Injury and Poisoning Mortality in England and Wales, 2011

Coverage: England and Wales
Date: 13 February 2013
Geographical Area: Country
Theme: Population
Theme: Health and Social Care

Key findings

- The total number of injury and poisoning deaths in 2011 was 10,738 for males and 6,351 for females.

- Injury and poisoning deaths accounted for 3.5% of all deaths registered in England and Wales in 2011. This proportion has remained largely unchanged over the last decade.

- 78% of female injury and poisoning deaths in 2011 were accidental, compared with 61% of male injury and poisoning deaths.

- The highest rate of accidental deaths in 2011 were from falls with 40.6 deaths per million population.

- The mortality rate for transport accidents fell 47% between 2001 and 2011, from 56.6 to 30.2 deaths per million population.

Summary

This statistical bulletin presents annual data and analysis on the main causes of death from injury and poisoning in England and Wales in 2011. All statistics are based on deaths registered in England and Wales in a particular year. Information on the impact of registration delays on injury and poisoning mortality is also included.

In addition, trends in accidental deaths and suicides since 2001 are reported.
Mortality rates for 2002-2010 included in this publication have been calculated using revised mid-year population estimates which take account of the 2011 Census. Figures may therefore differ from those previously published.

**Main causes of death from injury and poisoning**

In this release, the total number of injury and poisoning deaths based on the International Collaborative Effort (ICE) matrix (see background note 2) are 10,738 for males and 6,351 for females, which accounts for 3.5% of all deaths registered in 2011. This proportion has remained largely unchanged for the last decade.

In 2011 almost four-fifths (78%) of female injury and poisoning deaths were unintentional (accidental), compared with 61% for males (Figure 1). Just over a third (35%) of male injury and poisoning deaths were due to suicide (intentional self-harm and event of undetermined intent) compared with 19% of female injury and poisoning deaths. Figures show that males are more likely than females to commit suicide at all age groups (ONS, 2013). Possible explanations for this include relationship breakdowns being more likely to lead men rather than women to suicide and men making risky choices under stress – such as drinking more heavily or making rash financial decisions leading to an increase in life problems (Samaritans, 2012).

In September 2012 the Department of Health launched ‘Preventing Suicide in England, a cross-government outcomes strategy to save lives’. This strategy aims to reduce the suicide rate and improve support for those affected by suicide. Following a public consultation in 2009, the Welsh Government published ‘Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014’. This plan aims to deliver co-ordinated action to improve the mental health and well-being of the population of Wales while delivering timely and effective services to those at risk of suicide and self-harm.

Homicides (including probable homicides) accounted for 4.5% and 3.3% of male and female injury and poisoning deaths respectively.
Figure 1: Injury and poisoning mortality: by intent and sex

England and Wales, 2011

Source: Office for National Statistics

Notes:
1. Death figures are based on deaths registered rather than deaths occurring in a calendar year. For information on the impact of registration delays, see http://ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/impact-of-registration-delays-on-mortality-statistics/index.html
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40-Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.
3. Deaths from intentional self-harm have been combined with deaths from injury or poisoning of undetermined intent to provide an estimate for suicide deaths.

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For males the majority of accidental deaths (where the cause of the accident was known) resulted from falls or poisoning (30% and 22% respectively). Similarly for females, falls were the most common cause, accounting for 39% of accidental deaths. Poisoning comprised 12% of accidental deaths for females. Rises in accidental deaths due to falls are likely to be related to the ageing population.

Although transport accidents remain a major cause of accidental death, various national and local government campaigns and regulations, which have targeted road safety, may have led to a fall in these types of deaths in recent years. For example the THINK! Road Safety campaign was launched
in 2000, as part of the Government’s road safety strategy (Tomorrow’s roads: safer for everyone). Regular improvements in car safety may also have contributed to the decline in motor vehicle deaths over the last decade. Directly age-standardised mortality rates are reported later in this bulletin; these take account of differences in the age structure of the population and are particularly useful for making comparisons over time (see background note 10).

The most common mechanism for suicide deaths was hanging, strangulation and suffocation for males (57%) and poisoning for females (38%). Suicides from poisoning in England and Wales involve drugs or exposure to noxious substances including gases.

**Causes of injury and poisoning mortality by age and sex**

For both males and females, mortality rates for accidental deaths were higher than those for homicide (including probable homicide) or suicide (intentional self-harm and events of undetermined intent) for most ages, except for males aged 35 to 54 (Table 1). The oldest age group (75 years and over) had the highest age-specific mortality rates for accidental deaths for both males and females (129.9 and 128.5 deaths per 100,000 population respectively). This is likely to be because of the high number of accidental falls in this age group.
### Age-specific mortality rates for injury and poisoning deaths: intent by age group and sex

**England and Wales, 2011**

<table>
<thead>
<tr>
<th>Males</th>
<th>0–14</th>
<th>15–34</th>
<th>35–54</th>
<th>55–74</th>
<th>75 and over</th>
<th>All ages</th>
</tr>
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<tbody>
<tr>
<td>Unintentional (Accidental)</td>
<td>1.8</td>
<td>15.9</td>
<td>22.3</td>
<td>21.7</td>
<td>129.9</td>
<td>23.6</td>
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<td>22.9</td>
<td>13.6</td>
<td>13.7</td>
<td>13.5</td>
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<tr>
<td>Homicide and probable homicide</td>
<td>0.4</td>
<td>2.5</td>
<td>2.4</td>
<td>1.3</td>
<td>1.5</td>
<td>1.8</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Females</th>
<th>0–14</th>
<th>15–34</th>
<th>35–54</th>
<th>55–74</th>
<th>75 and over</th>
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<td>7.5</td>
<td>11.3</td>
<td>128.5</td>
<td>17.4</td>
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<tr>
<td>Intentional self-harm and event of undetermined intent</td>
<td>0.1</td>
<td>3.7</td>
<td>6.1</td>
<td>4.9</td>
<td>4.9</td>
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<td>1.0</td>
<td>0.7</td>
<td>0.7</td>
<td>0.8</td>
<td>0.7</td>
</tr>
</tbody>
</table>

**Table source:** Office for National Statistics

**Table notes:**
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40-Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.

**Download table**

[XLS](XLS format) (30.5 Kb)
Mortality rates from suicides (intentional self-harm and event of undetermined intent) were highest among the 35 to 54 age group for both males and females (22.9 and 6.1 deaths per 100,000 population respectively). The mortality rate for homicides and probable homicides was highest for both males and females aged 15 to 34 (2.5 and 1.0 deaths per 100,000 population respectively). However, homicide remains a rare cause of death in England and Wales, even after the standard ONS addition of adjourned inquest (probable homicides) as in this bulletin (see background note 2).

**Injury and poisoning deaths by mechanism**

Mortality rates for injury and poisoning deaths vary by age group according to the mechanism of death. In 2011, other than unspecified mechanisms, the four most common mechanisms for injury and poisoning deaths were:

- hanging, strangulation and suffocation,
- poisoning,
- falls and
- transport.

Hanging, strangulation and suffocation and poisoning were the most common mechanisms for males in the 15 to 34, 35 to 54 and 55 to 74 age groups (Figure 2). For males, the rate for falls increases with age, rising sharply for those aged 75 years and over, to 84.2 deaths per 100,000 population in 2011. Despite the overall decline in male death rates from motor vehicle accidents over the last decade, they remain a major cause of premature death among young males in England and Wales.
Figure 2: Male age-specific mortality rates for injury and poisoning deaths: four main mechanisms

England and Wales, 2011

Source: Office for National Statistics

Notes:
1. Death figures are based on deaths registered rather than deaths occurring in a calendar year. For information on the impact of registration delays, see http://ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/impact-of-registration-delays-on-mortality-statistics/index.html
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40-Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.
3. Excludes other and unspecified mechanisms.

Download chart

XLS format

For females aged 35 to 54, poisoning was the principal mechanism of deaths (7.2 deaths per 100,000 population). This age group also had the highest female suicide rate at 6.1 deaths per 100,000 population (Figure 3).

Similarly to males, falls were by far the most common mechanism for deaths in the oldest female age group (75 and over) accounting for 94.6 deaths per 100,000 population. Female mortality rates for transport accidents were lower than for males in all age groups. The highest female rate for transport deaths was in the oldest age group accounting for 4.2 deaths per 100,000 population. The...
female rates for hanging, strangulation and suffocation were also lower than for males in all age groups.

**Figure 3: Female age-specific mortality rates for injury and poisoning deaths: four main mechanisms**

**England and Wales, 2011**

![Chart](chart-image)

Source: Office for National Statistics

Notes:
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40-Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.
3. Excludes other and unspecified mechanisms.

**Download chart**

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**Trends in injury and poisoning mortality rates 2001-11**

Over the period 2001 to 2011, transport accidents had the highest age-standardised rate for accidental deaths up until 2009 (Figure 4). In 2010 transport accidents dropped below the rate for falls. The rate for transport accident deaths fell to 30.2 deaths per million population in 2011 from
56.6 in 2001 (a decrease of 47%). Government campaigns and regulations which have targeted improvements in both in road and car safety may have contributed to this reduction.

The rate for accidental falls increased by 16% between 2001 and 2011 from 35.1 to 40.6 deaths per million population. This rate may well be an underestimate as the majority of accidental deaths with an unspecified mechanism are thought likely to be falls (see background note 6). Age UK has highlighted the need for more preventative measures to reduce the number of deaths from falls in older people. Their 'Make your home “falls-free” campaign' aims to reduce the risk of people falling in their own home by promoting various support services including home improvement schemes.

The mortality rate for deaths from accidental poisonings reached 35.2 deaths per million population in 2011. This compares with the lowest rate for accidental poisonings over the decade of 15.8 deaths per million population in 2003. The increase in 2011 may be exaggerated by the International Classification of Diseases, Tenth Revision (ICD-10) coding change. Accidental hanging, strangulation and suffocation deaths remained relatively stable between 2001 and 2007 (around 8 deaths per million population), rising to 10.2 deaths per million population in 2008 and 2009 and falling slightly to 7.6 deaths per million population in 2011.

**Figure 4: Age-standardised mortality rates: by selected mechanism for accidental deaths**

*England and Wales, 2001-11*

![Graph showing mortality rates for different mechanisms.](image)

**Source:** Office for National Statistics

**Notes:**
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40–Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.

3. ASMRs for 2002-2010 are calculated using revised population estimates following the 2011 Census. ASMRs for 2011 are calculated using mid-2011 population estimates based on the 2011 Census.

4. These rates are for all ages and are standardised to the European standard population, expressed per million population; they allow comparisons between populations with different age structures, including between males and females and over time.

Download chart

Hanging, strangulation and suffocation and poisoning were the most common methods for suicide over the period 2001 to 2011 (Figure 5). The age-standardised rate for suicide due to poisoning fell by 36% between 2001 and 2011 from 30.4 to 19.4 deaths per million population. Conversely, the rate for suicide due to hanging, strangulation and suffocation increased by 21%, from 36.4 deaths per million population in 2001 to 44.0 in 2011. The rate for suicide due to drowning fell from 4.9 in 2001 to 3.0 in 2011. As the likelihood of committing suicide can be affected by access to the lethal method, the fall in suicides from drug poisoning may in some part be due to restrictions on the availability of certain drugs commonly associated with suicide deaths. For example, the prescription only painkiller coproxamol has gradually been phased out in England and Wales since 2007 (NMHDU 2009).

Suicides from firearms and from cuts and piercings remained at a low level throughout the period, with around 2.0 deaths per million population each year for both types of mechanism.
Figure 5: Age-standardised mortality rates: by selected mechanism for suicides
England and Wales, 2001-11

Source: Office for National Statistics

Notes:
1. Death figures are based on deaths registered rather than deaths occurring in a calendar year. For information on the impact of registration delays, see http://ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/impact-of-registration-delays-on-mortality-statistics/index.html
2. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40-Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in these figures.
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4. These rates are for all ages and are standardised to the European standard population, expressed per million population; they allow comparisons between populations with different age structures, including between males and females and over time.

Download chart
XLS format
(32 Kb)

Additional commentary and analysis of suicide rates and figures for the UK, England, Wales and regions in England is available in the statistical bulletin Suicide in the United Kingdom, 2011. An article assessing the impact of narrative verdicts on the quality of injury and poisoning statistics in England and Wales also provides additional context for this bulletin (Hill and Cook, 2011 (197.6 Kb Pdf)). The findings of this study showed that in the last ten years there has been a substantial increase in the use of narrative verdicts by coroners in England and Wales. Some of these narrative
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verdicts are difficult to code with an underlying cause of death. This is especially true for injury and poisoning deaths where the intent behind the event which led to the death may not always be clear from the information provided by the coroner. However, the study concluded that the increase in ‘hard to code’ narrative verdicts has not yet had a significant impact on suicide rates in England and Wales.

Background

Deaths from injury and poisoning have a large impact in terms of premature deaths and potential years of life lost. The analysis in this bulletin uses an internationally accepted standard framework specifically designed for presenting data on injury. The matrix, developed by the International Collaborative Effort (ICE) on injury statistics, displays injury and poisoning data by intent (for example, unintentional (accidental), intentional self-harm and injury and poisoning of undetermined intent, or homicide and probable homicide) and by mechanism (for example, poisoning, transport, firearm or drowning). See background note 2 for more information on the ICE classification.

This analysis excludes deaths with an external cause attributed to complications of surgical and medical care (codes Y40–Y84) and sequelae (see definition below) with surgical and medical care (Y88). There were 489 such deaths in 2011. Sequelae means that the death resulted from the late (residual) effects of a given disease or injury one year or more after the original event (WHO 1992–1994).

Deaths attributed to legal intervention or operations of war (Y35–Y36) and sequelae of legal intervention and sequelae of war operations (Y89.0–Y89.1) were also excluded; there were 12 such deaths in 2011. These exclusions mean that figures for 2011, and earlier years, may differ from previously reported totals of deaths from all external causes (U50.9, V01–Y89)¬ published in Table 5.19 of deaths registered in England and Wales, 2011. Table 5.19 also contains detailed statistics of injury and poisoning mortality in 2011 by individual International Classification of Diseases, Tenth Revision (ICD-10) code.

The Office for National Statistics (ONS) combine data on deaths from intentional self-harm and injury or poisoning deaths of undetermined intent to give an overall estimate of suicides in England and Wales. Accelerated registration deaths (adjourned inquests pending further investigation) have been classified as ‘probable homicides’ and combined with homicides to give an overall estimate of homicides.

The mechanism of death is important when looking at preventing the incidence of injury and poisoning deaths. For example, changes to the law (such as gun control legislation) or developments in technology (such as to improve car safety) are implemented to try and reduce the number of avoidable deaths from these mechanisms. The removal of potential ligature points in psychiatric units and prison cells to reduce the risk of hanging as a means of suicide (NMHDU 2009).

Categorising deaths by intent is important when looking at interventions which aim to prevent deaths across mechanisms of death for the same intent.
Impact of registration delays on injury and poisoning deaths

In England and Wales almost all injury and poisoning deaths are certified by a coroner following an inquest. The death cannot be registered until the inquest is completed, which can take many months or even years. ONS is not notified that a death has occurred until it is registered. If someone is to be charged in relation to the death, the coroner must adjourn the inquest, and they may carry out an accelerated registration. However, the full details are not recorded until the inquest is completed. The ICE matrix has been modified slightly to include accelerated registration deaths (adjourned inquests pending further investigation) as ‘probable homicides’ in line with other ONS publications.

In common with most other mortality statistics, figures for injury and poisoning deaths are presented for deaths registered in a particular calendar year, which enables figures to be published in a timely manner. The alternative would be to publish statistics based on the year in which the death occurred. However, if ONS were to do this the publication would be delayed by at least six months to allow enough time for the majority of the deaths that occurred in a given year to be registered. If it was produced any earlier the data would be incomplete, and hence inaccurate.

Due to the length of time it takes to hold an inquest, this bulletin actually presents information on deaths that may have occurred in years prior to the registration year. Out of the 17,089 injury and poisoning-related deaths registered in 2011, 7,227 (42%) occurred in years prior to 2011.

ONS is carrying out research on the impact of registration delays on mortality statistics and initial findings for injury and poisoning-related deaths are presented below.

**Figure 6: Average (median) registration delay for all injury and poisoning deaths: deaths registered in 2001 and 2011.**

England and Wales
Source: Office for National Statistics

Notes:
1. Death figures are based on deaths registered rather than deaths occurring in a calendar year. For information on the impact of registration delays, see http://ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/impact-of-registration-delays-on-mortality-statistics/index.html
2. The registration delay is calculated as the difference between the date each death occurred and the date it was registered, measured in days. The average delay is represented using the median (see background note 11).
3. Figures for England and Wales include deaths of non-residents.

Download chart

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Figure 6 shows that the average registration delay has increased since 2001 for all intents apart from homicide, where the delay reduced by 25%. In 2001 the average delay was 109 days for all injury and poisoning-related deaths, and this had increased to 141 days in 2011.

Impact of coding changes

In January 2011, the software used for cause of death coding was updated from the International Classification of Diseases, Tenth Revision (ICD-10) version 2001.2 to version 2010. The main changes in ICD-10 v2010 are amendments to the modification tables and selection rules, which are used to ascertain a causal sequence and consistently assign underlying cause of death from the conditions recorded on the death certificate. Overall, the impact of these changes is small although some cause groups are affected more than others. For further information, see the results of the bridge coding study on the ONS website.

Analyses showed that the change to using v2010 resulted in no change to the number of deaths coded as intentional self-harm but a slight increase (2%) in the number of deaths coded as undetermined intent. This is because in the previous version of ICD-10 (software version 2001.2) deaths mentioning both acute poisoning and drug dependence would be assigned an underlying cause of a mental and behavioural disorder due to psychoactive substance use (an ICD-10 F code). However, in software v2010 this causal sequence is no longer valid, so the acute poisoning is selected as the underlying cause of death. The acute poisoning may be accidental (ICD-10 codes X40–X49) or a poisoning of undetermined intent (Y10–Y19), depending on the intent.

Users and uses of injury and poisoning mortality statistics

ONS uses injury and poisoning mortality statistics to carry out further analysis on suicides and deaths related to drug poisoning.

The Department of Health (DH) is a key user of mortality statistics. Data are used, for example, to inform policy decisions and to reduce avoidable mortality from the major causes of premature death including road traffic accidents and suicides.
Users also include other public sector organisations such as the Police and the Home Office who are interested in data on external causes of death.

Other users include academics, demographers and health researchers who conduct research into mortality trends. Lobby groups and charities use injury and poisoning mortality statistics to support their cause, for example, campaigns for the prevention of accidents on the road, in the home and at work. Organisations such as Eurostat and the United Nations use mortality statistics for making international comparisons. The media also report on key trends in mortality, including suicides and road traffic accidents.

**Further information**

This bulletin accompanies tables published in the annual publication, *Injury and poisoning mortality in England and Wales, 2011* (142 Kb Excel sheet). The published tables also contain information on the other mortality outputs released by ONS and provides links to these on the ONS website.

Detailed mortality data for England and Wales by underlying cause of death, can be found in *Mortality statistics: Deaths registered in 2011* (Series DR).

For information on data quality, legislation and procedures relating to mortality statistics, please see *Mortality metadata (2.46 Mb Pdf)* and *Quality and Methodology Information (222.3 Kb Pdf)*.

For further information on drug poisoning deaths in England and Wales please see *Drug related deaths to poisoning, 2011*.

For further information on suicides please see *Suicides in the UK, 2011*.

For injury and poisoning data for other UK countries please see *statistics on injury and poisoning deaths in Scotland* and *statistics on injury and poisoning deaths in Northern Ireland*.

Future changes to mortality outputs are outlined in the *plan for mortality outputs (116 Kb Pdf)* available on the ONS website.

Further information on the *Impact of Registration Delays on Mortality Statistics* is available on the ONS website.

**References**

Age UK (2012) ‘Make your home “falls-free” campaign’


Rooney C and Devis T (1999) ‘Recent trends in deaths from homicide in England and Wales’ (100.7 Kb Pdf), Health Statistics Quarterly 03, pp 5–13

Samaritans (2012). ‘Men, Suicide and Society, Why disadvantaged men in mid-life die by suicide’


Background notes

1. Deaths are classified according to the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (WHO 1992–1994). Injury and poisoning deaths are accidental or violent deaths that are attributed to external causes. They exclude those deaths that have disease and other internal conditions as their underlying cause. External cause of injury codes are taken from Chapter XX of ICD-10 (prefixes V01 to Y89).

2. This bulletin presents injury and poisoning data according to an internationally accepted standard framework, known as the International Collaborative Effort on Injury Statistics (ICE) matrix, specifically designed for presenting data on injury (McLoughlin et al. 1997). Two aspects of the cause of injury and poisoning deaths are captured by the ICD codes for the underlying cause of death. The first is the intent of the deceased, or third party (sometimes called manner of death) and includes accident, suicide, homicide, undetermined intent. The second is the mechanism of death and includes for example, drowning, poisoning, suffocation and transport. Presenting information solely on either one of these masks important information on the other factor. Presentation of data using the ICE matrix allows easy access to information on both mechanism and intent. The ICE matrix shows the ICD-10 codes used in classifying deaths according to the matrix. The matrix is used in other countries and has been used to present international comparisons of injury mortality (Fingerhut et al. 1998). The matrix has been modified slightly to incorporate accelerated registration deaths (adjourned inquests pending further investigation) as ‘probable homicides’ in line with other ONS publications. From 2007...
onwards, ONS has used ICD-10 code U50.9 for deaths with adjourned inquests. In the past, these deaths were coded to Y33.9. The principal reason for the change was to exclude these deaths from the Y10–Y34 range, making the tabulation of events of undetermined intent easier. Deaths from intentional self-harm have also been combined with deaths from injury or poisoning of undetermined intent to provide an estimate for suicide deaths in line with other ONS publications.

3. Since 1 January 2007, accelerated registrations that are not transport incidents have been assigned to code U50.9 (event awaiting determination of event), these would have previously been coded to Y33.9 (other specified events, undetermined intent). Most of these deaths are eventually reassigned to assault (X85–Y09), but the delays before this happens can affect the published figures leading to under estimation of deaths from assault (Rooney and Devis 1999 (100.7 Kb Pdf)). Accelerated registrations that are motor vehicle incidents are assigned to a code in the range V01–V89 (land transport accidents) if sufficient information is available on the coroner’s certificate of adjournment.

4. In this bulletin suicides (intentional self-harm and injury and poisoning of undetermined intent) include deaths at all ages unlike the ONS publication Suicide rates in the United Kingdom, 2011 which only includes suicides for children and adults aged 15 years and over.

5. Injury and poisoning deaths attributed to complications of medical and surgical care (Y40–Y84), sequelae with surgical and medical care (Y88), legal intervention or operations of war (Y35–Y36), sequelae of legal intervention (Y89.0) and sequelae of war operations (Y89.1) are not included in the analysis.

6. The majority of accidental deaths with an unspecified mechanism are likely to have been falls and thus the figures for falls presented here are probably an underestimate of the true contribution of falls to injury and poisoning mortality.

7. The statistics presented here are based on deaths registered in a reference year and may differ from any previously published data which was based on deaths that occurred in a calendar year.

8. The tables and figures are based on the final underlying cause of death. This takes account of additional information on the cause of death that becomes available after the death has been registered. Around 0.2% of all deaths have their underlying cause amended.

9. The population estimates used for the calculation of mortality rates are the latest consistent estimates available at the time of production. Further information on population estimates and their methodology can be found on the ONS website.

10. The directly age-standardised mortality rates in this release are for all ages and are expressed per million population. Age-specific rates are calculated using the latest mid-year population estimates based on the 2011 Census. These are then directly age-standardised to the European Standard Population, which allow comparisons between populations with different age structures, including between males and females and over time.
11. The median registration delay is the registration delay in the middle of the group, such that one half of the group has a shorter registration delay while the other half have a longer registration delay.

12. There is a large degree of comparability in mortality statistics between countries within the UK. However, there are some differences although these are believed to have a negligible impact on the comparability of the statistics. These differences are outlined in the Quality and Methodology Information (222.3 Kb Pdf) document for mortality statistics.

13. Special extracts and tabulations of mortality data for England and Wales are available to order (subject to legal frameworks, disclosure control, resources and agreements of costs, where appropriate). Such enquiries should be made to:

Vital Statistics Outputs Branch
Life Events and Population Sources Division
Office for National Statistics
Segensworth Road
Titchfield
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 PO15 5RR
Tel: +44 (0)1329 444 110
E-mail: vsob@ons.gsi.gov.uk

14. We would welcome feedback on the content, format and relevance of this release. The Health and Life Events user engagement strategy is available to download from the ONS website. Please send feedback to the postal or email address above.

15. Next publication date: February/March 2014

16. Follow ONS on Twitter and Facebook

17. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

• meet identified user needs;
• are well explained and readily accessible;
• are produced according to sound methods; and
• are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

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This document is also available on our website at www.ons.gov.uk.

Statistical contacts

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