Wakefield Suicide Audit 2019-21

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Foreword

This report describes what we know about people who died by suicide from the Wakefield District between 2019 and 2021. Information in the report is presented as charts and percentages but every case the team reviewed describes the life of a person with friends, family, and colleagues. The reasons behind every death by suicide are complex and individual. This audit will help us to understand factors they had in common. This knowledge will help us develop our Suicide Prevention Strategies and by doing so, to prevent future tragedies.

Steve Turnbull
Director of Public Health
Wakefield Council

The Wakefield Suicide Audit 2019-21 includes information on 120 Wakefield residents who died by suicide. One such death is one too many, and each one leaves people behind whose lives are shattered by the loss. It is my hope that nobody should ever reach the point where they feel that suicide is their only option.

This report was published in May 2024.

Introduction

****** Content warning. This audit report discusses suicide and data and statistics about people who died by suicide ******

The 2023 national policy paper, ‘Suicide prevention in England: 5-year cross-sector strategy’ highlights that timely and high quality data, evidence and intelligence allows for better understanding of the drivers of suicide, the development of more effective interventions, and more rapid responses to prevent suicides.

It is the responsibility of local authorities, through their public health teams, to undertake audits and produce up to date information about suicide to inform local planning and suicide prevention strategies.

This audit is the fifth undertaken in Wakefield and covers people whose deaths were registered as due to suicide in the period January 2019 to December 2021.

What are the aims of the audit?

- Gain an understanding of local suicide patterns.
- Compare local data and trends with national data.
- Identify any high-risk groups.
- Identify any high-risk locations locally.
- Identify any frequently occurring or similar issues in the circumstances of people who died by suicide.
- Inform future suicide prevention strategies and action planning.
- Contribute to a better understanding of suicide epidemiology across Yorkshire and the Humber.

The purpose of this report is to present the audit findings in a way which will inform our Wakefield Suicide Prevention Strategy, helping us to plan the most effective ways to address this preventable cause of death.

How will the audit make a difference?

Suicide is a high priority public health issue for Wakefield.

The rate of people taking their own lives by suicide is higher in Wakefield than in England and Wales, and we are committed to bringing this number as close to zero as we can. Each death by suicide is one too many.

Our suicide prevention activity is overseen by Wakefield's Health and Wellbeing Board and contributes towards delivering outcomes set out in the Wakefield Corporate Plan.

Wakefield has a Suicide Prevention Strategic Group which includes primary and secondary healthcare, third sector, education, media, the police, fire service, transport and rail sector, and the local authority among others. Because the factors leading to someone taking their own life are complex, no one organisation is able to directly influence them, and suicide prevention is really everybody's business.

The Wakefield Suicide Audit will be used alongside local suspected suicide surveillance data, the national evidence base, information from the Office for National Statistics (ONS), and knowledge and insight from agencies across Wakefield and those affected by suicide. It is a key tool in helping us to understand common risk factors or circumstances that occur when people die by suicide in Wakefield, and to use this insight to develop and deliver effective interventions to prevent future tragedies.

Wakefield's multi-agency Suicide Prevention Action Plan will be refreshed using new insights from this audit and continue to be delivered by the Strategic Group described above.

Findings at a glance

- The Wakefield Suicide Audit 2019-21 includes 120 Wakefield residents who died by suicide in that time period.
- Two thirds of the people in the audit were male, compared to one third female.
- There were higher rates in males aged 20-59, in particular those aged 20-29.
- Methods of suicide varied between males and females, also between age groups.
- Rates of suicide were not significantly different in different areas of the district. There was no clear association between suicide and areas of deprivation.
- There was no location of concern identified in Wakefield with the majority of deaths happening in the person's own home.
- The median number of risk factors is 5 (ranging from one recorded risk factor to 13), showing the complexity of suicide cases.
- Having a history of mental health issues was the most common risk factor recorded.
- Just under half of people who died by suicide had a history of alcohol and/or drug misuse.
- A quarter of people who died by suicide had some kind of financial difficulty recorded in the audit.
- Just under half of people in the audit were in contact with their GP within three months of their death.
- A third of people in the audit were in contact with specialist and/or community mental health services at some point in their lives.

Context

Office for National Statistics (ONS) data on suicide - national comparison

The main purpose of this report is to summarise the findings of our local audit, which reviewed deaths in Wakefield District over a three-year period between 2019 and 2021. This section uses nationally published data to compare Wakefield District to other areas of the country.

The ONS collects and publishes data on the number of suicide registrations in each local authority area, and for England and Wales overall. This provides opportunities for comparison with other areas and trends over time.

These rates are available as a three-year average with a two-year delay before its publication.

These numbers are not identical to our audit data, due to different collection methodologies. The ONS data include some deaths caused by injury/poisoning of undetermined intent which were not included in the current audit.

How does the ONS collect and publish data on suicide?

The ONS usually releases data on suicides every year at the start of September. The latest published data for 2023, however, was delayed and released in December 2023 and is a culmination of three years data from 2020-2022: ONS Suicides in England and Wales: 2022 registrations.

ONS published figures show information about suicide registrations that happened in a given calendar year, including in each local authority area.
The ONS publishes suicide registration data in two ways:

Counts - the number of suicides registered each year in a local authority, regionally and nationally.

Counts alone can give a misleading picture because they do not take account of the size of the local authority's population. They also do not consider the age structure of a local authority's population. As we know that people in some age groups are at greater risk of dying by suicide, again this can give a misleading picture.

Rates – the ONS publish Age Standardised Mortality Rates as a more reliable way of understanding trends in the suicide data (how it is changing over time) and comparing different areas.

Age-standardised mortality rates (ASMR) allow for differences in the age structure of populations and therefore allow valid comparisons to be made between geographic areas and over time.

The ONS publish an age standardised mortality rate which calculates the number of deaths by suicide per 100,000 people for each local authority, taking into account differences in population size and age structure.
Because total numbers are small, the rate is presented as a three year rolling average.

Coroner’s inquests for suicide

In England and Wales, all deaths that are suspected to be suicide are referred to the coroner. An investigation into the circumstances of the death are reviewed at a coroner's inquest. Evidence relating to the circumstances of the death are reviewed, this includes statements from the police, witnesses, and family and friends of the person who has died, medical records, autopsy and toxicology reports and other relevant evidence. If the cause of death is identified as suicide it is certified by the coroner and cannot be registered until the inquest is completed. There are delays between the date of the suicide and the date of the inquest and so the number of registrations in a year does not equal the number of suicide deaths in that year. Delays can vary considerably from coroner to coroner.

Change in the standard of proof used by coroners

In England and Wales, when someone dies unexpectedly, a coroner investigates to establish the cause of death. In July 2018, the standard of proof used to determine whether a death was caused by suicide was lowered to the "civil standard"; balance of probabilities. Previously a "criminal standard" was applied; beyond all reasonable doubt.

This makes it slightly more likely that a person’s death will be registered as being due to suicide. However, since the change in the standard of proof, suicide registration rates have not seen unprecedented increases when explored by ONS nationally (report).

Wakefield compared to regional and national rates - ONS data

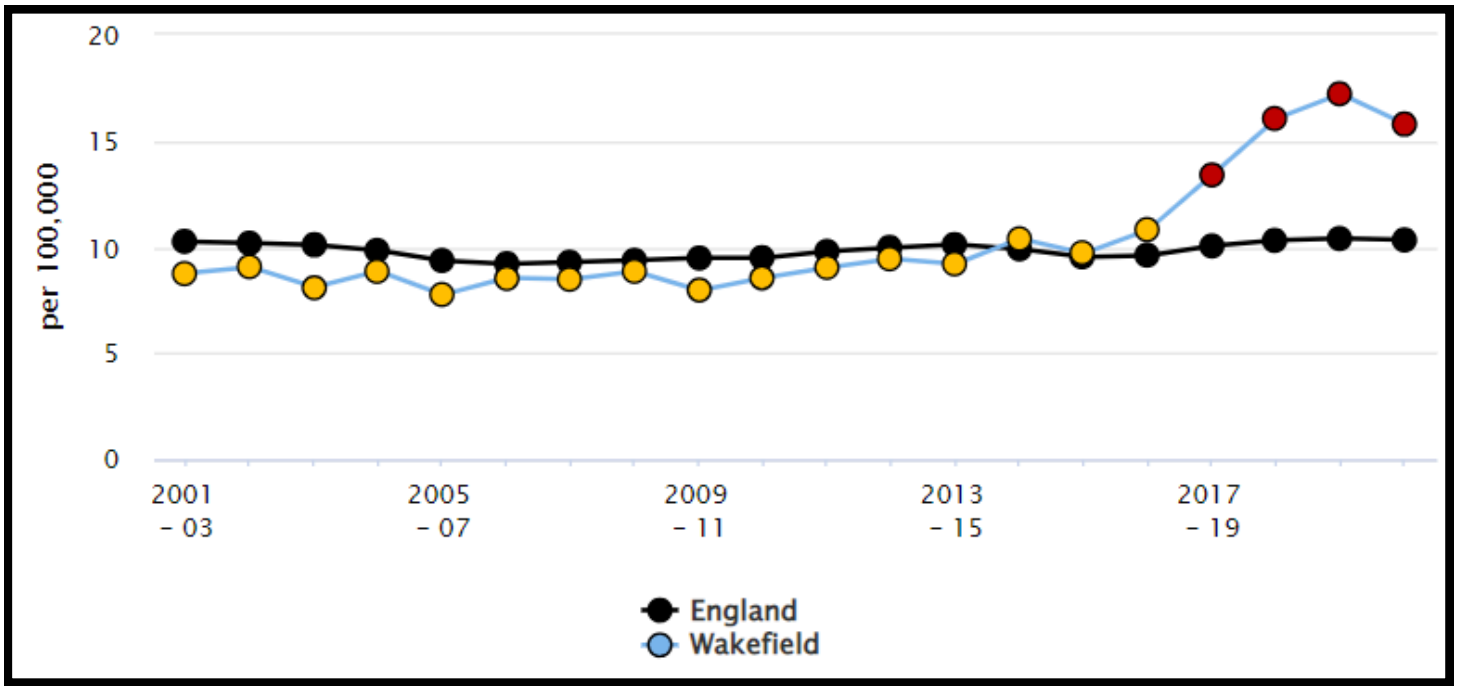
ONS data shows that in 2022, there were 5,642 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people; this is the same as in 2021 (5,583 registered suicides equivalent to a rate of 10.7 deaths per 100,000 people).

The most recently published data for Wakefield (2023) shows an age standardised rate for 2020-22 of 15.8 deaths per 100,000 people.

This is higher than the overall rate in England and Wales, and higher than the West Yorkshire rate of 12.5 deaths per 100,000 people. Wakefield has the second highest rate of death by suicide in Yorkshire and Humber.

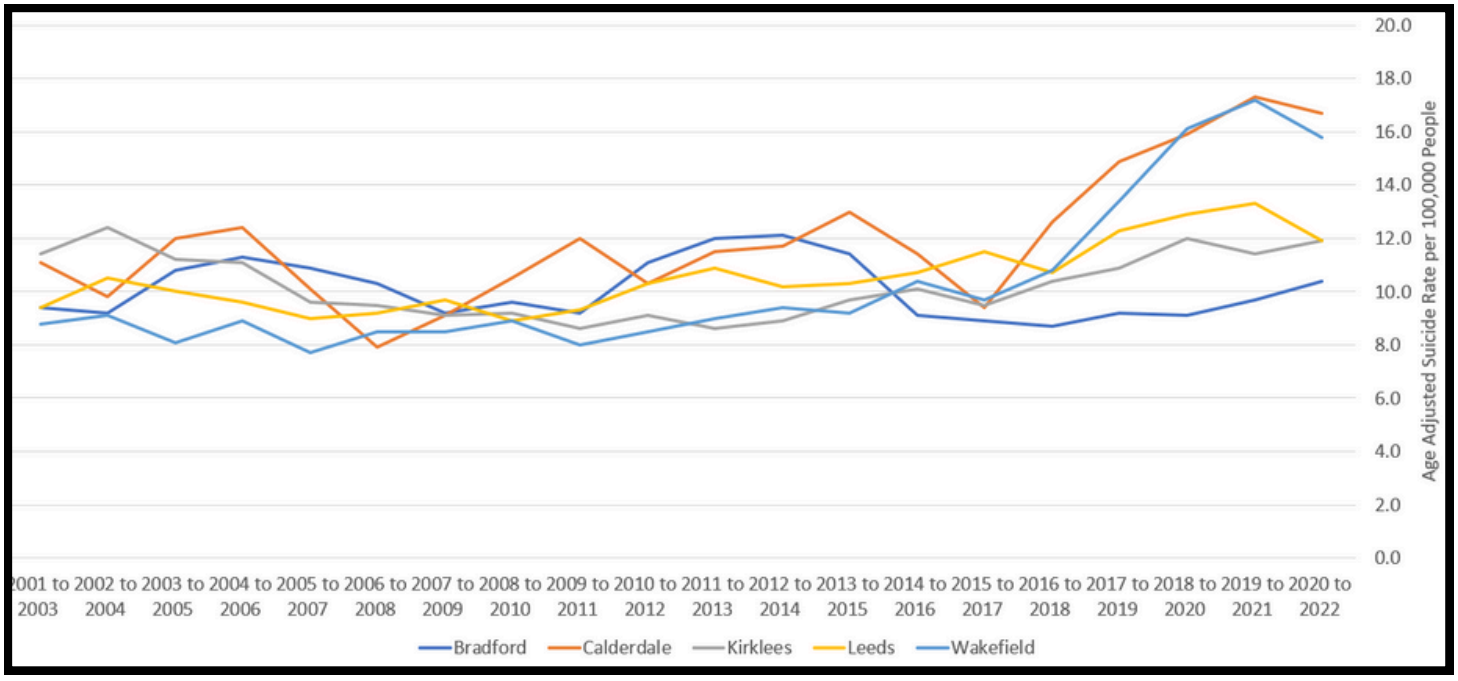
We have seen a reduction from the 2021 rate, in part because a particularly high number of deaths in 2019 is no longer included in the three-year average. Although it is good to see this positive change, suicide prevention remains a high public health priority in Wakefield District.

Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population



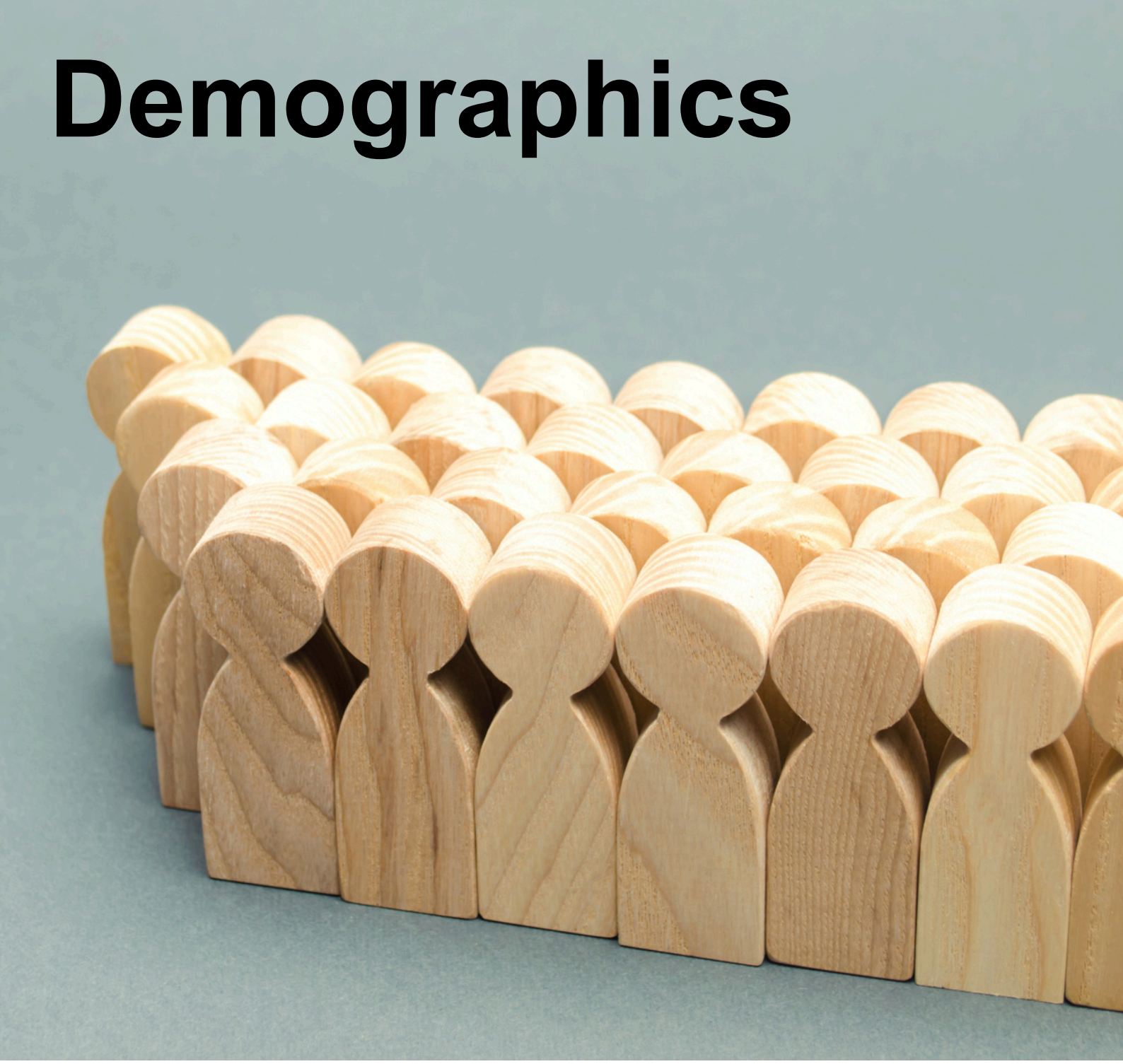
Wakefield suicide rate trend compared with England average over several years (Source: OHID Fingertips).

Age-standardised mortality rate from suicide per 100,000 population, by West Yorkshire Local Authority



Wakefield suicide rate compared with West Yorkshire Local Authorities (Source: Office for National Statistics).

Demographics



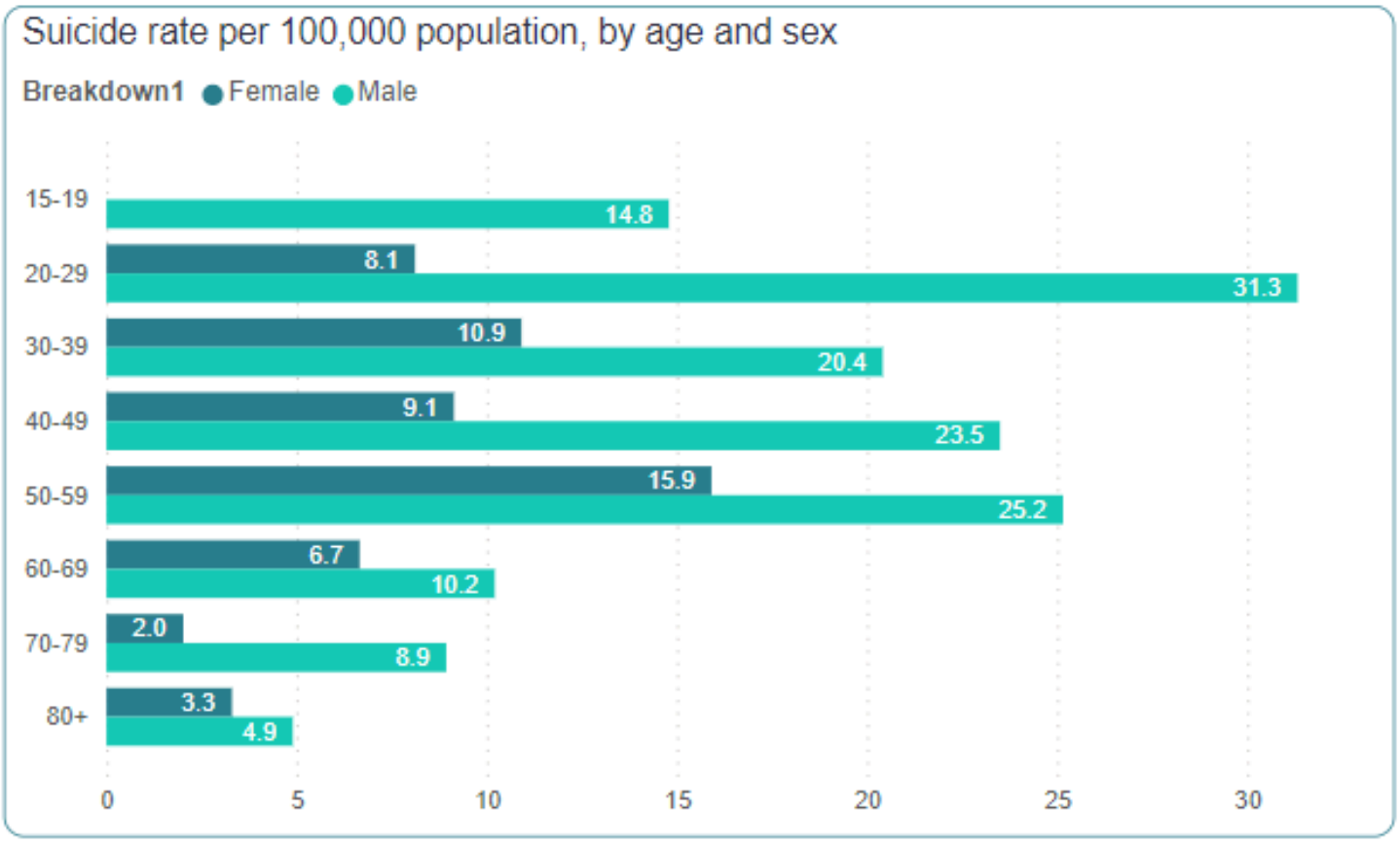
- Just over two thirds (68%) of people in Wakefield who died by suicide in the audit were men. The highest rate of deaths was in men aged 20-29.
- Two thirds (66%) of people in the audit were single, divorced, widowed or separated.
- Just over one third (34%) of people in the audit were living alone.

Demographics

This section describes some of the demographic information including age, sex and ethnicity. Individual characteristics will affect a persons risk of suicide.

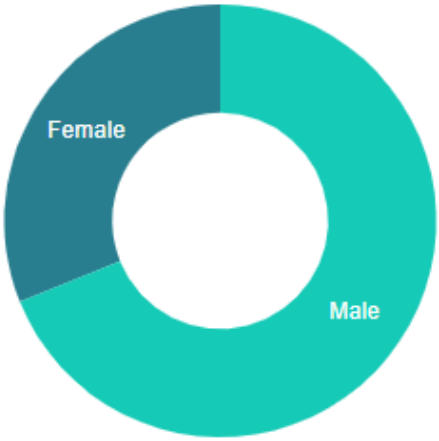
Age

- **The highest crude rate of deaths by suicide was in males aged 20-29 at 31.3 per 100,000 population.**
- **In females, the highest crude rate was in the 50-59 age group at 15.9 per 100,000.**



Sex

- **Just over two thirds (68%) of people in Wakefield who died by suicide in the audit were male.**

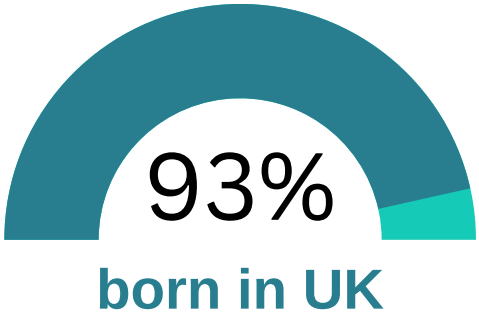


Ethnicity

- A person's ethnicity is not routinely recorded on the coroner system, therefore auditors were reliant on evidence from other coronial documents such as the post-mortem report, witness statements and GP reports.
- **An ethnicity could not be identified for 20% of people in the audit.**
- **Of the 80% of people for whom the audit team could determine an ethnicity, 94% were of white British or other white background.**
- Wakefield has a Gypsy and Traveller population, with some community members living on the Heath Common Traveller Site. This group was identified as a possible high risk group for suicide in a recent health needs assessment, with residents on the site describing bereavement by suicide as a very common experience. It was not possible to clearly identify members of the Gypsy and Traveller population in the audit due to a number of factors, including traveller status not being recorded, stigma or worries about discrimination, and people being bereaved of friends or relatives in other communities across the region and country.

Place of birth

- **The majority of people who died by suicide in Wakefield were born in the UK (93%). Just over half (55%) of all people in the audit were born in Wakefield District.**

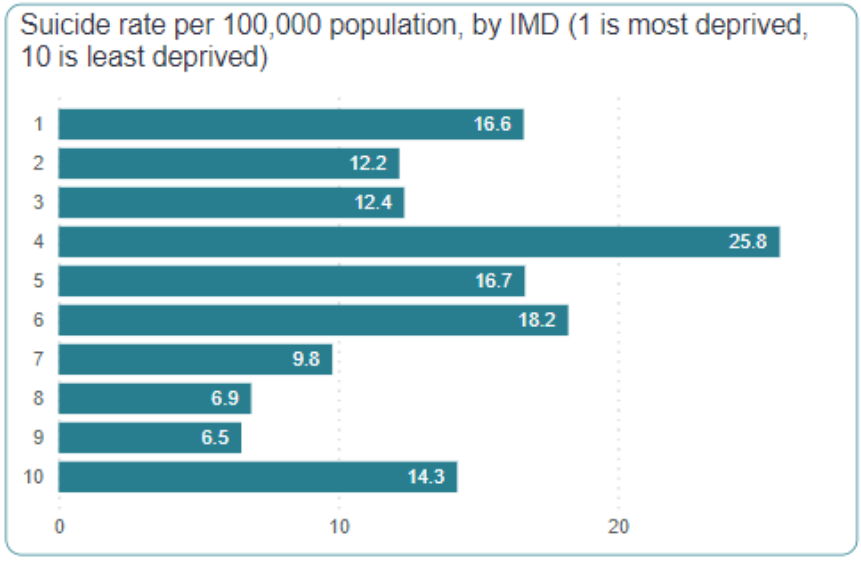


Sexual orientation and gender identity

- Sexual orientation is not routinely recorded in coroners' verdicts or inquest reports. Nor is whether a person's gender identity was different from that assigned at birth.
- Auditors were therefore reliant on other documents in the coronial files which might mention sexual orientation or gender identity, or circumstances from which either of these might reasonably be inferred (for example, the sex of a partner).
- **The number of people whose gender identity differed from that assigned at birth was too small to report.**
- **In 13% of cases there was no information relevant to the person's sexual orientation.**
- **85% of people in the audit were inferred to be heterosexual.**

Place of residence and deprivation

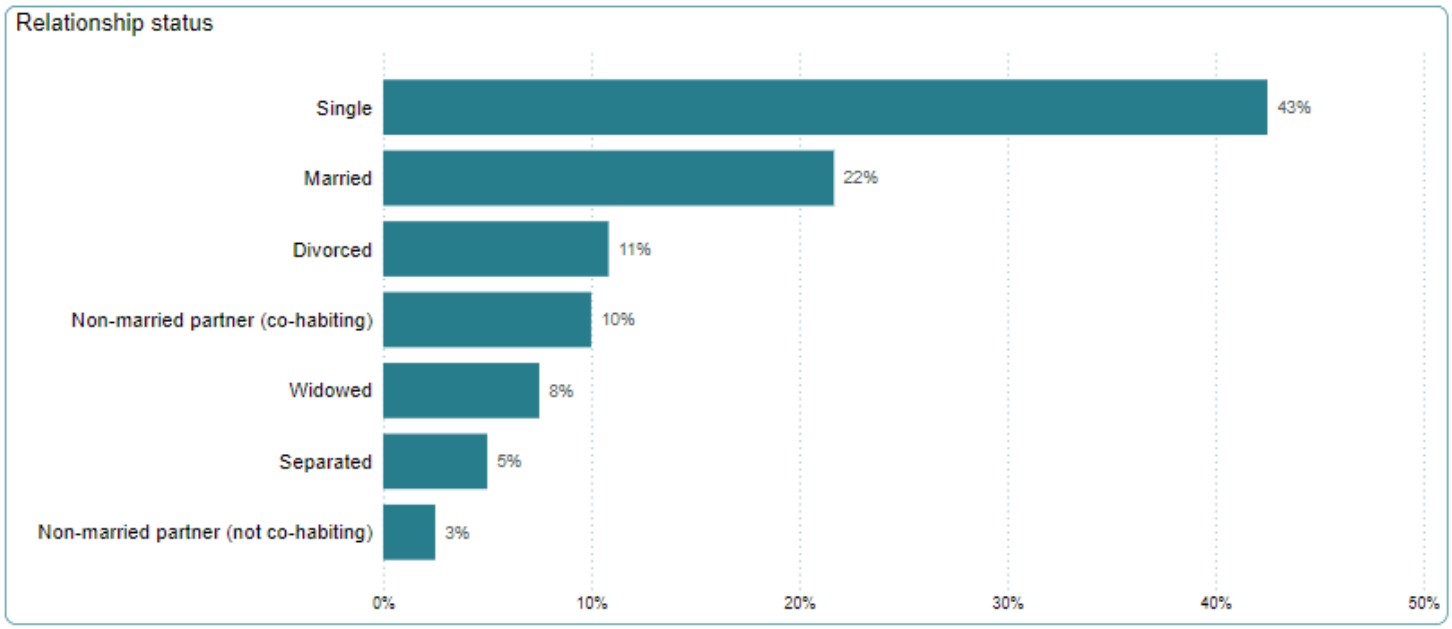
- **Rates of suicide were not significantly different in different areas of the District.**
- The Index of Multiple Deprivation (IMD) measures the relative deprivation of small areas in the UK, based on a range of indicators including income, health and crime, and assigned using a person's postcode.
- We looked at crude rates of suicide by deciles of IMD deprivation, based on the person's home postcode.



There is no clear relationship between deprivation and the rate of suicide.

Relationship status and living situation

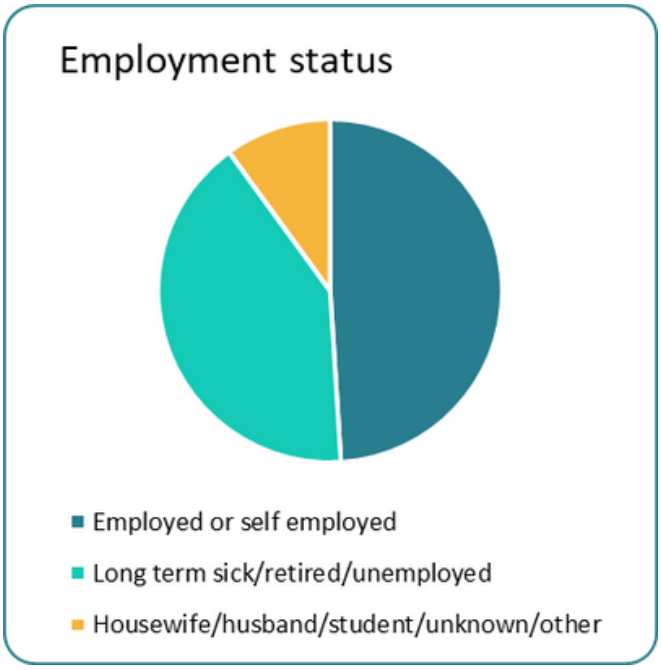
- Relationship status within the audit was categorised as single, married, divorced, widowed, separated, non-married partner (co-habiting), and non-married partner (not co-habiting).
- **The largest group of people in the audit were recorded as being single (43%)**.
- Just over one third (34%) of people who died by suicide were living alone.
- **Two thirds (66%) of people in the audit were recorded as single, widowed, separated or divorced.**



The potential impact of relationship breakdown, whether recent or in the person's past, is discussed further in the section on Risk Factors.

Employment

- **Nearly half of people who died by suicide were employed or self-employed (49%).** According to the 2021 Census, 57% of Wakefield District (aged 16 and over) were in employment.
- **A slightly smaller percentage (41%) were unemployed, retired, long-term sick or disabled.**
- A smaller percentage (10%) were students, homemakers, or had unknown employment status.



Carers and veterans

- Carers and veterans were identified as groups at possible higher risk of suicide when the audit was being developed.
- **A small number people in the audit were identified as carers (3%), whether paid or unpaid. This is possibly an underestimate as it may not have always have been recorded.** In the 2021 Census, 11% of the Wakefield population (aged 16+) were identified as unpaid carers.
- **A small number of people who died by suicide were identified as veterans (4%).** The same percentage of the Wakefield population were identified in the 2021 Census as having served in the regular or reserve forces at some point in their lives.

****** Content warning. This section includes information that may be upsetting and distressing to read ******

Circumstances

- **No high risk location for suicide was identified in Wakefield District.**
- **The majority of suicides (seven out of ten) happened in a person's own home.**
- **Over two thirds of deaths were caused by hanging/strangulation.**

Circumstances

Identifying the circumstances of a persons death can help to inform prevention strategy. Understanding where people have taken their own lives can be important if a particular location is involved, especially a public place. This can help us to plan interventions to reduce the risk in a particular location.

Understanding the methods used by people is also important if it identifies preventative actions that can be taken. A historical example would be the introduction of restrictions on sales of over-the-counter medicine.

The suicide audit can be used alongside local suspected suicide surveillance to identify if there are any emerging changes in location or method of suicide in Wakefield.

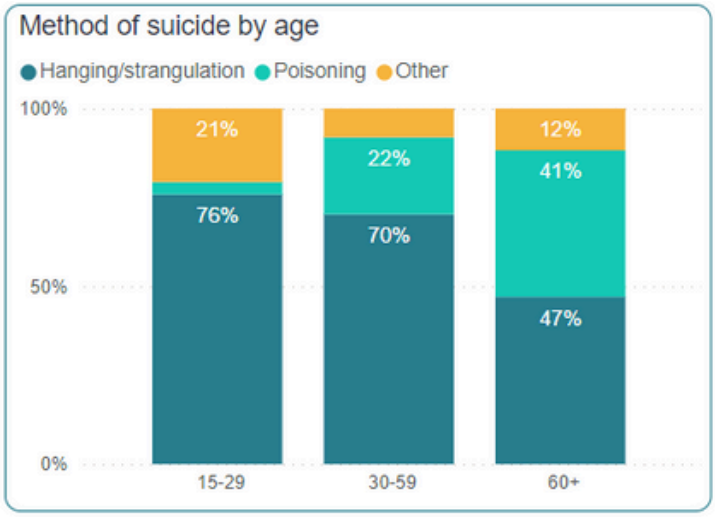
Location

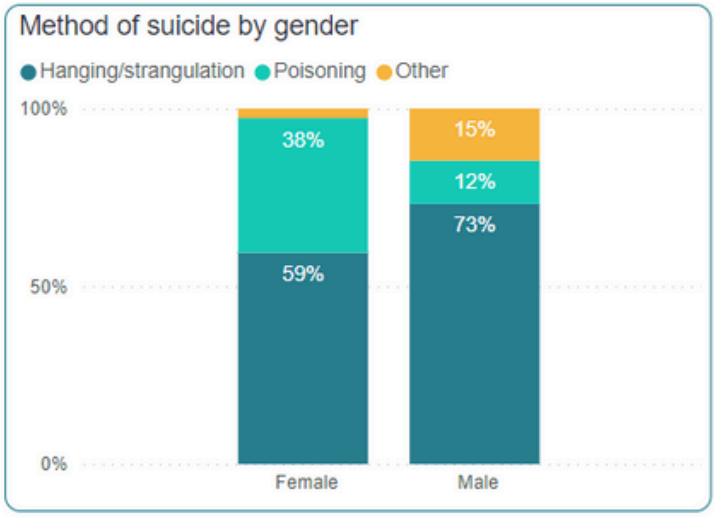
- **No specific locations of concern were identified in the Wakefield audit. The majority of suicides (70%) happened in the person's own home and one in ten (10%) happened in a park or greenspace.** A small number of deaths happened on the railway network (3%).

Method

- **Hanging/strangulation was the most common method of suicide across all ages with just over two thirds (68%) of all suicides.** Poisoning, generally due to overdose, account for 20% of all suicides.
- **There were differences in method between men and women, and also between age groups.** Hanging/strangulation was used in just under three quarters (73%) of suicides in men and 60% of women.

- Poisoning was more common in women, used in 38% of cases. It was also more common in older age groups, used in four in ten (41%) of suicides in people aged 60 and over.



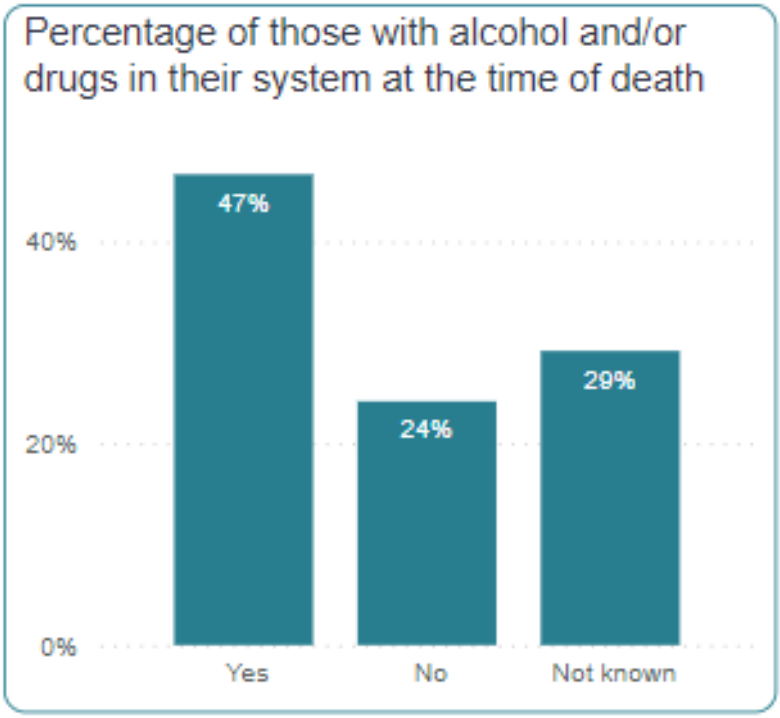


Suicide intention

- Understanding whether people had left evidence of their intention helps us to be sure that the person did intend to take their own life, and therefore to consider what intervention might have been possible.
- **Just under half (45%) of all people who died by suicide provided some evidence of suicide intention.** The majority of these left a note but there were also text/social media messages, as well as a small number of verbal exchanges.
- Women were more likely to provide evidence of their intention with 57% doing so, compared to 39% of men.
- Messages included providing reasons for their actions and apologising to and stating their love for family and friends. Some people provided passwords and access to accounts and pensions.

Alcohol and/or drugs at the time of death

- Prior to the COVID-19 pandemic, almost all cases of suicide in Wakefield included a toxicology report on the coroner's system, which would tell us whether the person who died had alcohol or drugs in their system at the time of death. From July 2020 onwards, a toxicology report was not a routine inclusion in documentation due to the pandemic.



- We are therefore unable to say whether alcohol and/or drugs were in the systems of almost a third (29%) of people who died.
- **Nevertheless, we do know that just under half (47%) of people who died by suicide had alcohol and/or drugs in their system at the time of their death. Given the information above, this is likely to be an underestimate of the total number.**
- Of the 47% of people with alcohol and/or drugs in their systems:
  - 73% had alcohol present.
  - 55% had drugs present, with the vast majority including at least one controlled drug.

Risk Factors

- The median number of risk factors identified was five. A history of Mental Health issues was the most commonly recorded.
- Just under half of people who died by suicide had a history of alcohol or drug misuse.
- More than four in ten people had previously attempted to take their own life.

Risk factors

This section describes the factors that may have contributed to a person's decision to take their own life. Understanding these risk factors is extremely important, as it helps us to understand who may be at risk and how we can identify those people and provide support before they reach a point of desperation.

The audit team searched for evidence in the records of 24 factors which are known or thought to be associated with suicide plus any other factors were noted as 'other'. These factors may have been recent or have occurred some time in the past. The team only recorded them if there was evidence from the inquest or coroner's files to suggest they could have contributed to the person's death. For example, a divorce or bereavement some years before the person's death would only be noted if the inquest evidence suggested that it had continued to affect the person.

'Contribution of COVID-19 pandemic' was added as an additional factor in this audit.

The audit relies on what is recorded in the coroner's files. These are not a structured or comprehensive record. In some cases, there may have been factors contributing to the person's state of mind or decision that have never been recorded anywhere.

Many people will have some of these risk factors in their lives and history and thankfully, very few people die by suicide. The findings of the audit, and established evidence, suggest that a combination of risk factors can be of particular concern.

Case complexity - combined risk factors

- We looked at how many risk factors associated with people who die by suicide were recorded for each person.
- In individual cases, the number ranged from one recorded risk factor to 13.
- **The median (average) number of recorded risk factors was five.**
- This emphasises that **the causes of suicide are often complex, and that a mixture of several different risk factors, events or circumstances are likely to contribute to a person's decision to take their own life.**

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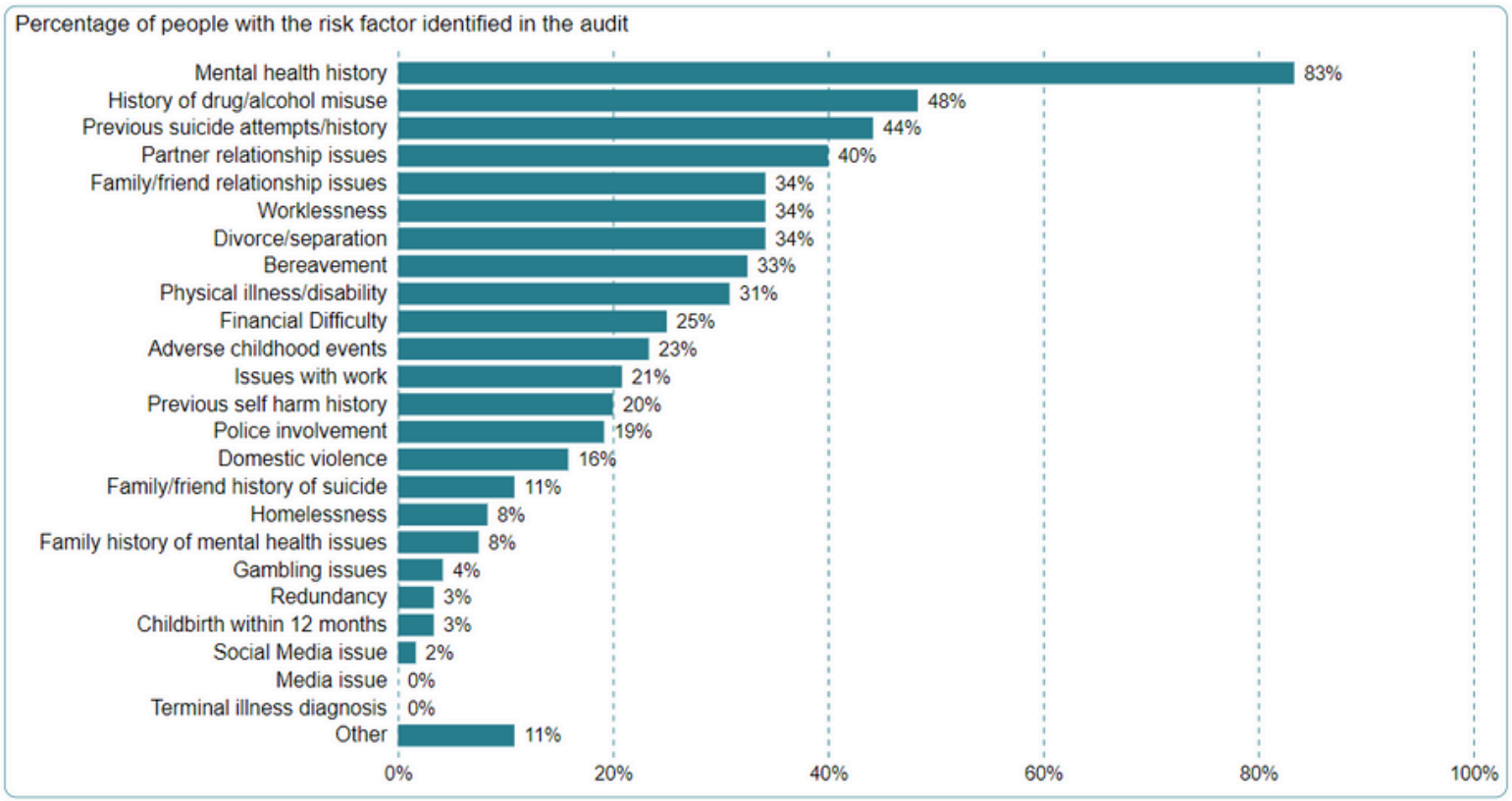
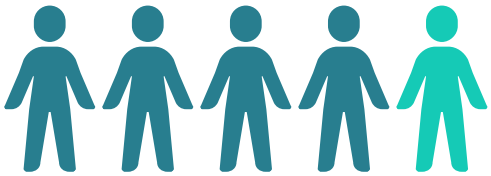
Median number of risk factors



History of Mental Health issues

- **Over 80% of people in the audit had a history of mental health issues recorded.** These ranged from extensive issues over a long period of time to a low mood recorded in the last month of a person's life.



4 out of 5 people had a history of mental health issues recorded

- Depression, anxiety and/or low mood were the most common mental health issues recorded.
- **It is important to note that there are over 40,000 adults in Wakefield with an unresolved GP record of depression and 3,700 with a serious mental illness diagnosis. Proportionately, the 96 people represented in this audit with a history of mental health issues are a tiny fraction of that number.**
- The interactions between the people who took their own lives and various support services is discussed further in the 'Access to Services' section.

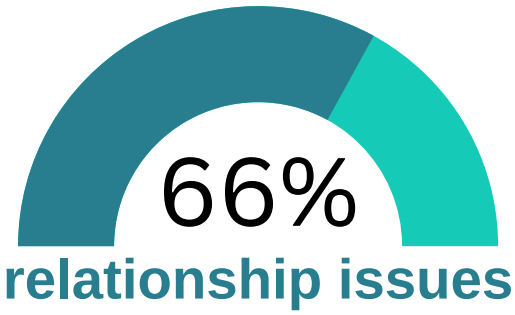
History of drug and/or alcohol misuse

- **Just under half (48%) of people who died by suicide have drug and/or alcohol misuse recorded.** Of these, the majority (88%) had experienced this within the last year of their lives.
- Over half of females who died by suicide had a history of drug and/or alcohol misuse recorded (54%), with 46% of males having a history recorded.
- Drug misuse was recorded in 31% of cases and alcohol misuse was recorded in 32% of cases. Of the cases where drug misuse had been recorded, more than half (57%) involved cocaine.
- A very small number of cases included the misuse of prescription drugs, however these were always recorded alongside misuse of other Class A controlled drugs.

Previous suicide attempts and self harm

- **Just under 45% of people who died by suicide were known to have previously attempted suicide.**
- Of those, just under half were known to have made an attempt within the last year of their life.
- One in five (20%) people in the audit were recorded as having a history of self-harm.
- Attempts recorded in the coroners' files were generally where an A&E attendance had been necessary. It is impossible to know how many previous attempts might have happened but were not recorded because the person did not present to services. Nevertheless, this highlights the importance of support and vigilance for people who have already attempted suicide.

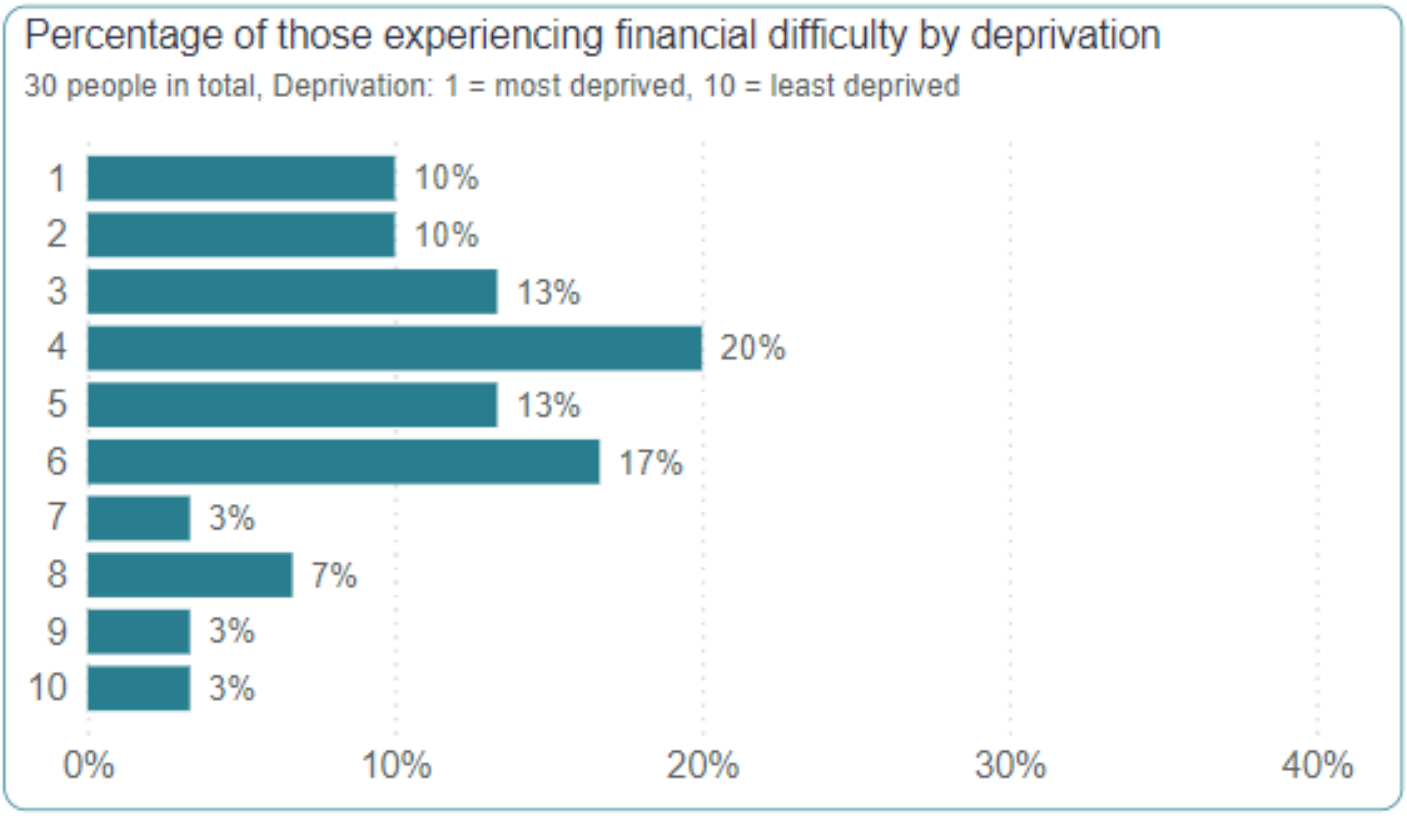
Relationship issues (including partner, friend and family, divorce or separation)



- **Two thirds of people who died by suicide (66%) had a relationship issue recorded in the audit.** This could concern a partner, friend or family member(s), or could indicate a divorce or separation.
- The audit team recorded this as a factor if there was evidence in the coronial files that the issue was thought to have a bearing on the person's death. This applied whether the relationship issue was recent or in the past.
- Just over a third (34%) of people had a divorce or separation recorded as a factor in the audit.

Financial Difficulty

- **A quarter of people (25%) who died by suicide had some kind of financial difficulty recorded in the audit.**
- Financial difficulty was less common in the least deprived areas, however those who had experienced financial difficulty were not necessarily living in the most deprived areas of the district.



Physical Illness and disability

- **Physical illness and/or disability was recorded in just under a third (31%) of people in the audit.** The most common age group where physical illness and/or disability was recorded was in those aged 50-59 (38% of those recorded as having a physical illness and/or disability).

Worklessness

- **Worklessness was recorded in just over a third (34%) of cases.** There were common recordings of people who had worked little in their life, were signed off work due to physical or mental health issues, and those who had been made redundant or lost their job.

Bereavement

- The audit team recorded this as a factor if there was evidence in the coronial files that the person had suffered a bereavement which was thought to have a bearing on their death. This applied whether the bereavement was recent or in the past.
- **A third (33%) of people in the audit had been through a recent or significant bereavement.** Three quarters (74%) of these were aged between 30-59 at the time of their death.
- The loss of a parent was most commonly recorded and, in the vast majority of cases, the bereavement was a direct relative - parent, partner, sibling, child or grandparent. Some people experienced multiple significant bereavements.
- One in ten people had a family member or friend who had taken their own life.

Police involvement and domestic violence

- **One in five (19%) people had a previous history of contact with the police, a smaller number had been previously incarcerated (7%) or were incarcerated at time of death (<1%).**
- **For one in ten (10%) people in the audit, there was some mention of potentially being the victim of domestic abuse in coronial files**, whether that was included in police statements, recorded in medical records, or described by family or friends. Of those, the majority of the victims were female (85%).

COVID-19 pandemic

- The COVID-19 pandemic came to prominence in the UK in March 2020, mid-way through the audit period.
- **The audit team included a risk factor category described as 'COVID-19 contribution'. However, it was very difficult to draw any conclusions as to how or whether the pandemic and associated lockdowns might have contributed to the deaths of people during this period.**
- All cases of suicide are complex and, as described previously in this report, people who take their own lives have often experienced a combination of different risk factors and challenging circumstances.
- While the periods of lockdown were undoubtedly stressful and isolating for many people, there is no evidence of an increased rate of suicide during the pandemic. This is in line with national evidence.
- Just under one in ten (12%) people had COVID-19 identified as a potential contributory risk factor, however they also had a median (average) of five other risk factors identified. Almost all had a history of Mental Health issues, as well as other contributory factors, including long-term physical health issues, bereavement, and relationship issues.

Access to Services

- One in ten people in the audit had contact with their GP within the last week of their life.
- One in six people in the audit had attended A&E within the last 3 months of their life, mostly for a reason related to mental health.
- One in five people had contact with crisis services at some point in their lives.

Access to services

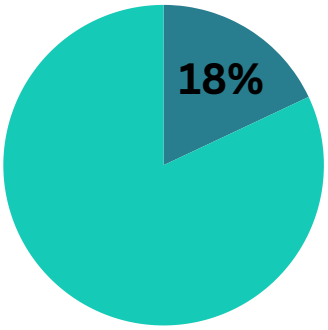
The audit recorded whether people had been in contact with a range of key services before their deaths, when and for what reasons.

Gathering this information was dependent on coroner and service documents which varied greatly in detail and structure. For example, a GP report could have been a few sentences written by one GP or it may be a full GP system list of every interaction between the person and their GP practice since registration.

GP contact

- **Just under one in ten (9%) people in the audit had been in contact with their GP within the last week of their lives and just under a third (31%) within the last month.**
- Just under half (47%) of people in the audit had been in contact with their GP within three months of their death. Of these, three quarters (75%) were seen about a mental health issue.
- Currently there are over 200,000 GP appointments across Wakefield every month with over 50,000 for people who have depression as an underlying condition. During the COVID-19 pandemic, access to primary care was different but this gives an indication of the large number of interactions GPs have with different patients.
- **GP practices are important services where people at risk of suicide are likely to present and seek help; identifying and helping the people most at risk is a challenging and complex task.**

Accident & Emergency (A&E) contact



18% in contact with A&E within last three months of life

- **Just over one in six (18%) people in the audit had been in contact with A&E within three months of their death.**
- Of these, 72% were seen due to a Mental Health issue (including suicidal intent or a suicide attempt).
- Again, although many people will present at A&E in acute crisis or with suicidal ideation, most will not go on to take their own lives. However, we can see from this that there is a significant opportunity to identify and help people presenting at A&E, which should not be missed.

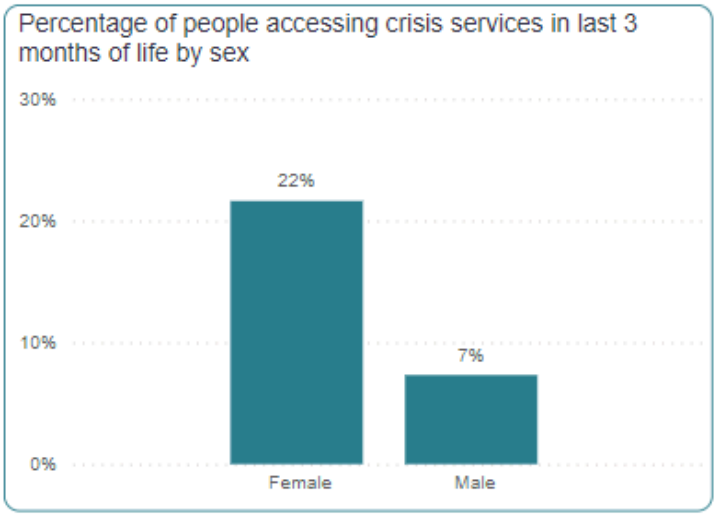
Mental Health Services contact (specialist and community)

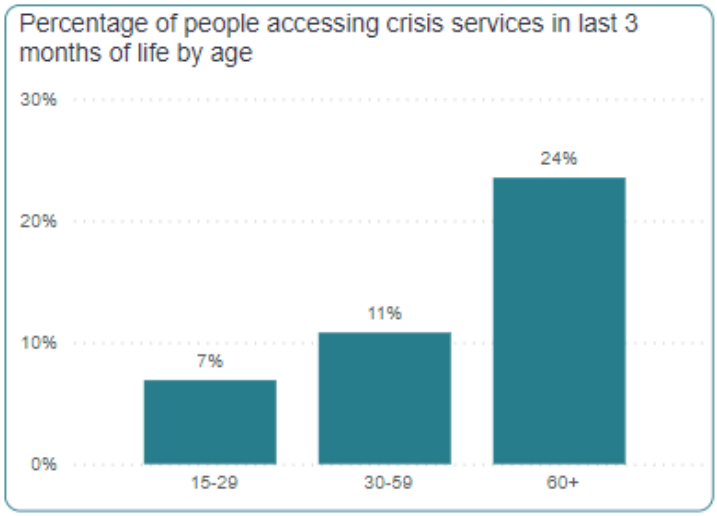
- **Just over a third of people who died by suicide had accessed specialist and/or community mental health services at some point in their lives.**
- Of those, over half accessed them within the last three months of their lives (19% of all people in the audit).

- 14 people (12%) were identified as having a mental health specialist inpatient stay, 9 (64% of those) had their most recent admission at some point in the last 12 months of their lives. Stays a long time previously may not always have been captured.

Crisis Services contact

- **One in five (20%) people who died by suicide had accessed crisis services at some point in their lives.**
- Of those, just over half accessed them within the last three months of their lives (12% of all people in the audit).
- Females and those aged 60+ were most likely to have been in contact with crisis services in the last 3 months.





Appendices

Acknowledgements

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Authors: Clare Offer, Chris Wathen, Matt Curley, Sarah Fleming.

Methodology

The audit was completed by a small team of public health staff, who attended the coroner's office and reviewed the case files of everyone for whom the coroner had recorded a verdict of suicide between 2019 and 2021.

The 2019-21 audit only includes deaths where the verdict was suicide as determined by the coroner. Previous audits have also included deaths with open verdicts where the audit team considered suicide to be the most likely possibility. **For this reason, rates and counts used in the 2019-21 suicide audit should not be directly compared with previous audits.**

The audit team extracted a small amount of standard data from the coroner's case management system. This system is not designed as a data collection tool but the team attempted to collect this data as consistently as possible.

For the remainder of the audit, the team searched for evidence of risk factors and circumstances known or thought to be associated with suicide, by reading through the case notes and reports including GP reports, post mortems, toxicology reports, witness statements, police reports, and any other report used by the coroner.

An inherent problem with this approach is that the team could only find evidence of risk factors or circumstances which had already been recorded in the coroner's inquest. Factors which were more recent are more likely to have been recorded and noted. In some cases there will be factors contributing to the person's death which were never raised at the inquest and which the team could not therefore have known about. Because the team searched for a range of predetermined risk factors and circumstances, other factors may have been missed.