4) Working together
   a. Consider how agencies and organisations work across Haringey to reduce suicide and evaluated whether these are having any significant impact
   b. Linking the voluntary sector with primary and secondary services is particularly important, particularly those working in the east of the borough, with Black and minority ethnic groups
   c. The findings of this audit need to be taken on by the council, particularly the Health and Wellbeing Board, to work across Haringey on reducing the risk factors for suicide.
d. **Appendix 1**

Recommendations of the latest national strategy on suicide prevention are being implemented both in the community and secondary care settings in Haringey. Following is a list of initiatives and programmes that are in place for children and adults.

**Children and adolescents**

- Children’s Mental Health Partnership Board (membership from all mental health services for children and adolescents including Jewish community).
- Haringey Youth Offending Service (YOS) provides the following service:
  - For Young People on Prevention, Triage or Final Warning Programmes (i.e. pre court) – Full health screening covering physical health, mental health and neurodisability carried out by a nurse. If any concerns regarding suicide or self-harm were raised by a young person then they would be given support and advice on how to keep themselves safe, a risk assessment would be carried out and they would be immediately (within an hour) referred onto the Adolescent Outreach Team (AOT) at CAMHS. If the young person was suicidal then an adult responsible for their care would be notified and both the child and the parent/carer would be given the emergency procedures (as are given out by CAMHS AOT).
  - For young people who are on a court order – The young people have a full assessment carried out by a YOS officer. If concerns regarding their mental health are raised then they are referred on and seen by either the mental health social worker or psychologist based at the YOS. These team members would also provide the young people with the emergency procedures (as are given out by CAMHS AOT). A referral would also be made to the CAMHS AOT team. If the YOS officer had immediate concerns about a young person they would call their parent/carer or 999.

- Pilot project with Young Minds in Haringey that is promoted via Healthy Schools Programmes to skill up and support staff and parents and delivery of group work for children
- [www.youthspace.haringey.gov.uk](http://www.youthspace.haringey.gov.uk) – is an online resource for the youth of Haringey that has helpful information on mental health warning signs, useful links and forums and helplines.
- Screening service by Child and Adolescent Mental Health Service for Barnet Enfield Haringey Mental Health Trust (CAMHS BEHMHT)
- Protocol for assessing self-harm by CAMHS (BEHMHT)
- Link between CAMHS (BEHMHT) and Youth Offending Service (YOS) and with North Middlesex hospital (NMH)
- A proposed pilot project to raise awareness of self-harm working with a volunteer secondary school, including possibly developing peer support network within the school.

**Adults**

- Adult Mental Health Partnership Board (membership from BEHMHT, Haringey Council, CCG, Public Health and voluntary sector) has mental health promotion and prevention of self harm (suicide prevention) as a sub group.
- Self-harm treatment at the Whittington Hospital and the North Middlesex Hospital
o Stigma campaign to recognise the differences in public attitudes to variety of mental illnesses. Following would be in place when campaign starts:
  ▪ People will be more comfortable to talk about mental illness
  ▪ Professionals explaining issues better
  ▪ Open dialogue
  ▪ Engaging young people
  ▪ Greater integration of medical bodies and charities
  ▪ Better understanding of the community and its diversity
  ▪ Availability of more translated material – Turkish is the second language in Haringey
  ▪ Integration of faith groups
  ▪ Raising awareness amongst teaching staff

o Clarendon Mental Health Day Opportunities Services – the Clarendon Recovery College and Wellbeing Kitchen and Café

o Deliberate self-harm treatment at North Middlesex hospital

o Adult secondary mental health services (BEHMT ) are conducting annual review informed by “The National Confidential Inquiry into Suicide and Homicide by people with mental illness, Annual Report for England, Wales, Scotland and Northern Ireland 2012” report by the following ways:
  ● Developing a clinical risk assessment dashboard
  ● Looking at In-patient absence without leave (AWOL) training
    ▪ Engaging in adherence therapy training
a) Appendix 2 – Data Collection Template

Time period minimum over 3 years, if possible 10 years or 5 years.

Depending on Coroners database and confidentiality, following fields to be collected if possible:

Coroner’s database number ________

Paper record number ________

**Demographic details**

Gender male female

Age at death ____

Place of birth ________________________

Sexual orientation ________________________

Marital status single / in a relationship / married / co-habiting / divorced / separated / widowed / unknown

Employment status paid employment / unemployed / long term sick leave / retired / housewife/husband / student / other ______________

Occupation (or previous) ________________________

Dependants yes / no <16 yes / no >16 yes / no

Living circumstances homeless / alone / with parents / with spouse/partner / with children (<16/16 plus) Other shared / other ______________

Registered with a GP yes / no Length of registration ______________

Ward of GP ________________________

Residence of Ward ________________________

History of prison / YOI in last 12 months yes / no / unknown

Comment_____________________________

**Case details**

Date of death / Year of death ________________________

Location of death home / hospital / mental health inpatient setting / other ______________

Mode of death ________________________

If poisoning: specify substance where was it obtained from? ______________

Alcohol at time of death? yes / no / unknown

Other non-prescribed drugs? yes / no / unknown

Comment_____________________________

Verdict suicide / open

Suicide note present yes / no Relationship problems yes / no / unknown

Known antecedents prior to suicide ________________________

In the opinion of the coroner any lessons learnt?

_____________________________

**Behavioural details**

History of DSH yes / no / unknown

Comment_____________________________

History of previous attempt yes / no / unknown

Comment (# in past 12 months)_____________________________

History of violence yes / no / unknown

Comment_____________________________

History of alcohol misuse yes / no / unknown

Formal treatment yes / no / unknown

Date from death & with whom ______

History of drug misuse yes / no / unknown

Formal treatment yes / no / unknown

Date from death & with whom ______

_____________________________
Problems with compliance? yes / no / unknown
Comment __________________________________________

Language difficulties? yes / no / unknown Comment
(medication / missed appointments)

Health details

Physical health conditions yes / no / unknown specify ______________________________
Known to mental health services yes / no / unknown diagnosis________________________
Past / Current / made in past 12 months / Unknown
Prescribed medication _____________________________________________________________

Last known contact with services

Any contact with primary care in the last 12 months? yes / no / unknown
Reason __________________________________________
Risk an issue? yes / no / unknown ______________________________
Action: _______________________________________________________
Interval between death and date of last contact with primary health service
Number of contacts in the last 12 months ____________
Any A&E presentations in the last 12 months? yes / no / unknown
Reason __________________________________________
Risk an issue? yes / no / unknown ______________________________
Action: _______________________________________________________
Interval between death and date of last contact with primary health service
Number of contacts in the last 12 months ____________
Any contact with mental health services in the last 12 months? yes / no / unknown
Risk an issue? yes / no / unknown ______________________________
Action: _______________________________________________________
Interval between death and date of last contact with mental health service
Any psychiatric inpatient discharge in the last 12 months? yes / no / unknown
Interval between discharge and death ______________________________
Interval between discharge and first contact ______________________________
Subject to CPA? No / Standard / Enhanced / Not clear
Evidence of risk assessment being carried out? yes / no / unknown
Patient's status at time of death outpatient / inpatient / day hospital / inpatient on leave / AWOL
Any of the following involved with the patient in the last 12 months of life?
CPN / SW / Health visitor / Psychiatrist / District/Practice nurse / Counsellor / Other
Did the patient refuse help? yes / no / unknown
Comment __________________________________________
C) Appendix 3 – Search Fields

For years 2002-2012:

- Year of death
- Gender
- Age
- Place of birth
- Presumed ethnicity
- Marital Status
- Occupation
- Ward of residence
- Location of death
- Cause of death
- Verdict (suicide or open)

Additional fields for 2008-2012 if possible through extra information from uploaded reports and documents:

- Living circumstances
- History of prison
- Alcohol at time of death
- Toxicology
- Suicide note
- Any antecedents
- History of deliberate self-harm or previous attempt
- History of drug / alcohol abuse
- Past medical history diagnoses
- Psychiatric history diagnoses
- Any GP contact
- Any Mental Health contact
- Risk assessment
- Psychiatric medication
- Recent Psychiatric inpatient admission
- Any extra notes
4. 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
7. Suicides associated with the 2008-10 economic recession in England: time trend analysis; Barr Ben, David Taylor-Robinson, Alex Scott-Samuel, Martin McKee and David Stuckler, British Medical Journal, 2012
13. NHS information Centre 2009-2011
14. Statistical neighbours share similar population demographics and are different to geographical neighbours
16. Analysis of Haringey suicide data 2006-07, part of Annual Suicide Prevention Audit, BEHMHT