Leeds Suicide Audit

2019 - 2021

LEEDS CITY COUNCIL IN PARTNERSHIP WITH THE LEEDS SUICIDE PREVENTION STRATEGIC GROUP

Leeds CITY COUNCIL

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Foreword

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This report is dedicated to the people in this audit and their friends, families, colleagues, communities and those affected by their deaths.

Suicide is a complex and devastating event and leaves lasting impacts on families, friends and entire communities.

We understand that many factors can contribute to suicide including poor mental health, social isolation, economic pressures, relationship breakdowns and more. Each life lost to suicide represents a profound and heart-breaking tragedy and it is with both a sense of responsibility and unwavering commitment to the well-being of our communities that we share the Leeds Suicide Audit Report 2019-2021.

We have a long-term commitment to suicide prevention in Leeds. As a compassionate city, our approach is rooted in the belief that every life is valuable and deserving of the opportunity to thrive. This audit takes a public health approach to identify who might be at highest risk of suicide and will support our continued efforts to prevent future deaths. Our approach will ensure that we have comprehensive, evidence-based initiatives that reflect all the new data, as well as learning from the experiences of those affected by suicide. This will inform our suicide prevention plan for Leeds.

We also acknowledge that suicide prevention must take a collaborative approach. Suicide prevention work is most effective when we work in partnership and draw upon available evidence of what can work. Local Government, the NHS, statutory services, the voluntary sector, local communities and families all have a valuable role to play in a partnership approach to suicide prevention. It is a shared mission to foster hope, reduce stigma, and create environments where people feel that they can reach out for support.

We remain committed to respecting the dignity and privacy of everyone who has been affected by suicide. We hope together, with a collaborative approach across the city, we can make a meaningful difference in the lives of those who may be struggling – offering hope, support and opportunity.

Our vision for Leeds is to be the Best City in the UK: one that is compassionate and caring.

Leeds is committed to reducing the number of lives lost to suicide.

In Leeds, around one person dies every five days as a result of suicide and every death leaves behind family, friends, colleagues and communities shattered by the loss.

Many others responding or providing support and care will also feel the impact suicide leaves.

National guidance recommends that every local authority carries out an annual suicide audit with a multiagency group coordinating effective and local action. The Leeds Suicide Audit will be used alongside suspected suicide surveillance data, the National evidence base and knowledge and insight from agencies across Leeds and those affected by Suicide.

The audit is a key tool in developing evidence to shape local work programmes by providing a focus for delivering effective suicide prevention interventions.

The factors leading to someone taking their own life are complex. This is why no one organisation is able to directly influence them. The Leeds suicide prevention action plan has been collaboratively developed by the 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 to name a few.

Our suicide prevention activity is overseen by the Leeds Health and Wellbeing Board and contributes towards delivering outcomes set out in the Leeds Health and Wellbeing Strategy.

Suicide is a high priority public health issue for Leeds.

Alongside this audit which includes deaths over a three year period from 2019-21, we use information from the Office of National Statistics (ONS) to give a broad picture of suicide deaths in England.

The Office for Health Improvement and Disparities (OHID) publish this data to provide opportunities for comparison with other areas and trends over time. The numbers are not identical to our audit data, due to different collection methodologies.

Office of National Statistics (ONS)

ONS data shows in 2021, there were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people; while this was statistically significantly higher than the 2020 rate of 10.0 deaths per 100,000 people, it was consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018.

The latest data is published on an annual basis

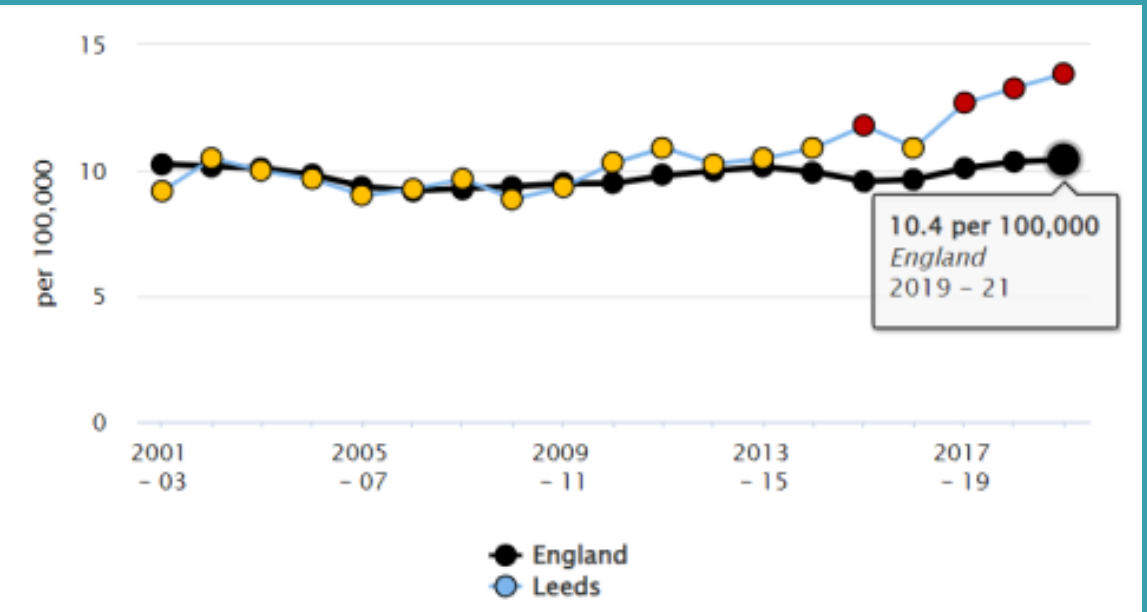
Office for Health Inequalities and Disparities (OHID) Published Data

OHID published data shows an England rate (2019 – 21) of 10.4 deaths per 100,000 and allows us to compare across different geographies.
OHID published data shows a Leeds rate (2019 – 21) of 13.9 deaths per 100,000 which is higher than both the England rate and the regional rate (Yorkshire and the Humber) of 12.5.

Leeds' rates (2019-21) are higher than those for all of the English Core Cities.

All core cities have a rate higher than the England average rate. (2019 - 2021)

Figure 1 Leeds Suicide Rate trend compared with England. (Source OHID Fingertips)



Further information on data can be found in appendix two

The 2019 - 21 Leeds audit showed 194 suicides by Leeds residents.

The Leeds Suicide Audit 2019-2021 shows a rate of 9.6 deaths per 100,000 for all persons with a female rate of 6.3 and a male rate of 12.9.

All rates in this audit have been calculated per 100,000 population of those aged 11 and above, registered with a Leeds GP in July of the years 2019, 20 and 21, and who are a resident of Leeds. These are crude rates and not age standardised rates.

GP data has been used as it includes ethnicity as well as deprivation data and means rates for the 2019-21 data are using the same denominator throughout.

Rates and counts used in the 2019 -21 suicide audit should not be compared with previous audits or with ONS or OHID published data sets due to the differing methods used and the change in the standard of proof used by Coroners.

Previous audits have also included deaths with open verdicts where the audit team considered the outcome to be most likely suicide. This audit includes deaths where the verdict was suicide as determined by the coroner.

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.

Since the change in the standard of proof, suicide rates nationally have not seen unprecedented increases.

Whenever a change in suicide rates occurs, the reasons are complex and will rarely be because of one factor alone.

Demographics

21%

of the audit population were people aged 40-49

66%

of the audit population were male

85%

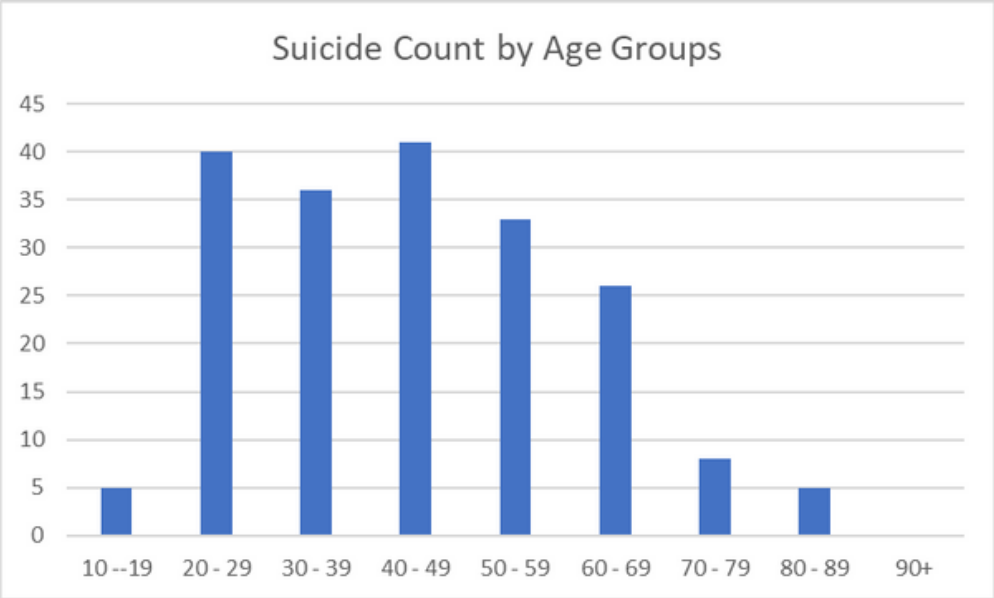
of the audit population were born in the UK

72%

of the audit population were either single, divorced, separated or widowed

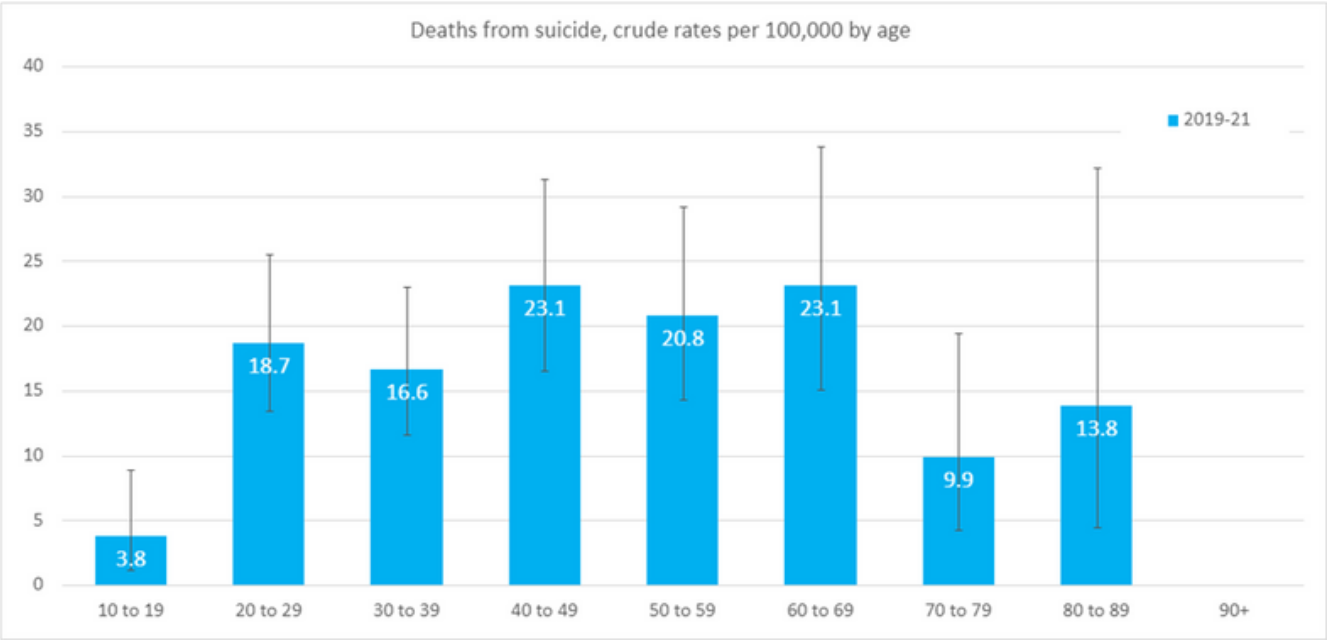
Age

Figure 2
Count of deaths by Suicide by Age



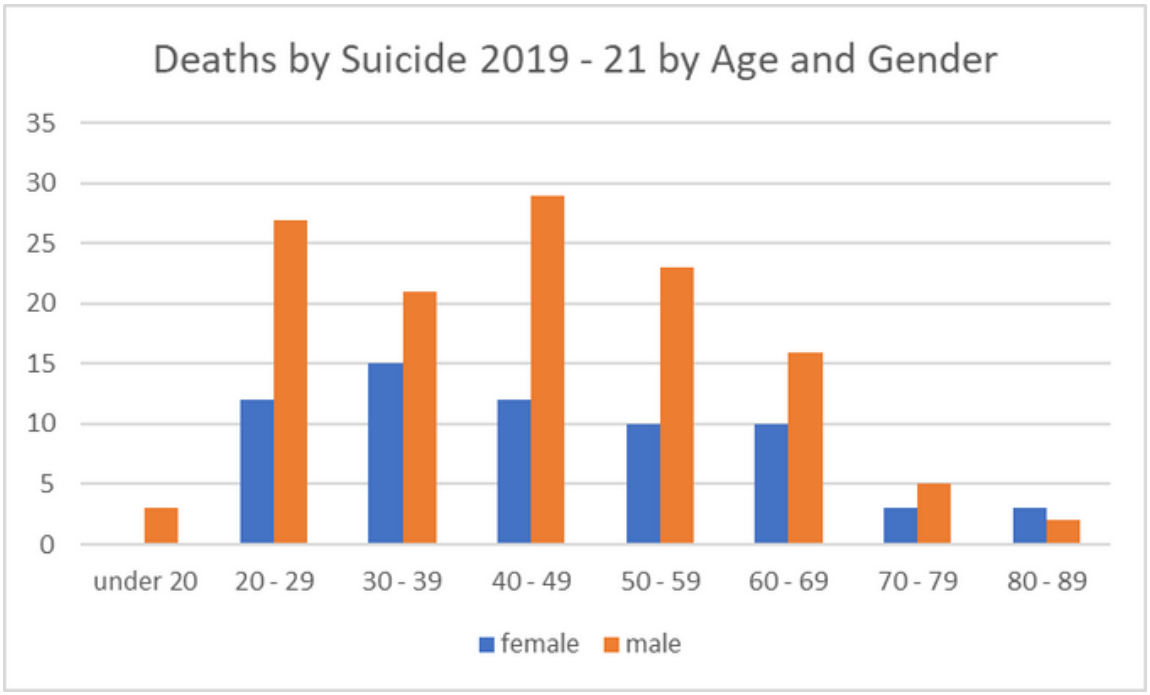
The age band with the highest count of suicides was 40-49 where 21% of all suicides occurred, however, this does not take into account the population size per age group. The following figure (3) accounts for the population of each age group at the time by demonstrating crude rates.

Figure 3
Deaths from Suicide - Crude Rates per 100,000 by age



By comparing rates and including the population size, the 60-69 age group has the same rate as the 40-49 age group.

Figure 4
Deaths by Suicide by Age and Gender (Count)



Gender

66% of the audit population were male which is lower than the national ratio of 3:1.

This is a considerable decrease in male suicides from 83% seen in the last audit where there was a ratio of 5:1. **This data should be used with caution due to the methodology differences referred to on p7.**

Figure 5
Deaths from Suicide - Comparison of Gender Counts

Audit	Female Count and Percentage (%)	Male Count and Percentage (%)
2008-10	38 (21%)	141 (79%)
2011-13	37 (17%)	176 (83%)
2014-16	34 (17%)	171 (83%)
2019 - 21	66 (34%)	127 (66%)

The ratio of males to females has lowered and this is reflected across younger age groups, deprivation and ethnicity as shown in figure 6.

Figure 6
Deaths from Suicide - Population and Demographic Comparisons with Previous audits

	% Males 2019 - 2021	% Males 2014 - 2016
Audit Population	65%	83%
Aged 10 -25	70%	87%
40% Most Deprived	50%	81%
Those from a Culturally Diverse Background	50%	86%

Sexual Orientation

Sexual orientation is rarely explicitly recorded by the coroner in the case notes. The relationship history of the individual was considered in conjunction with witness statements from those who knew the person. If, for example, they were married to a member of the opposite gender and there was no evidence to suggest any other sexual orientation, the person would be recorded as heterosexual.

This method of data collection is limited and may be inaccurate; it should be used with caution.

19% of the audit population's sexuality was unknown.

Of the people who had their sexuality recorded, 94% were heterosexual and 6% were from the LGBTQ+ community

Ethnicity

The reporting of ethnicity in Coroner's records is often limited due to inconsistencies with how it is recorded by numerous sources, such as within police and medical records. This is an ongoing national issue which can impact the quality and interpretation of suicide data.

Ethnicity was not specifically recorded in a standardised format in the vast majority of the Coroner's case notes and this is consistent with previous audit findings. However, we have proactively continued to strengthen our process of evidencing ethnicity from the case notes within records collated by the Coroner. This process involved triangulating information from post-mortem reports and additional narrative in witness statements and medical records.

32% of the audit population's ethnicity was unknown

Of the people whose ethnicity was recorded, 91% were recorded as White and 9% were recorded as being from an ethnic minority background.

Place of Birth

85% of individuals in the audit population were born in the UK and 50% of the audit population were born in Leeds.

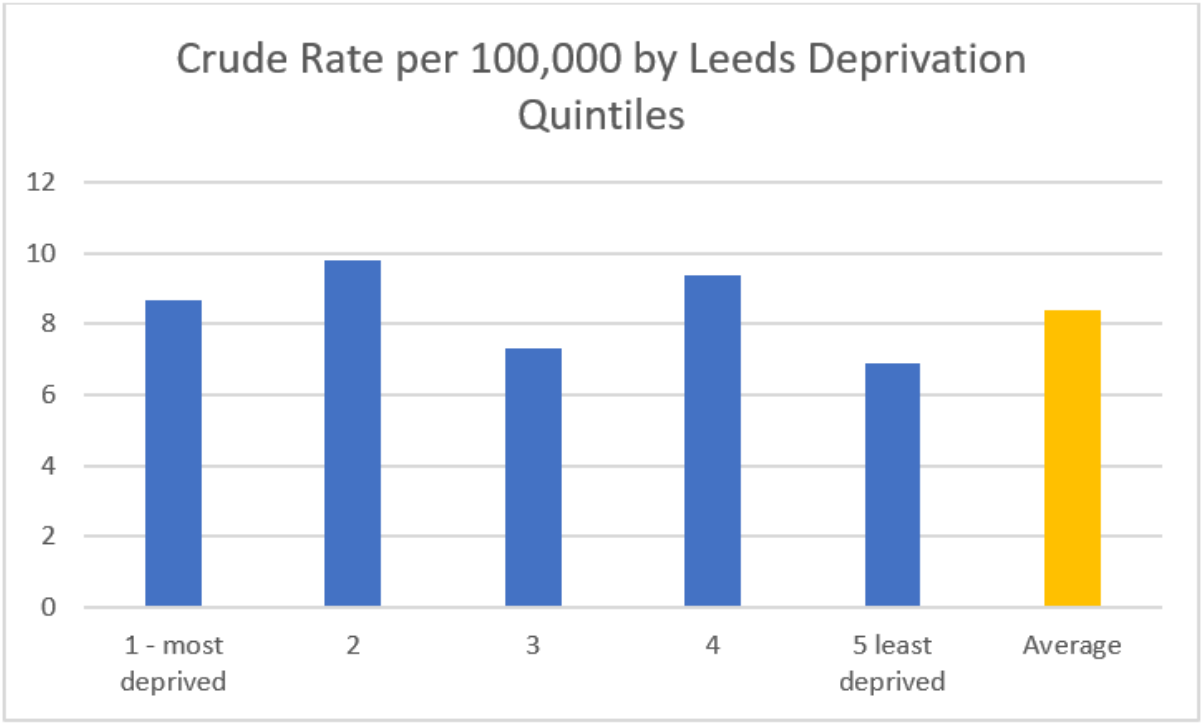
Home Postcode and Ward

26% of all suicides in Leeds occurred amongst people whose home postcode was in the 10% most deprived decile (using the Index of Multiple Deprivation and England deciles).

59% lived in the areas of Leeds falling into the most deprived 50% in Leeds (using England deciles).

The following figure accounts for the population of each quintile in Leeds at the time (calculated by the three year combined average population) demonstrating crude rates per 100,000

Figure 7
Deaths from Suicide - by deprivation quintiles



Of the 27 postcode districts recorded as home postcodes for people in the audit population, over half were from just eight: LS12, LS14, LS10, LS28, LS17, LS9, LS6 and the WF postcodes that come under Leeds City Council Boundaries.

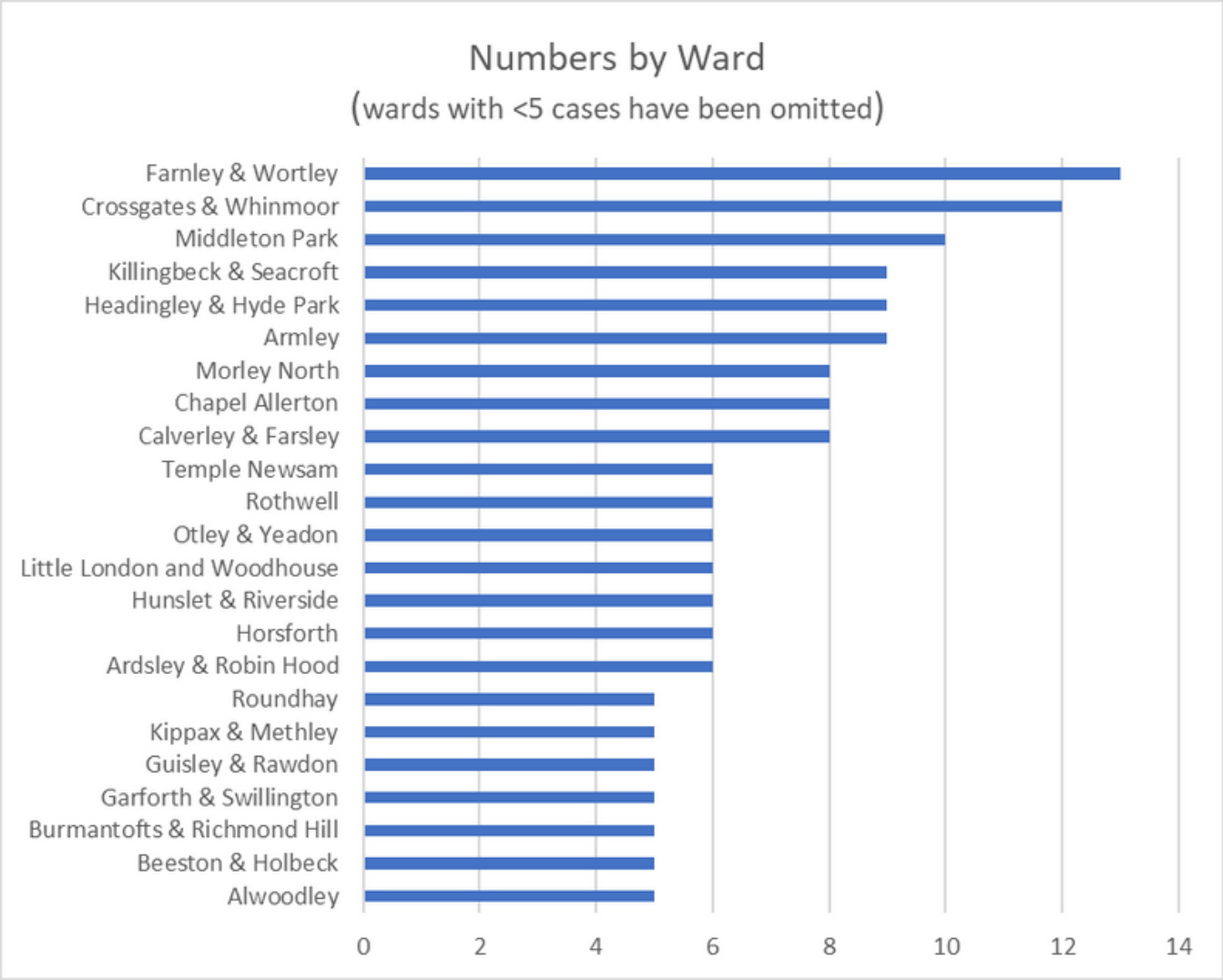
The most common home postcode recorded was the LS12 district which had just under 10% of all suicides.

Leeds is divided into 33 geographical wards with similar population numbers.

The most common ward to be recorded is Farnley and Wortley, with 13 suicides.

10 wards had fewer than 5 suicides recorded and are therefore not included in figure 8.

Figure 8
Deaths from Suicide - Count per Ward



Relationship Status

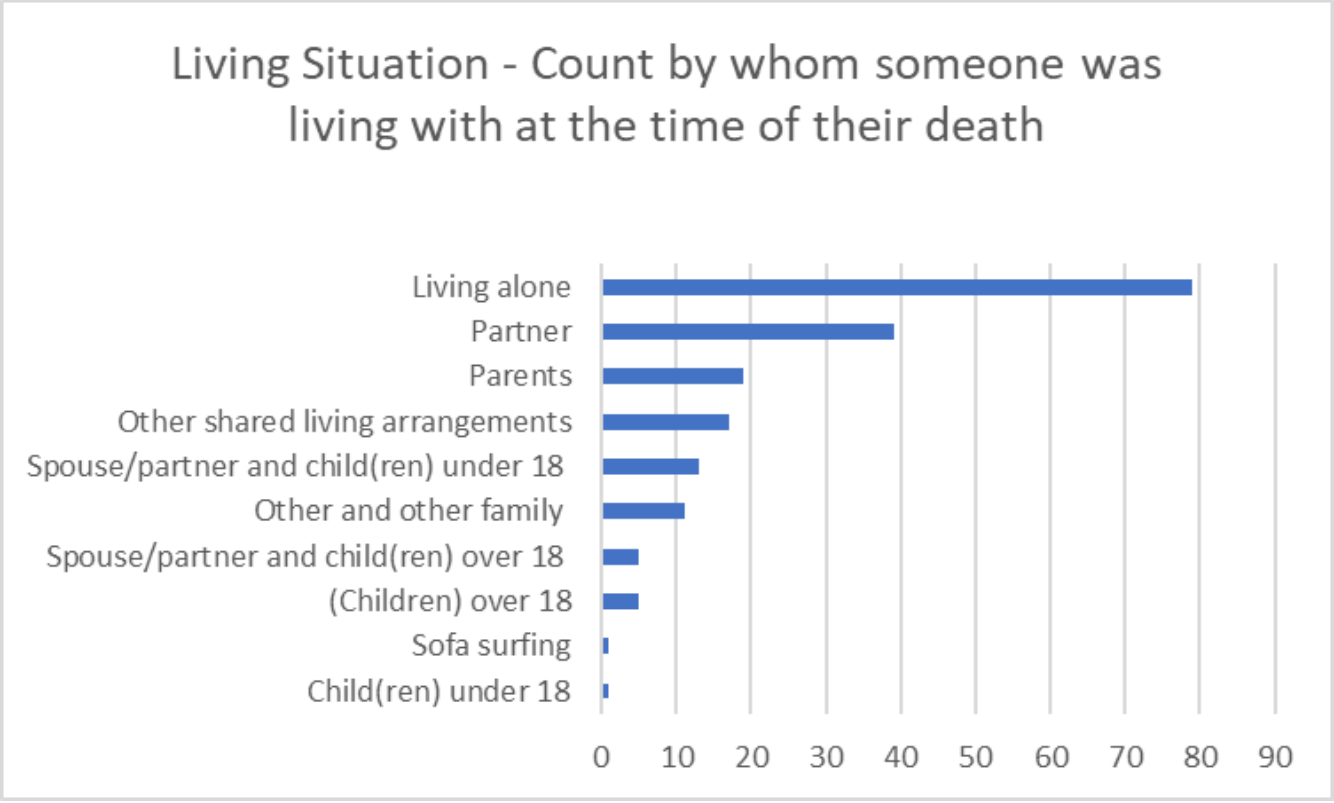
The most commonly recorded relationship status amongst the audit population was ‘single’, this replicates the finding from the previous three audits. 72% of people were recorded as either single, divorced, separated or widowed which is consistent with previous years audit findings.

Living Situation

41% of the audit population were living alone at the time of their death.

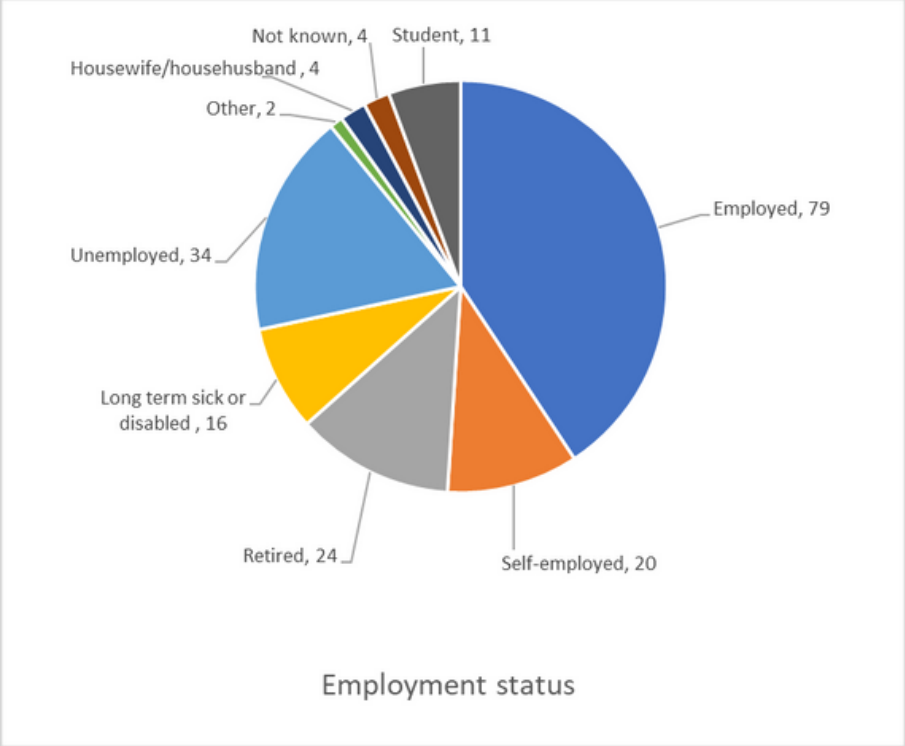
Figure 9

Living Situation at Time of Death



Employment

Figure 10
Employment Status



Just over half of the audit population were described as employed or self employed. (Note that some people were off work due to ill health)

"Problems with work" was recorded in 22% of people who were either employed or self employed.

These ranged from historical to more current problems.

The following table highlights the difference in employment status in the audit population broken down by gender.

Figure 11
Employment Status by Gender

Status	Male %	Female %
Employed or self employed	49	55
Retired	13	10
Long term Sick or disabled	8	9
Unemployed	22	9
Student	5	7
Other, unknown or housewife	3	9

Carers

3% of the audit population were recorded as being unpaid carers. This should be used with caution due to the likelihood of under reporting.

ONS suggests around 9-10% of people in the UK are unpaid carers.

Recorded Risk Factors

36%

of the audit population had a recent or significant bereavement

85%

of the audit population had a noted mental health problem either on medical records or from witness statements

43%

of the audit population had a recorded previous attempt of suicide.

47%

of the audit population had recorded misuse of either drugs or alcohol with most being in the last 12 months.

The audit data collection searched for evidence of 26 factors known to be associated with suicide with “Impact of COVID” being added from previous audits.

An inherent bias to this methodology is that only those risk factors which had already been recorded in the Coroner’s inquest could be noted.

Capturing this information in the first instance required a family member statement, witness statement, medical record, police investigation or post-mortem examination to mention factors associated with the identified risk factors.

As expected, risk factors which were more recent were more likely to be recorded and noted (for example, a bereavement) than something that may have taken place a number of years ago (for example an adverse childhood experience).

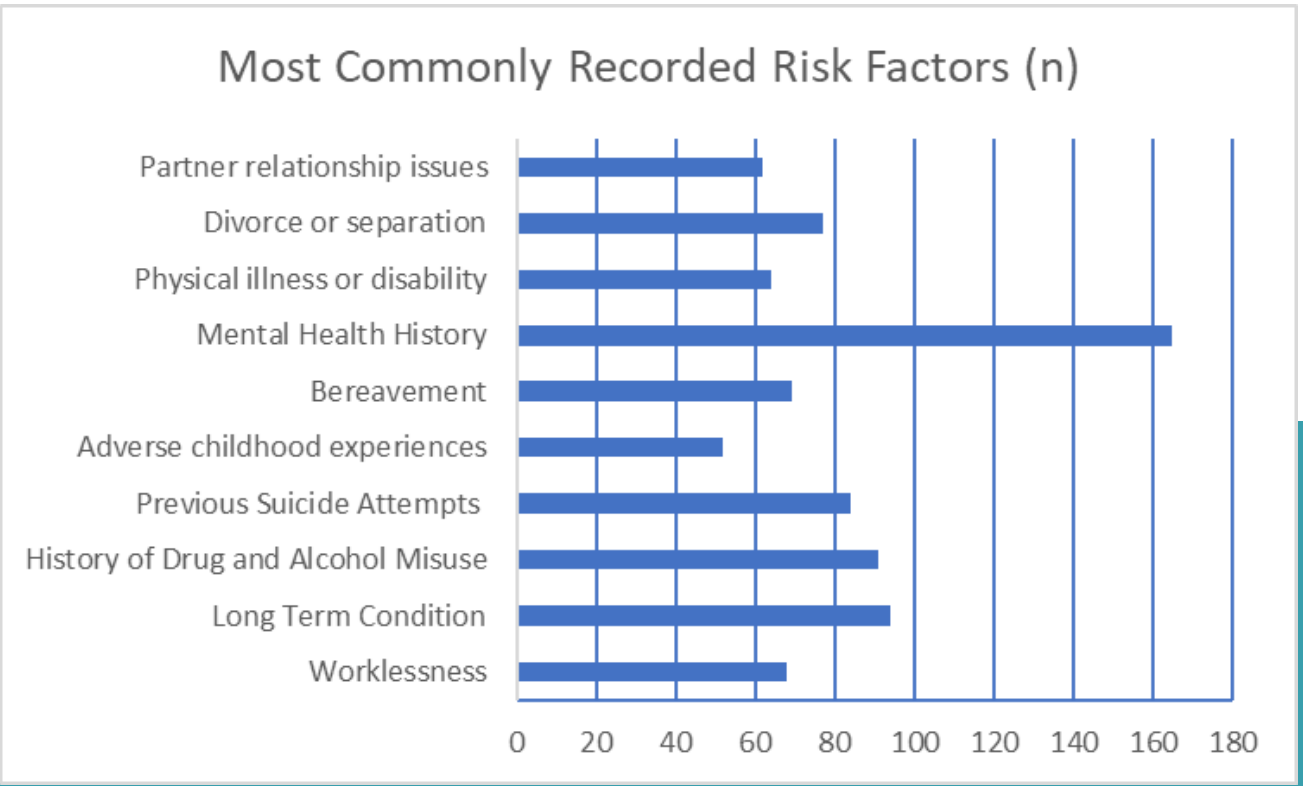
These findings are specifically labelled ‘Recorded Risk Factors’ as they only reflect factors clearly identifiable in the information provided. The findings will miss factors which are less likely to have been recorded, as well as suicide risks that weren’t specifically searched for in the process.

Multiple Risk Factors

The average number of recorded risk factors present in the audit population was 6.5 with consistency between genders. This compliments what is already known from practice; those who die from suicide often live complex lives, experiencing compounding risk factors.

The most commonly recorded risk factor was having a history of a mental health problem.

Figure 12
Count of Most Commonly Recorded Risk Factors



The risk factors that occurred most commonly together were a mental health history with a previous suicide attempt, mental health history with a drug and/or alcohol misuse history and mental health history with divorce or separation. Figure 13 shows the risk factor which most commonly occurred alongside a mental health history.

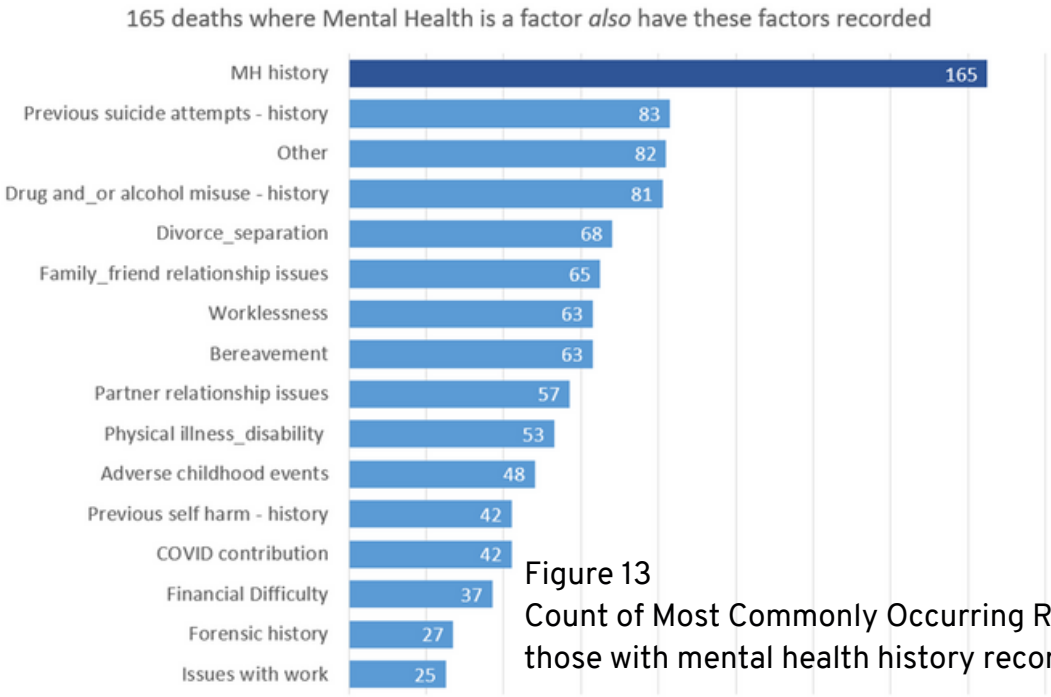


Figure 13
Count of Most Commonly Occurring Risk Factors for those with mental health history recorded.

"Other" includes circumstances and feelings recorded outside of the common risk factors collected such as; frustration with a recent car accident, a recent house move, struggling with language barriers, being worried about family members and being the victim of assault.

Mental Health Problems

A history of mental health problems was the most commonly recorded risk factor with 85% of the audit population having some kind of recorded mental health history. This was observed equally between males and females.

In addition to medical notes reporting a common or serious mental health problem, this also includes where witness statements, notes or clinical records have cited low mood, night terrors and phobias that have a negative effect on wellbeing. The percentage in this audit is higher than previous audits (78% in 2014 – 16 and 70% in 2011 – 13).

To note; the Leeds population with a common mental health problem on their GP record is 22.6% and the Leeds population with a serious mental illness noted on their GP record is 0.9%.

Financial Problems

Financial difficulties were recorded in 24% of the audit population which was lower than the previous audit. This equated to 46 people which is considerably less than the previous audit which highlighted 72 people.

The most common age group where financial difficulties was recorded was the 40-49 age group. The audit showed that men were more likely than women to have recorded financial difficulties and those identified as having financial difficulties were evenly represented across the Leeds deprivation quintiles. There were frequent records of negative benefit decisions, debt, housing debt, repossession, and drugs debt amongst other worries and concerns.

Physical Illness and Disability

A physical illness and/or disability was recorded in a third of the audit population.

There are records of: failed surgery, diagnosis with poor prognosis, chronic/painful conditions, deteriorations in conditions, delayed operations due to the pandemic, loss of eyesight and loss of work or independence (eg driving) due to health.

Physical illness or disability was much more likely to be recorded in older people in the audit population. 11% of those under 30 had an illness or disability recorded compared with 66% of those 60 and above and 77% of those 70 and above.

Physical illness or disability was recorded in 30% of the male audit population and 37% of the female audit population.

Bereavement

There were 69 people within the audit population who had experienced a recent or significant bereavement (36%).

The relationship of the bereavement recorded most frequently was the loss of a parent.

17 people (9%) in the audit population recorded having a family member or friend having taken their own life and this ranged from a time very close to their death to a historical bereavement many years ago.

Adverse Childhood Experiences

Adverse childhood experiences were recorded in 27% (52) of the audit population.

This should be used with caution due to the likelihood of under reporting. This data relies on witnesses providing a statement knowing this information, believing it relevant and recording accurately. Bullying at school was frequently mentioned, as well as previous abuse and involvement with social care. Published evidence highlights the proportion of people who died by suicide and experienced adverse childhood events may be far higher than what was observed in this audit.

Previous Suicide Attempts

In 57% of the audit population, this was the first known attempt.

27% had attempted once before and 17% had made multiple previous attempts (2 or more)

Of the audit population, females were more likely to have made previous attempts than men, who were more likely to die on their first attempt.

Drug and Alcohol Misuse

Just under half (47%) of the audit population had recorded misuse of either drugs or alcohol with most (84%) of those being in the last 12 months.

The following figure shows the type of misuse from those in the audit population with a recorded history of drug and/or alcohol misuse.

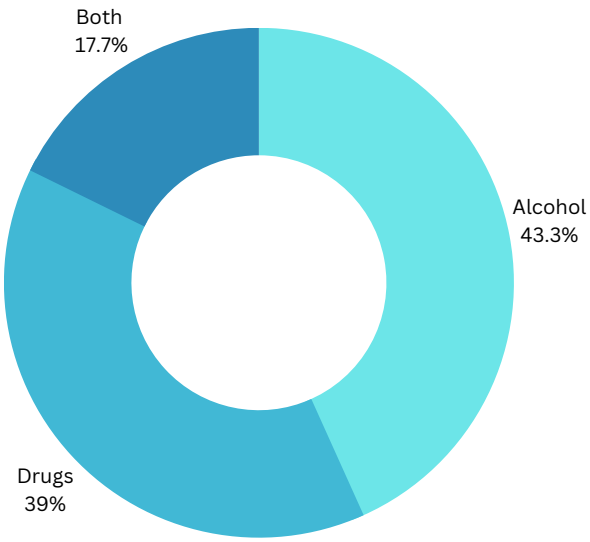


Figure 14
History of drug and/or alcohol misuse

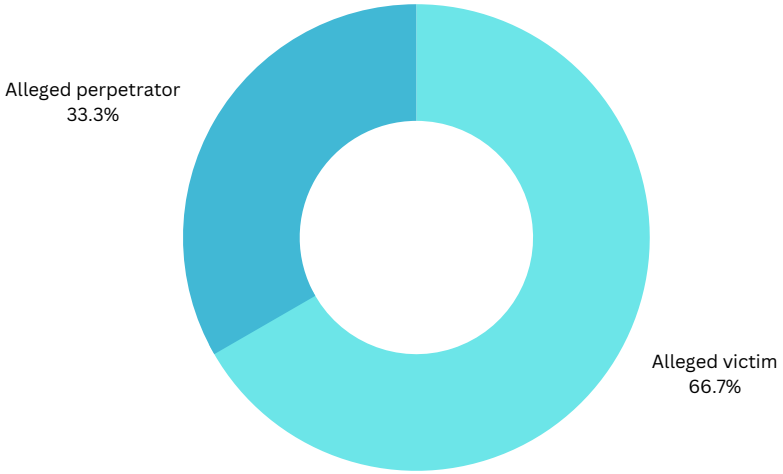
Self Harm

21% of the audit population had a record of self harm with 32% of those having self harm recorded more than once.

Self harm was more commonly recorded in females than males (28% compared with 17% respectively).

39% of the audit population with a history of recorded self harm lived in the most deprived decile in Leeds (England deciles)

Domestic Violence



27 people within the audit population had domestic violence recorded (14%).

Of the 27 people, 2/3 were alleged to be the victim of domestic violence and 1/3 were alleged to have been the perpetrator.

Figure 15
Alleged perpetrator/victim of domestic violence

Connection to the Criminal Justice System - History

16% of the audit population had a recorded contact with the Criminal Justice System with 94% of those being male.

Police statements record a variety of reasons for contact with the criminal justice system with a majority reporting recent interactions where people had been arrested on the morning of their death, were on probation at the time of their death or awaiting a court appearance at the time of their death.

COVID-19

25% of the audit population had a record that COVID-19 was a contributing factor to their death.

Witness statements provided reasons that included; increased anxiety and fear of getting the virus; being unable to work and volunteer; disappointment and frustration with cancelled trips and events; not being able to see friends, family and partners; and finding it difficult being at home with family too much.

Data included in this audit and national rates suggests that numbers of people taking their own lives during the pandemic did not increase and the variety of reasons for impact demonstrates the complexity of COVID-19 as a potential risk factor.

Circumstances of Death

Content Warning - this section includes information that may be upsetting and distressing to read

65%

of all suicides were from hanging or strangulation

73%

of the suicide audit population took their life in their own home

50%

of the audit population left a note of intent

23%

of the audit population had drugs or alcohol in their system at the time of death

Method

Hanging/strangulation was the most common suicide method overall, accounting for just under two thirds (65%) of all suicides.

Nationally, hanging and strangulation was the most common method used by both men and women in the UK (61.1%)

Poisoning (18%), predominantly through medication or drug overdoses, and cutting/stabbing (6%) were the next most common methods.

More than a third of women who took their own lives did so by poisoning (38%), compared with fewer than one tenth of men.

This is consistent with national figures.

Figure 16
Suicide Method by Age

	Hanging / Suffocation	Cutting / Stabbing	Poisoning
Under 30	83%	3%	14%
30-59	78%	6%	17%
60+	46%	16%	38%

Methods did vary by age as per figure 16 which shows lower rates of hanging/strangulation in people over 60 and higher rates of poisoning

Just under 5% of all suicides were from jumping or were on a railway line. All of these suicides were men. Nationally, it is reported around 4.4% of suicides in the UK take place on the railway.

Location

There were 16 types of locations recorded in the suicide audit.

73% of all Leeds suicides occurred in the person's own home, 9% occurred in a park/wood and 4% occurred on the railway.

Of those who took their own life in their own home, 51% lived with someone else and 13% lived with their children (this includes those under and over 18)

Note of Intent

There was evidence of a suicide message left (using a variety of media such as a note or text) in half of all suicides with a physical note being the most common.

Some people had ensured their affairs were in order, sorted and guided people to financial details, warned loved ones not to enter a room and others apologised, gave reasons for their choices and shared messages of love.

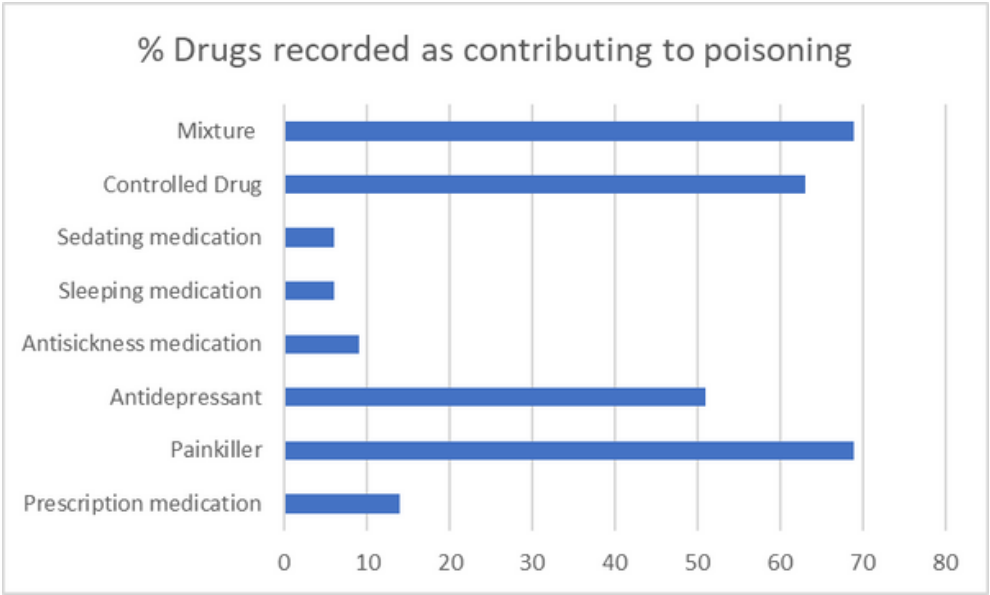
Alcohol and Drug Use at time of Death

Alcohol was recorded as being in the system in 23% of all people in the audit population.

Drugs were recorded as being in the system in 23% of suicides.

8% of the audit population had both alcohol and drugs recorded in their system

Figure 17
Type of Drug contributing to Death by Poisoning



63% of those with drugs and/or alcohol in their system at the time of their death also had a history of drug and/or alcohol misuse

Access to Services

11%

of the audit population had been in contact with primary care a week prior to their death

34%

of the audit population had been in contact with mental health services

21%

of the audit population had been in contact with community healthcare services

22%

of the audit population had contact with a crisis service at some time in their lives

Primary Care

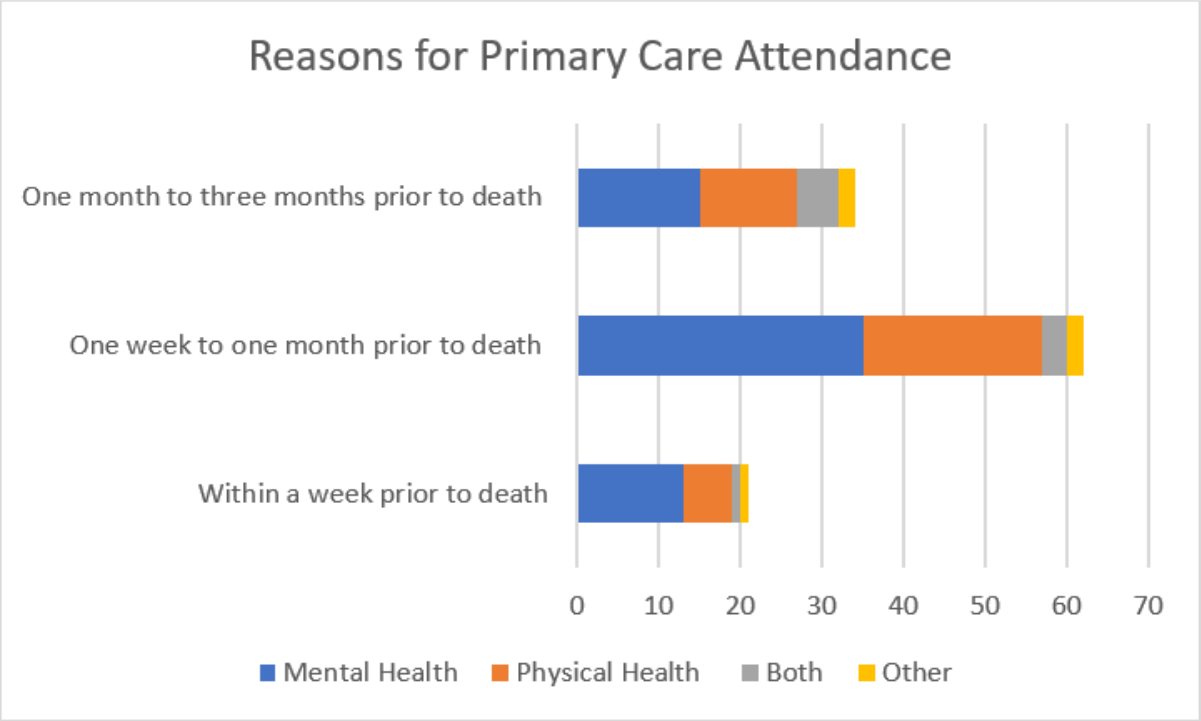
In the audit population, more than 1 in 10 people (11%) had been in contact with their GP within one week prior to their death and nearly 1 in 3 (32%) within one month prior to their death.

Nearly half of the audit population (49%) had come into contact with Primary Care in the 3 months prior to their death (calculated by combining “within the previous week”, “within the previous month” and “within the previous three months”).

For those that had come into contact with Primary Care in the three months prior to their death, 60% were male.

Figure 18 shows the primary reason for primary care attendance

Figure 18
Reasons for Primary Care Attendance in those most recently attending



Mental Health Services

66% of the audit population had never come into contact with Mental Health Services.

For those who had contact with Mental Health Services, 42% were in contact three months prior to their death and 24% of those had expressed suicidal ideation.

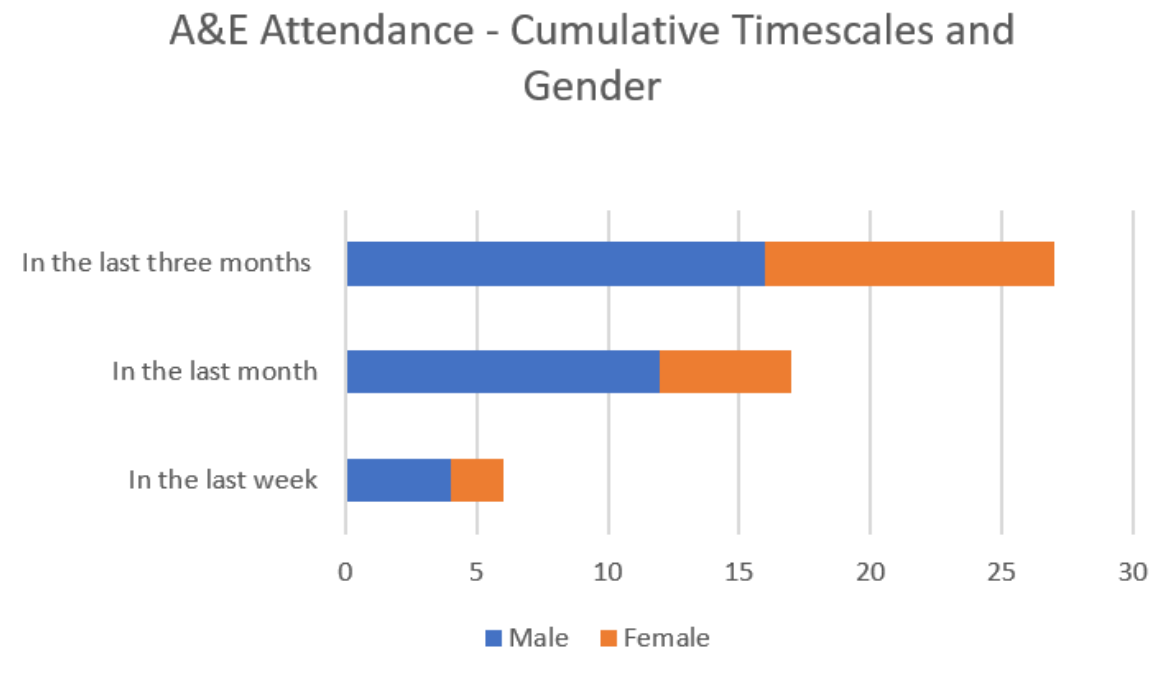
55% of those in contact with mental health services in the audit population were male.

A&E Attendance

A third of all of those in the audit population had an A&E attendance on their records (at some time in their lives) with 62% recorded as being for a mental health problem.

The following demonstrates the cumulative breakdown of the timeframes of the most recent attendances.

Figure 19
A&E Attendance by gender for those most recently attending



Community Healthcare Services

21% of the audit population had been in contact with community based healthcare services within the last year. 61% of those accessed for mental health support

Crisis Services

22% of the audit population had a recorded contact with a MH crisis service at some time in their lives.

Of those, only 4 had had contact in the week prior to the death, 12 within a month prior to the death with the majority having accessed crisis support more than a year ago.

Appendix One Acknowledgements

Lead Author - **Rachel Brighton** - Health Improvement Principal (Public Mental Health) - Leeds City Council

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Other Contributors

Lucy Insam - Health Improvement Specialist (Public Mental Health) - Leeds City Council

Caron Walker - Chief Officer/Consultant in Public Health (Public Mental Health/Localities/Migrant Health/communities of interest) - Leeds City Council

Laura Hodgson - Head of Public Health (Public Mental Health) - Leeds City Council

Ryan Rothery - Health Improvement Specialist (Public Mental Health) - Leeds City Council

Lizzie Greenwood - Health Improvement Principal (Public Mental Health) - Leeds City Council

Dr. Alex Thompson - Public Health Registrar - Leeds City Council

We are grateful to many colleagues and partners for their contributions and continued support throughout the entire audit process.

We would particularly like to thank HM Coroner Mr Kevin McLoughlin, Simon Walker, and all those in the West Yorkshire Eastern Coroner's Service for their continued commitment to the suicide prevention agenda.

We would also like to particularly thank Matt Curley and Kelly Zuc, colleagues in the Public Health Intelligence team at Wakefield Council, who were integral in data collection alongside Kerry Badger a registrar in Public Health in Leeds City Council at the time.

We would also like to acknowledge all of the families, friends, colleagues and communities who have lost someone to suicide aswell as those delivering services, working to create a caring and compassionate City and all those looking out for others and checking in on their friends and families.

Appendix Two - Data

ONS data on Suicide

The Office of National Statistics releases data on suicides every year at the start of September.

Downloadable excel spreadsheets are available from the ONS website showing information for suicide registrations that happened in a given calendar year, including in each local authority area.

A registration happens following an inquest at a coroner's court. 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.

In England and Wales, all deaths by suicide are certified by a coroner and cannot be registered until an inquest is completed. This results in a delay between the date the death occurred and the date of registration.

For suicides, the median registration delay for England was 180 days in 2021 (up from 165 days in 2020) and 291 days for Wales (up from 214 days in 2020). The median registration delay in both countries increased to its highest level since 2001, and was likely explained by the continuing disruption to inquests caused by the coronavirus (COVID-19) pandemic.

Delays can vary considerably from coroner to coroner.

ONS data covers male/female gender and age only.

Counts and Rates

It is important to understand the difference between suicide registration rates and suicide registration counts.

Counts - the ONS publish the number of suicides registered each year by local authority, as well as regionally and nationally.

Rates – the ONS publish Age Standardised Mortality Rates as a more reliable way of understanding trends in the suicide data ie how it is changing over time.

Data Collection Notes

The audit included one trans woman who identified as female. They are therefore included in female categories in this audit.

Authors of the Leeds suicide Audit recognise the importance of more thorough data collection on ethnicity and in future would advocate for recording categories recommended by Central Government to be used. Data in this field therefore remains limited.

Percentages have been rounded up rather than using decimal places.

Appendix Three Glossary and Key terms

Key term	Definition
Balance of probabilities	When an event is proved on a 'balance of probabilities', it is more likely than not to have occurred. It means that the event having occurred is probable, i.e. the probability of the event occurring is over 50%.
Beyond reasonable doubt	A legal term whereby if something is proved 'beyond reasonable doubt', it is shown to be almost certainly true.
Burden of proof	A legal standard that requires parties to demonstrate that a claim is valid or invalid based on facts and evidence.
Core Cities	A collaborative advocacy network of ten city councils representing ten large regional cities outside of Greater London (Birmingham, Bristol, Cardiff, Glasgow, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield). The Core Cities group serves as a delivery partner for Government and its agencies.
Decile	A quantitative method of splitting up a set of ranked data into 10 equally sized subsections. A decile therefore represents 1 out of 10 (10%) of the sample or population.
Postvention	Timely and appropriate interventions that are conducted after a suicide, largely taking the form of support for those who are bereaved (including family, friends, colleagues, neighbours and peers). Those who are bereaved by suicide are more likely to be at increased risk of suicide themselves.
Quintile	A quantitative method of splitting up a set of ranked data into five equally sized subsections. A quintile therefore represents 1 out of 5 (20%) of the sample or population.
Rate	A measure of the frequency with which an event occurs in a defined population over a specified period of time.