



Department
of Health

Statistical update on suicide

February 2015

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Statistical update on suicide

February 2015

Prepared by Office for National Statistics

Introduction

1. Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available to coroners is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on balance of probability). They include those cases where there may be doubt about the deceased's intentions.
2. Statistics on causes of death produced by the Office for National Statistics (ONS) are based on the information provided at death registration. These statistics are provided to the Department of Health on an annual basis. Open verdicts are generally coded by the ONS as deaths from injury or poisoning of undetermined intent. When national statistics are presented, suicides and deaths of undetermined intent are combined. This reflects research studies which show that the majority of open verdicts are most likely suicides, although they do not meet the high legal standard of evidence required for a coroner to record a suicide verdict. Therefore official suicide rates are measured by a definition that is broader than the definition of suicide used by coroners.
3. In the remainder of this update we use the term suicide to refer to deaths from both intentional self-harm and injury or poisoning of undetermined intent.

Suicide numbers and rates

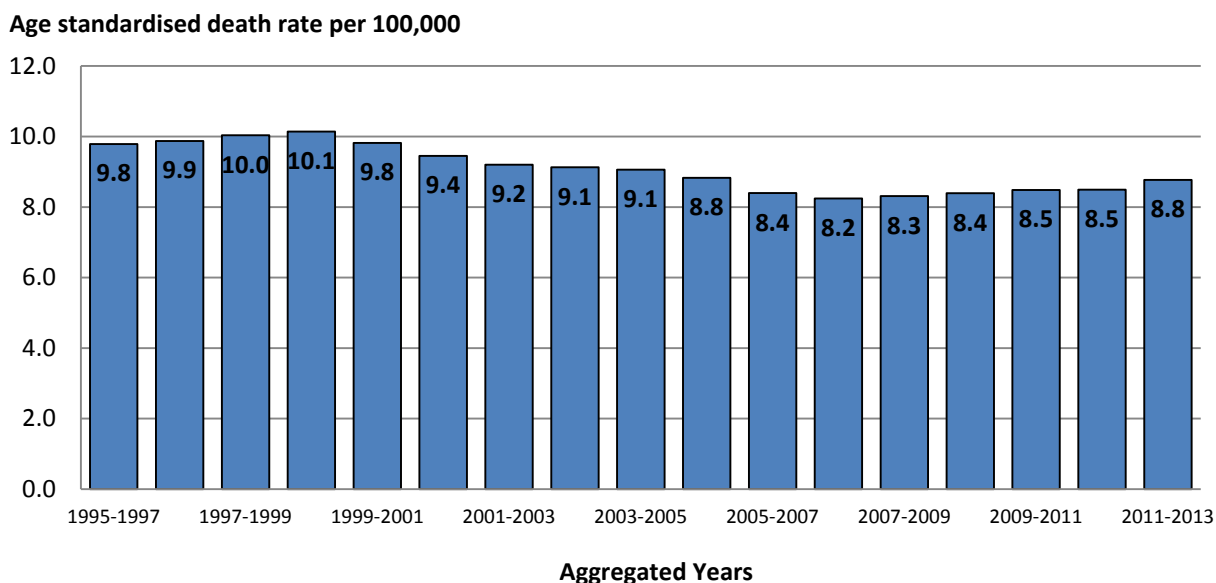
4. The number of suicide deaths refers to the actual number of people who have taken their own life.
5. The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population. The published rates are age-standardised to take account of changes in the size and age structure of the population to provide a comparable trend across time and across different areas. All age standardised rates in this report have been calculated using the new 2013 ESP, with revisions to the back series (see below).
6. In 2013 the ESP was updated to take into account the changes in the EU population, resulting in a more current, methodologically sound and acceptable basis to calculate age standardised rates. ONS, on behalf of the Government Statistical Service, has carried out a [public consultation on how to implement the new ESP in the UK \(552 Kb Word document\)](#). In addition, ONS have published a study on the impact of calculating mortality rates using the [2013 European Standard Population on causes of death](#). The new ESP has given more weight to older age groups to account for the aging population. As a result, less weight is given to the younger age groups. The impact of implementing the 2013 ESP on the suicide mortality rates presented in this report is that the rates have increased; in the later years there is a difference of approximately 0.5. The back series has been revised to account for this change; as a result the age standardised rates in this report will differ from those previously published.
7. Three-year rolling averages are generally used for monitoring purposes, in preference to single-year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.

8. In 2011, the introduction of a new version of the International Classification of Disease (ICD-10) software (version 2010) changed the coding rules for drug related deaths. In particular, some deaths from 'drug abuse' and 'acute intoxication' previously coded under 'mental and behaviour disorders' are now coded as 'self-poisoning of undetermined intent' and therefore included in suicide statistics. ONS have implemented these changes but analysis by ONS has shown that the new coding rules have not made a significant impact to suicide figures in England. More information about the changes to the coding rules can be found on the [ONS website](#).
9. Deaths under ICD-10 codes X60-X84 (intentional self harm) and Y10-Y34 (injury/poisoning of undetermined intent) are classified as suicides. ONS figures do not include under 15s for codes Y10-Y34. Further information about the suicide definition is available on the [ONS website](#).
10. Figures provided by ONS are for deaths registered in each year, rather than occurring each year. There can be a substantial delay between the date of death and date of registration. [Information on registration delays](#) for a range of causes in England and Wales in 2011 can be found on the ONS website.

Current position

11. There were 4,727 suicides recorded in 2013, a rise of 214 since 2012. The overall trend in the suicide rates has been decreasing since 1998 until 2008 but has been rising slightly since. The three-year average rate for 2011-13 was 8.8 suicides per 100,000 general population (see figure 1).

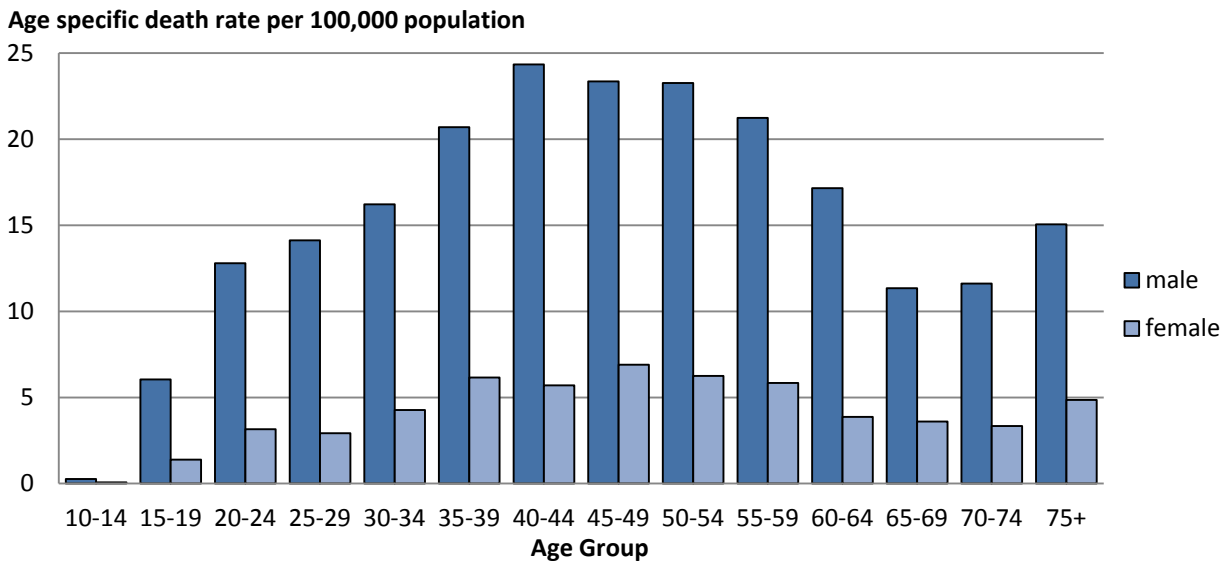
Figure 1: Death rates from Intentional Self-harm and Injury of Undetermined Intent, England, registered in 1995-2013



Source: ONS ICD 10 codes X60-X84 (for 10 year olds and over), Y10-Y34 (for 15 year olds and over), excluding Y33.9 - where the coroner's verdict was pending up to 2006. ICD 9 codes E950-E959 (for 10 year olds and over) and E980-E989 (for 15 year olds and over), excluding E988.8.

12. The three-year average rate for 2011-13 for males and females was 13.8 and 4.0 per 100,000 population, respectively. For males this is the highest rate since 2003-2005; for females the rate has been quite steady since 2006-2008.
13. The majority of suicides continue to occur in adult males, accounting for over three quarters of all suicides in 2013 (78%).
14. In comparison to women of the same age, men are more likely to take their own lives, but the difference varies by age. Latest figures show the peak difference, both in terms of number of suicides and rate, is in the 25-29 age group, where there are almost 5 male suicides for each female suicide (see figure 2).
15. There were 5 deaths for those aged 10-14 in 2013, a decrease from 6 in 2012. This is the number of suicide verdicts and does not include deaths coded as injuries of undetermined intent. This is because, in contrast to older age groups, deaths of undetermined intent in under 15s cannot be assumed to be suicide due to the possibility that these deaths were caused by unverifiable abuse, neglect or accidents. In 2013, there were 7 deaths of undetermined intent for 10-14 year olds, the equivalent 2012 figure is 10. Suicide verdicts are not returned for children aged under 10.

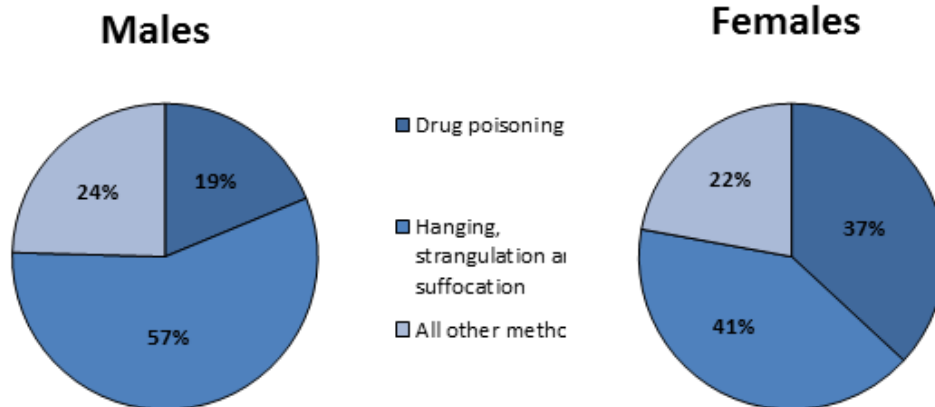
Figure 2: Death rates from Intentional Self-harm and Injury of Undetermined Intent by five-year age band and sex, England, registered in 2013



Source: ONS ICD10 X60-X84 (for 10 year olds and over) and Y10-Y34 (for 15 year olds and over)

16. Figures for 2013 show hanging (including strangulation and suffocation) is the most common method of suicide for both sexes accounting for 57% and 41% of all male and female suicide deaths, respectively. This is the first year that hanging (including strangulation and suffocation) is the most common method for females. The second most common method is drug poisoning (see figure 3).

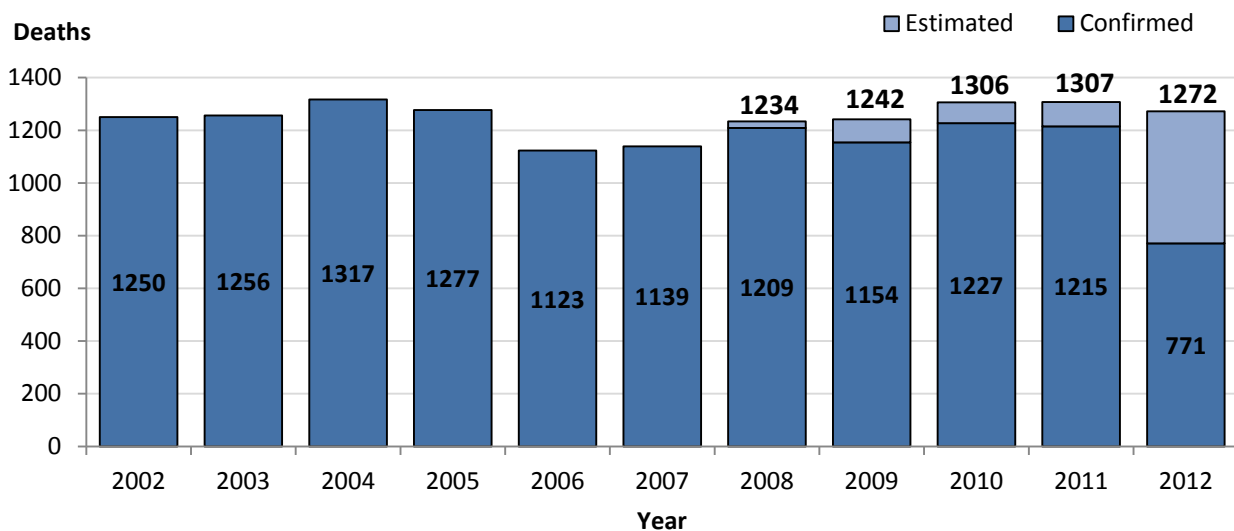
Figure 3 Deaths from Intentional Self-harm and Injury of Undetermined Intent by method and sex, England, registered in 2013



Source: ONS ICD10 X60-X84 (for 10 year olds and over) and Y10-Y34 (for 15 year olds and over)

17. In 2012 there were 1,272 estimated suicides by people in contact with mental health services in the year prior to death (figure 4). This is slightly lower than 2010 and 2011, but still higher than that seen in 2006 - 2009.

Figure 4: Suicides by people in contact with mental health services (in 12 months prior to death), England 2002 - 2012*



*The estimated figures provide the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

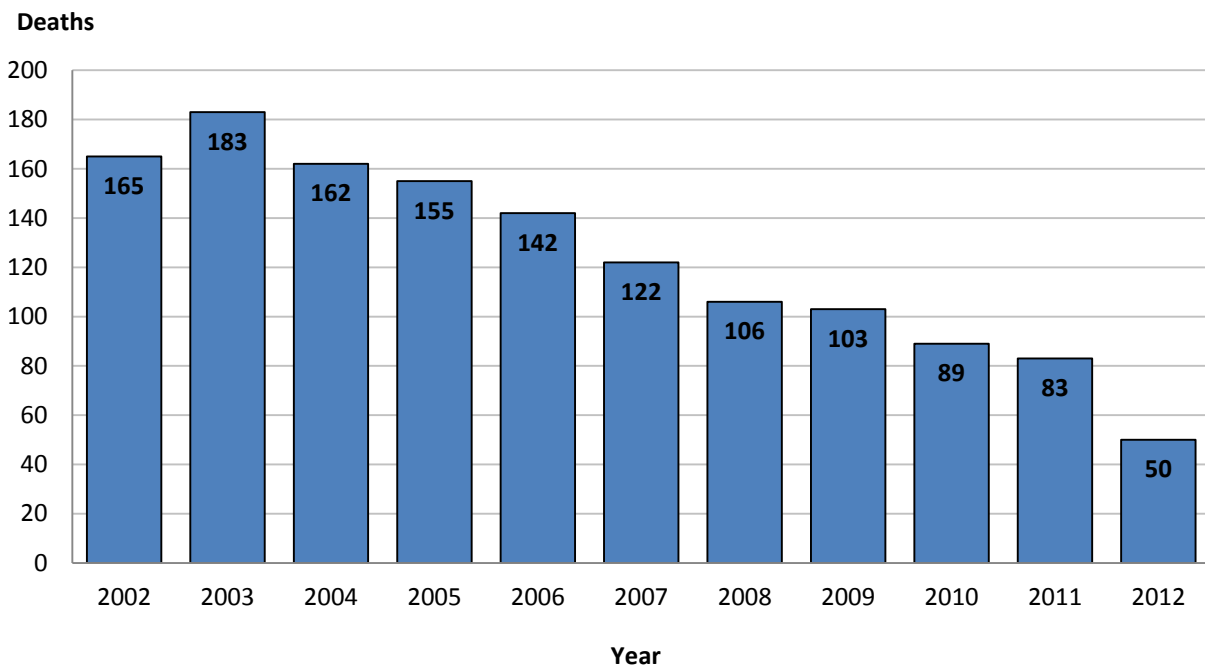
Source: National Confidential Inquiry into Suicide and Homicide by people with mental illness

18. The 2014 report published by the National Confidential Inquiry into Suicide and Homicide by people with mental illness highlights that higher suicide rates from 2008 have been widely reported and linked to the economic crisis. However their figures suggest that the impact of

the crisis has been varied and inconsistent, affecting age and gender groups differently, showing fluctuations since 2008 and different patterns for the UK.

19. The latest data show the number of inpatients taking their own life in England has continued to fall, with 83 inpatient suicides in 2011 (figure 5). The estimated figure for 2012 shows 50 inpatient suicides, however in-patient deaths are more often subject to late notification and so the estimated figure should be viewed with caution.

Figure 5: Inpatient suicides, England 2002 - 2012*

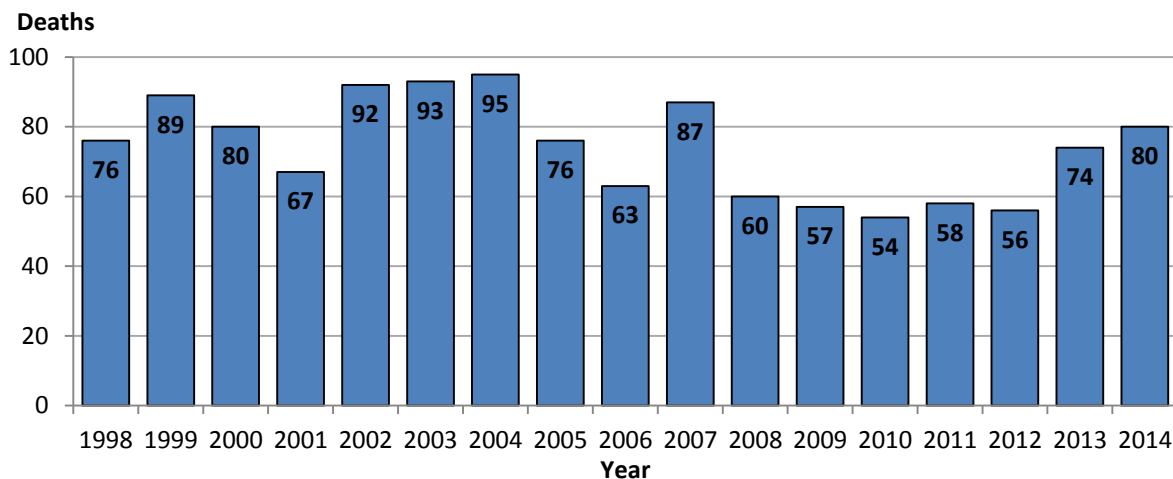


*The estimated figures provide the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

Source: National Confidential Inquiry into Suicide and Homicide by people with mental illness

20. Figure 6 shows the number of self-inflicted deaths in prisons was fairly consistent between 2008 and 2012 ranging from 54 to 60 deaths each year. Numbers rose in 2013 to 74 deaths and again in 2014 to 80 deaths, although these figures are not as high as previously seen 10 years ago.

Figure 6: Self-inflicted deaths* in prison, England 1998-2014

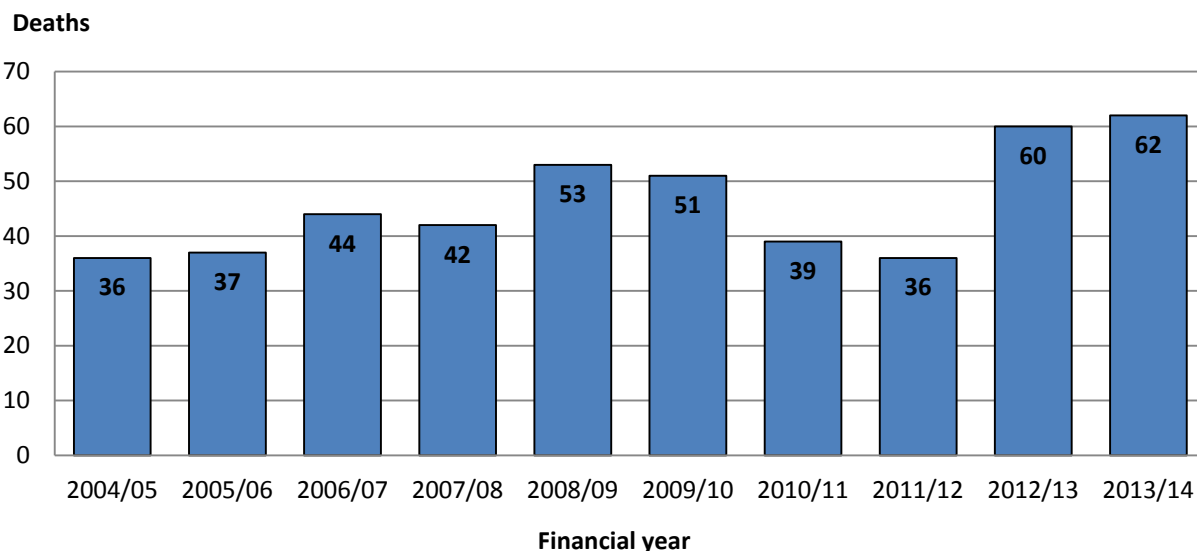


*Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 percent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

Source: National Offender Management Service

21. There were 62 'apparent suicides following police custody' during 2013/14 in England. This is similar to 2012/13 when there was a large rise from 2011/12. The 2013/14 figure is the highest seen in the last decade (figure7).

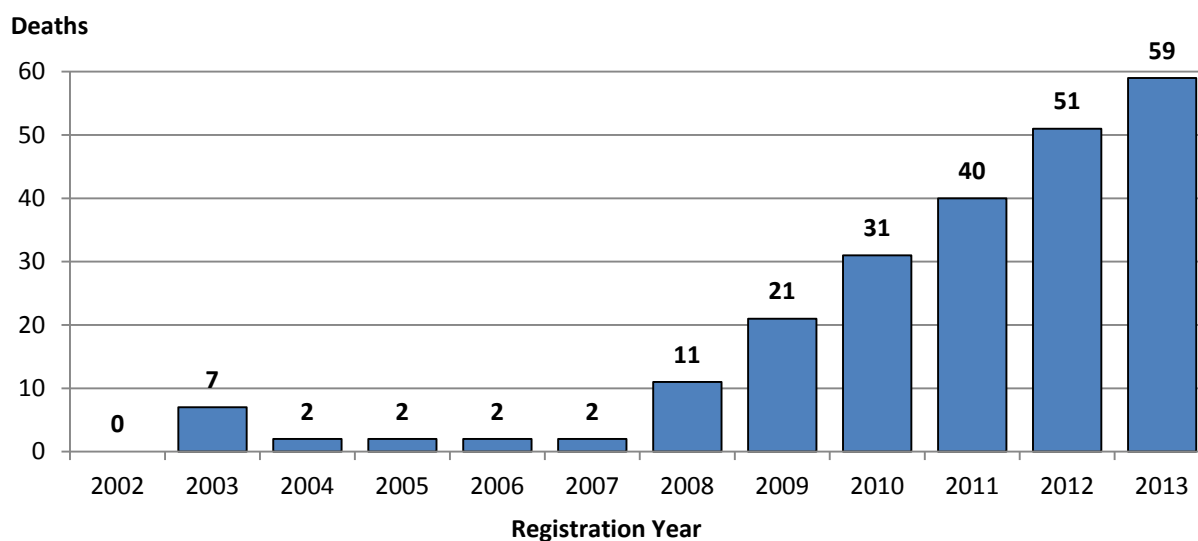
Figure 7: Apparent suicides following police custody*, England 2004/5–2012/13



* Includes apparent suicides that occur within two days of release from police custody. Also includes apparent suicides that occur beyond two days of release from custody, where the period spent in custody may be relevant to the subsequent death.

Source: Independent Police Complaints Commission (IPCC)

22. There were 59 deaths mentioning helium in 2013 in England, over 5 times higher than the 11 deaths recorded in 2008 (figure 8). Although the number of deaths involving these substances is still relatively small, the large increases are of particular interest as almost all of these deaths were suicides.

Figure 8: Deaths mentioning helium poisoning*, England registered in 2002-2013

* Cause of death was defined using ICD-10 codes related to drug poisoning (F11-F16, F18-F19, X40-X44, X60-X64, X85, Y10-Y14). Deaths were included where helium was mentioned on the death certificate.

Source: ONS

Other sources

23. Existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide include:

- ONS currently produces national mortality statistics from the information supplied to the registrar on cause of death. This information includes age, sex and occupation of the deceased, their usual place of residence, the method of suicide used and the location of their death. These statistical data are used nationally and locally to identify priorities for health care and public policy, to measure progress, and to assess the effectiveness of health services and other interventions. The Public Health Outcomes Framework Data Tool published by Public Health England facilitates comparisons of suicide rates between local areas: see [Indicator 4.10](#).
- The [National Confidential Inquiry](#) into Suicide and Homicide by People with Mental Illness (NCI) – this is a long-term study of suicides and homicides by people in the care of the mental health services. Conducted by the Centre for Mental Health and Risk at the University of Manchester, it has published a number of reports on incidence, trends, causes and recommendations for improving suicide prevention. Services adopting these recommendations have been found to have lower patient suicide rates.
- The Multicentre Study of Self-harm in England – this project is collecting data on national and regional trends in self-harm presenting to health services, including data on methods of self-harm, how self-harm is managed, compliance with national guidance, and self-harm in young people and in different ethnic groups. The study is also able to collect important data on outcomes (including suicide), and risk factors.

- Coroners' records from inquest proceedings can provide a wealth of information about the who, how and where of suicides, which tell us about the demographics of suicide, and may also tell us more about the motivations and causes of suicide.
- Important additional information is available from serious untoward incident inquiries, Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The purpose of SCRs and CDOPs are to learn lessons to better safeguard and promote the welfare of children. Regular reports draw out key findings from SCRs. The Department for Education publishes data about preventable child deaths in England.
- The National Offender Management Service (NOMS) has a system in place to monitor all deaths and other incidents in prison custody. This provides up to date information on each incident and those involved. Since 2009, the Ministry of Justice has published an annual statistical bulletin on deaths, self-harm and violence in prison custody, looking at trends across age, gender and time in prison custody. In addition, the Prisons and Probation Ombudsman publishes a report on every fatal incident in prison custody.
- Under the Police Reform Act 2002, forces in England and Wales have a statutory duty to refer to the IPCC any complaint or incident involving a death that has occurred during or following police contact and where there is an allegation or indication that the police contact, be it direct or indirect, contributed to the death. The IPCC considers the circumstances of all the cases referred to it and decides whether to investigate the death. The IPCC has published an annual report of all such deaths since 2004-05.