Cheshire West and Chester Suicide Audit 2020-2024: Executive Summary

1. Acknowledgements

We would like to thank Cheshire Coroner's Court for allowing us to access the inquest files and enable the completion of this audit. We would also like to acknowledge the families and friends of those who have died by suicide. We recognise that, although the individual is no longer burdened by the distress that preceded their death, those who knew and loved them continue to live with deep and enduring sorrow. We acknowledge the profound impact such loss has on families, friends, and communities. We appreciate the hurt and devastation created by suicide, and we hope through this audit we act on the lessons learned to make improvements to prevent this in the future. We are committed to learning from every loss, so fewer families endure such tragedy in the future.

2. Introduction

This suicide audit reviewed cases of individuals living in Cheshire West and Chester who died in the borough and also individuals who died in the borough but were not a resident. Cases relate to inquests that concluded between 1 January 2020 and 31 December 2024. In total, 196 cases were included in the audit, including 190 cases with a suicide verdict and 6 narrative cases indicating suicidal intent.

The audit provides a detailed analysis of local suicide patterns, risk factors, service contacts, and opportunities for prevention. The findings show a clear upward trend in suicide rates across the borough, driven largely by an increase in male suicide. The audit identifies several modifiable risks, areas of unmet need, and system gaps that require coordinated action across health, social care, community and voluntary services.

3. Key Findings

- The local suicide rate has risen significantly, reaching **14.3 deaths per 100,000** in 2022-24 - **higher than the England average** of 10.9 per 100,000.

- Men account for **three quarters (77%)** of suicide cases, consistent with national patterns, while female suicides have increased in recent years.

- The highest number of deaths occurred among **45-64year olds (38%)**, with females more likely than males to be aged 25-44. The most common method was **hanging (64%)**, and nearly two-thirds (**62%)** of suicides occurred in the person's home.

- Patterns of vulnerability were widespread across the borough, cutting across urban and rural areas. Socioeconomic factors played a role, with more suicides than expected occurring in the most deprived neighbourhoods. However, deprivation alone does not explain the distribution of deaths.

- Clinical risk factors were common. Nearly **three-quarters (73%)** of individuals had a diagnosed or suspected mental health condition, yet **over a quarter (29%)** of those with a diagnosis were **not known** to mental health services. **Half (49%)** of all cases had previously been in contact with mental health services, and **one in five** had contact in the week before death. Despite this, many experienced **delayed access**, disengagement without follow-up, or gaps in crisis planning and family involvement.

- Other contributory factors included **physical health problems (58% of cases)**, **previous suicide attempts (39%)**, **chronic illness (38%)**, **self-harm (31%)**, **bereavement (26%)**, **financial pressures (22%)**, and **relationship breakdown (17%)**. Women were more likely to have experienced domestic abuse, self-harm, or loneliness.

- A significant proportion of cases (1 in 6) **had no recorded service contact at all** in the year before death, even though those who did access help most often engaged with GPs, A&E, mental health services, or crisis teams.

4. Recommendations

The audit highlights several opportunities to strengthen the local suicide prevention system:

- **Strengthen workforce capability** by expanding suicide prevention training across frontline services - including primary care, emergency departments, social care, housing, criminal justice and the voluntary sector - with enhanced training for staff supporting higher risk groups.

- **Improve access, responsiveness and continuity** within mental health services by reviewing crisis pathways, addressing waiting lists, improving triage, strengthening follow-up, and involving families/carers more routinely.

- **Enhance the role of primary care** through improved identification, structured medication reviews, proactive follow-up for non-attendance, better coding, and stronger links with crisis and mental health teams.

- **Improve data quality** within coronial records to strengthen real time intelligence and better target interventions.

- **Address broader social and economic risks** by ensuring timely support for housing, employment, financial stress, trauma, and domestic abuse.

- **Promote safety planning and means restriction**, focusing on the home environment and high-risk public locations.

- **Develop community based and targeted support**, including crisis cafés, men’s mental health groups, bereavement support, and interventions for groups at increased risk (e.g. middle-aged men, young women, people living alone, LGBTQ+ individuals, those with chronic illness, or criminal justice involvement).

- **Strengthen governance** by updating the local Suicide Reduction Action Plan with clear accountability and ensuring future audits take place more frequently to support continuous learning.

5. Finding Help

It's okay not to be okay and there are many services that can offer free help and support**:**

- If you or someone you know is in need of help for a mental health crisis or emergency, you can go to NHS 111 online or call 111 and select the mental health option.
- Samaritans: 24/7 service for anyone struggling to cope. Call 116 123 for free.
- Papyrus: 24/7 suicide prevention helpline for persons under the age of 35, or anyone concerned about a young person. Call 0800 068 4141 or Text 88247
- CALM: Suicide prevention helpline, open from 5pm – midnight every day on 0800 58 58 58. Contact through WhatsApp and Live Chat are also available.
- Cruse: Bereavement support at 0808 808 1677. Open Mon, Weds, Thurs and Fri 9.30am – 5pm, and Tuesday 1pm – 8pm.
- GamCare: 24/7 helpline for anyone affected by gambling harms. Call 0808 8020 133, WhatsApp on 0208 3031 8881 or visit the website for Live Chat.
- The National Domestic Abuse Helpline: 24/7 support at 0808 2000 247 for anyone who is or knows someone experiencing domestic abuse.