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# Statistical update on suicide

January 2014 (revised)

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# Statistical update on suicide

January 2014 (revised)

**Prepared by Health Improvement Analytical Team**

## Introduction

1. In September 2012, a statistical document presenting key statistics and relevant information was published alongside 'Preventing suicide in England: A cross-government outcomes strategy to save lives'. This document provides an update with latest available information.
2. 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.
3. 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.
4. 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

5. The number of suicide deaths refers to the actual number of people who have taken their own life.
6. 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.
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 general population suicide figures in England. More information about the changes to the coding rules can be found on the ONS website.

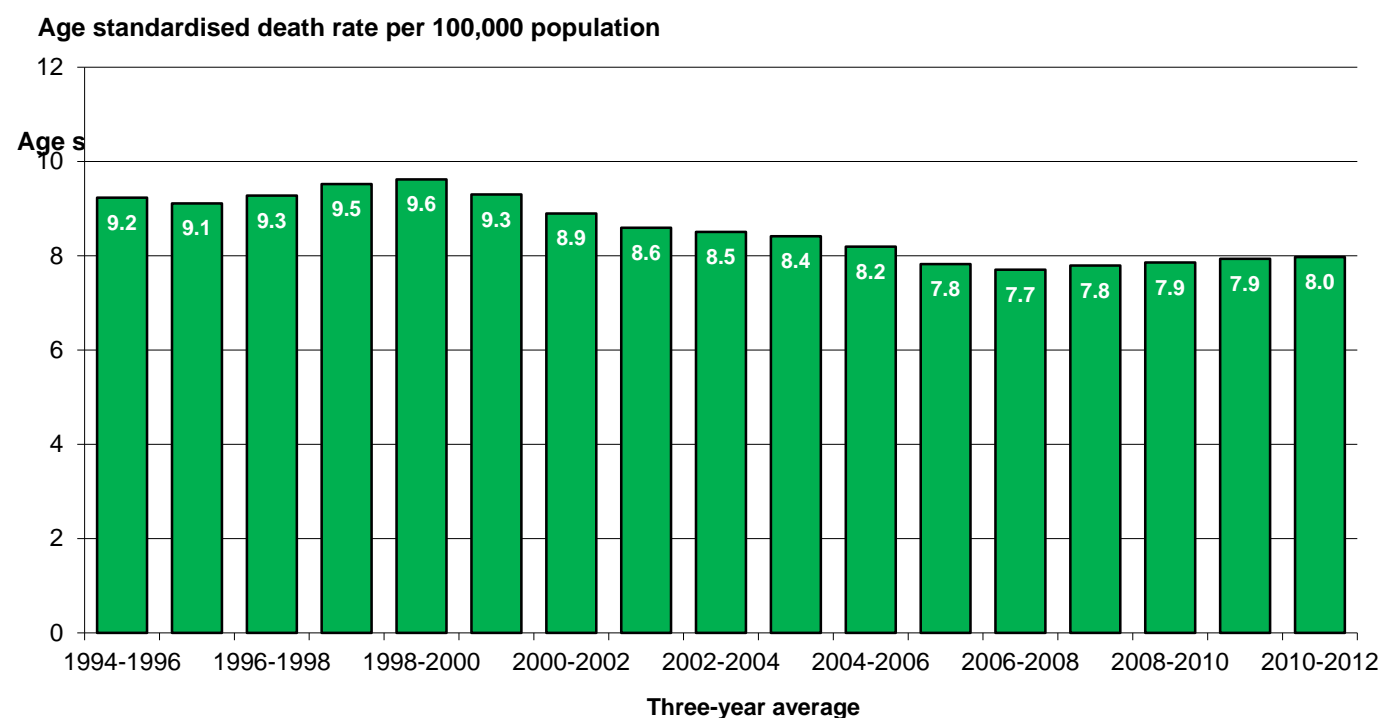
(<http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2011/stb-suicide-bulletin.html#tab-Coding-changes>)

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. (<http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2011/stb-suicide-bulletin.html#tab-Suicide-definition>)

## Current position

10. There were 4,513 suicides recorded in 2012, similar to the 2011 figure of 4,518. In the past decade, the overall trend has been a decrease in the suicide rate but with a small rise in the last 4 years. The three-year average rate for 2010-12 was 8.0 suicides per 100,000 general population, 17% lower than in 1998-2000 (see figure 1).

**Figure 1: Death rates from Intentional Self-harm and Injury of Undetermined Intent, England 1994-2012**



Source: ONS (ICD9 E950-E959, E980-E989, excluding E988.8; and ICD10 X60-X84, Y10-Y34, excluding Y33.9 up to 2006)

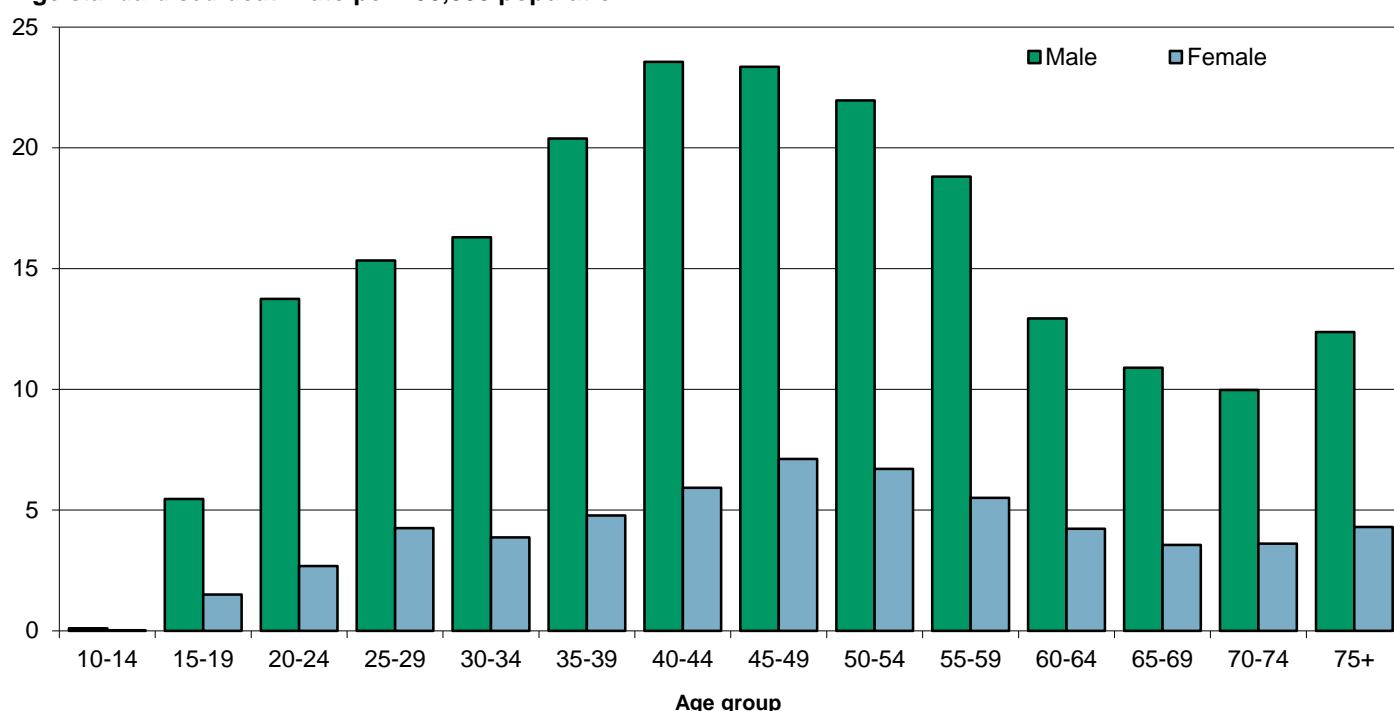
Note: Deaths with a E988.8 or Y33.9 code were excluded to remove pending verdicts from the figures. This method may miss a small number of cases where there are pending verdicts (assigned to codes other than E988.8 or Y33.9); it may also wrongly omit some cases where a verdict has been returned (included under codes E988.8 or Y33.9). We expect the error caused by this methodology to be negligible for figures in years up to and including 2006 and there will be no effect on more recent figures due to new codes introduced in 2007.

11. The three-year average rate for 2010-12 for males and females was 12.4 and 3.7 per 100,000 population, respectively. The rates are similar to the three-year average rates for 2009-11 and 2008-10.
12. The majority of suicides continue to occur in adult males, accounting for approximately three quarters of all suicides (77%).

13. 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 20-24 age group, where there are five male suicides for each female suicide (see figure 2).
14. The difference between male and female suicide rates is also noticeable in those aged 75+. Although a comparably low number of suicides occur for both males and females in this group, the low population makes the rates per 100,000 population relatively large, particularly for men.
15. There were 6 deaths for those aged 10-14 in 2012, a decrease from 9 in 2011. 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 2012, there were 10 deaths of undetermined intent for 10-14 year olds, the equivalent 2011 figure is 7. 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 2012**

Age standardised death rate per 100,000 population

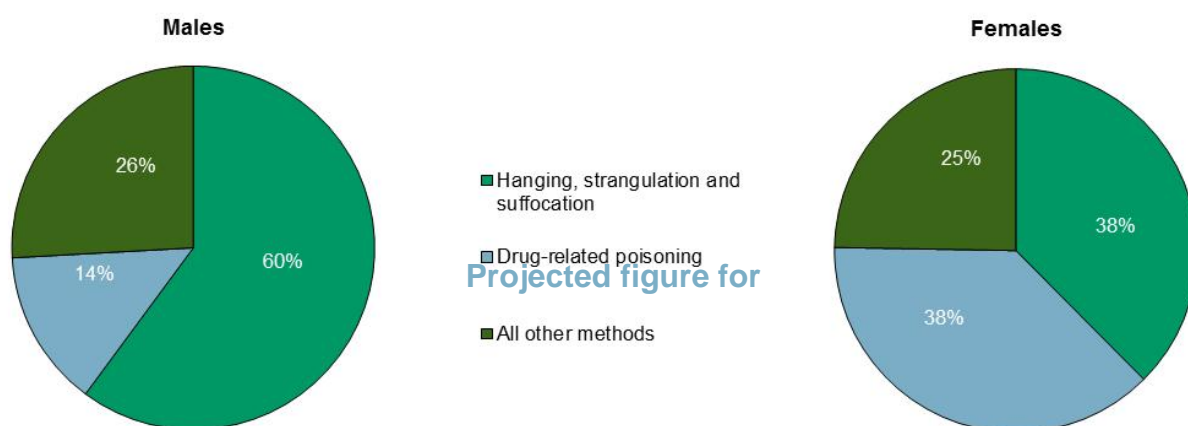


Source: ONS (ICD10 X60-X84, Y10-Y34)

16. Figures for 2012 suggest hanging (including strangulation and suffocation) continues to be the most common method of suicide for men, accounting for 60% of all male suicide deaths.

Along with drug-related poisoning, this is also a common method amongst women, with each accounting for 38% of female suicides in 2012 (see figure 3).

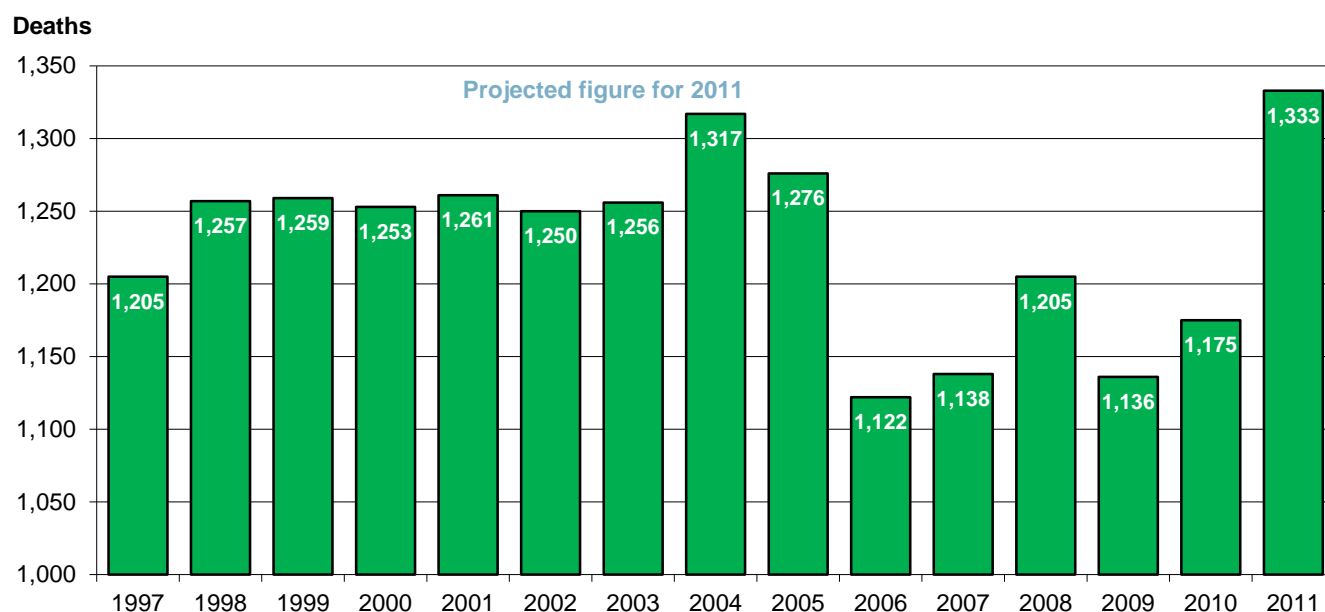
**Figure 3 Deaths from Intentional Self-harm and Injury of Undetermined Intent by method and sex, England 2012**



Source: ONS (ICD10 X60-X84, Y10-Y34)

17. In 2010 there were 1,175 suicides by people in contact with mental health services in the year prior to death (figure 4). The estimated figure for 2011 is 1,333, a 13% rise.

**Figure 4: Suicides by people in contact with mental health services (in 12 months prior to death), England 1997-2011\***

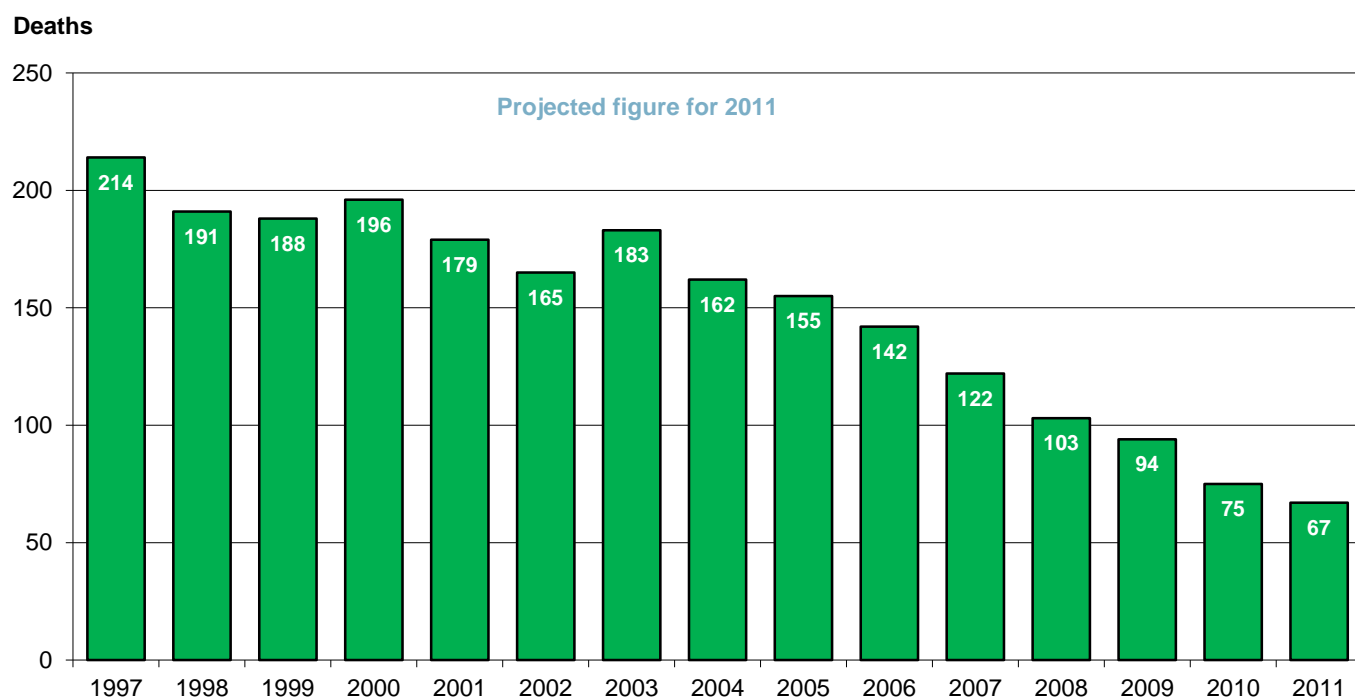


\*The projected figure for 2011 provides the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

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

18. The 2013 report published by the National Confidential Inquiry into Suicide and Homicide by people with mental illness suggests this increase is likely to reflect the rise in suicide in the general population, attributed to economic factors.
19. The latest data show the number of inpatients taking their own life in England has continued to fall, with 75 inpatient suicides in 2010 (figure 5). The estimated figure for 2011 shows 67 inpatient suicides.

**Figure 5: Inpatient suicides, England 1997-2011\***



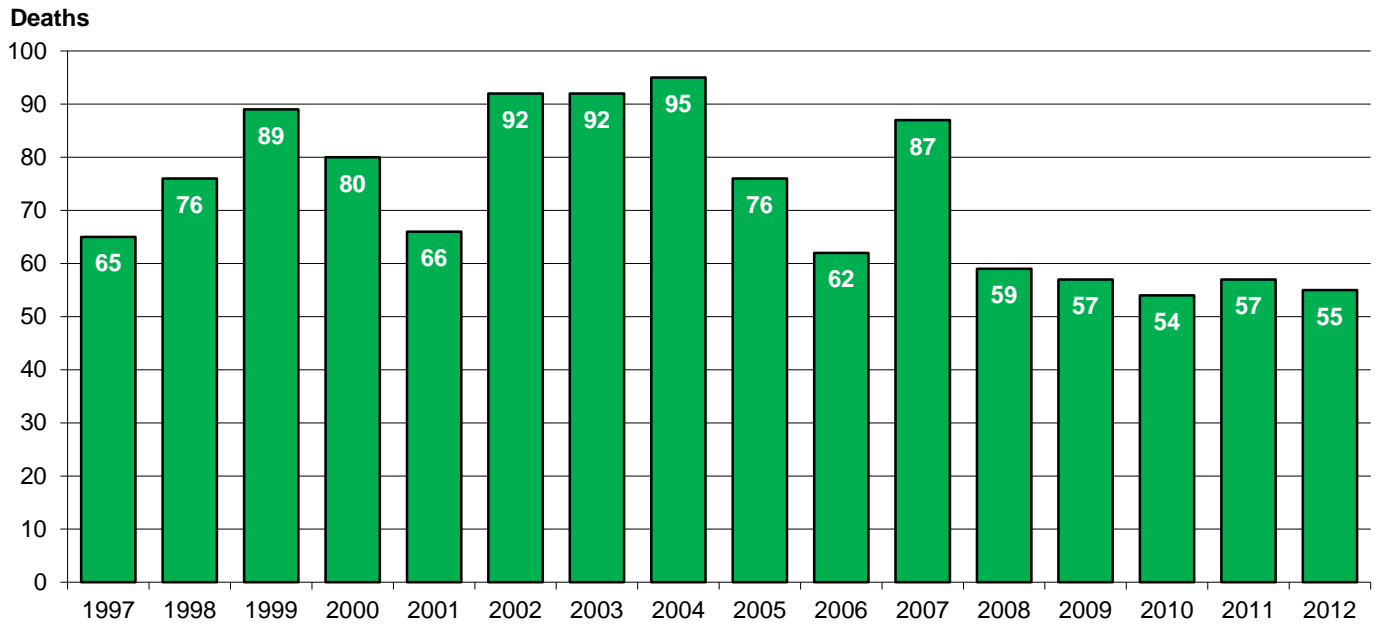
\*The projected figure for 2011 provides the most accurate estimate of the number of cases expected. The projected figure may change as data becomes more complete.

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 between 1997 and 2012. Numbers fell after a peak in 2004 but have remained between 54 and 59 since 2008.



**Figure 6: Self-inflicted deaths\* in prison, England 1997-2012**

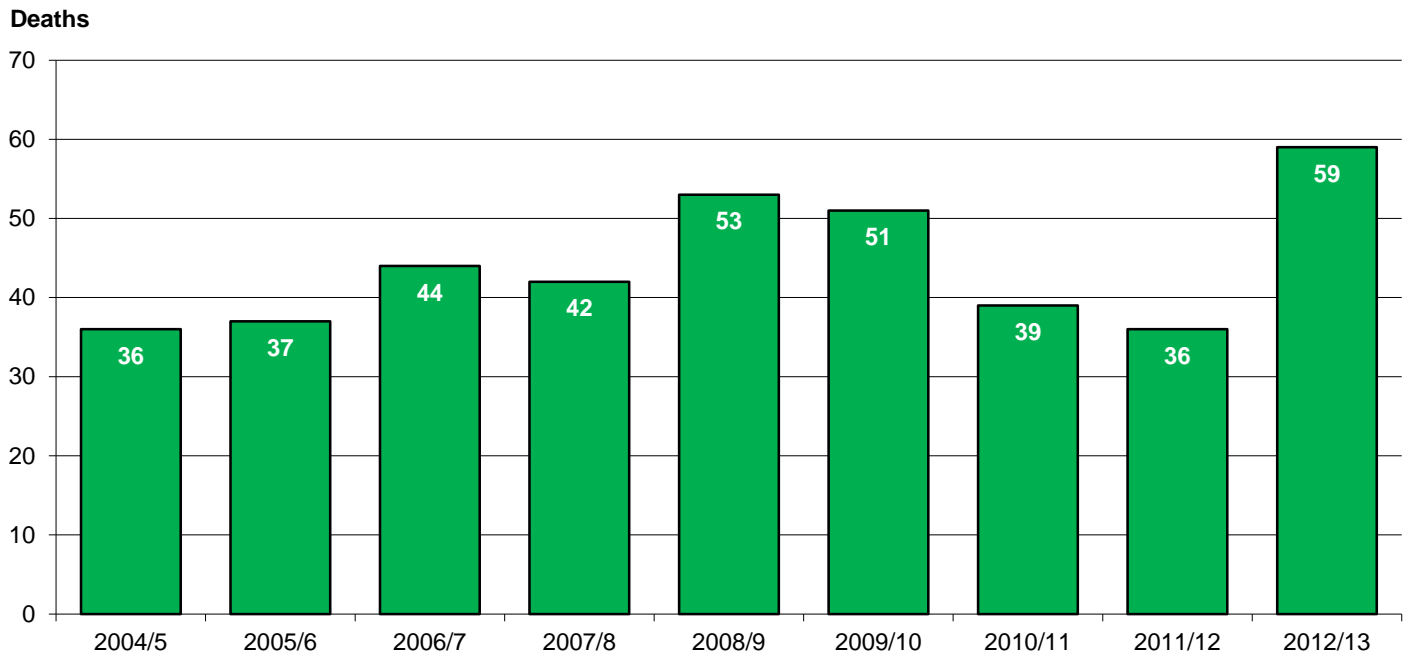


\*Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 percent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

Source: National Offender Management Service

21. There were 59 'apparent suicides following police custody' during 2012/13 in England. This is notably higher than the 2011/12 and is the highest since 2004/5 (figure7).

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

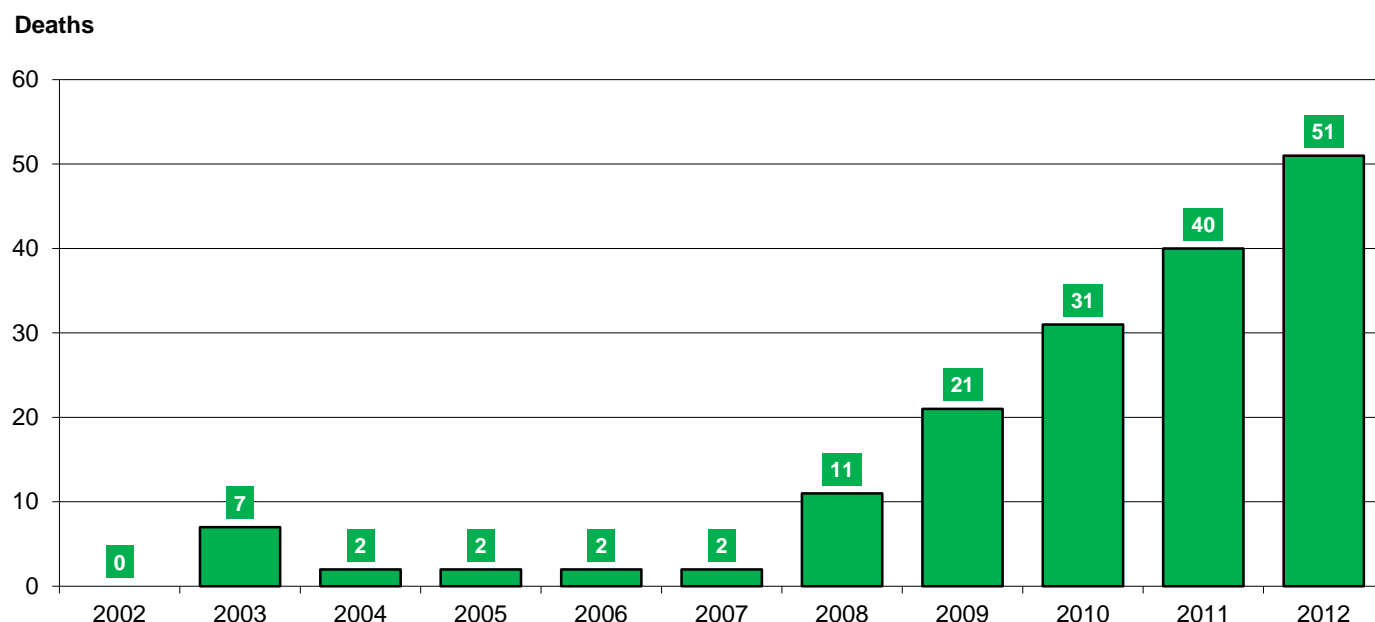


\* Includes apparent suicides that occur within two days of release from police custody. Also includes apparent suicides that occur beyond two days of release from custody, where the period spent in custody may be relevant to the subsequent death.

Source: Independent Police Complaints Commission (IPCC)

22. There were 51 deaths mentioning helium in 2012 in England, almost five 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 2002-2012**



\* 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 <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/3/par/E12000004/are/E06000015>)
- 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 (see

<http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/>)

- 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.