

Suicides in the United Kingdom, 2012 Registrations



Coverage: **UK**

Date: **18 February 2014**

Geographical Area: **Region**

Theme: **Health and Social Care**

Theme: **Population**

Key Points

- In 2012, 5,981 suicides in people aged 15 and over were registered in the UK, 64 fewer than in 2011.
- The UK suicide rate was 11.6 deaths per 100,000 population in 2012, but there are significant differences in suicide rates between men and women. Male suicide rates were more than three times higher at 18.2 male deaths compared with 5.2 female deaths per 100,000 population.
- The highest suicide rate was among men aged 40 to 44, at 25.9 deaths per 100,000 population.
- The most common methods of suicide in the UK in 2012 were hanging, strangulation and suffocation (58% of male suicides and 36% of female suicides) and poisoning (43% of female suicides and 20% of male suicides).
- In 2012 in England, the suicide rate was highest in the North West at 12.4 deaths per 100,000 population and lowest in London at 8.7 per 100,000 population.
- The median registration delay for deaths where suicide was the underlying cause of death was 155 days in England and Wales and 144 days in Northern Ireland. In Scotland, the time taken to register a death did not exceed the allocated eight days.

Summary

The latest suicide statistics for the UK, England (including figures for regions) and Wales. New figures are presented for deaths registered in 2012, with a previously released time series covering 1981 to 2011 to allow comparisons to be made. New rates have been produced for the period 2002 to 2010, to take account of revised mid-year population estimates. Information on the potential impact of the use of narrative verdicts by coroners on suicide rates at regional level in England, and

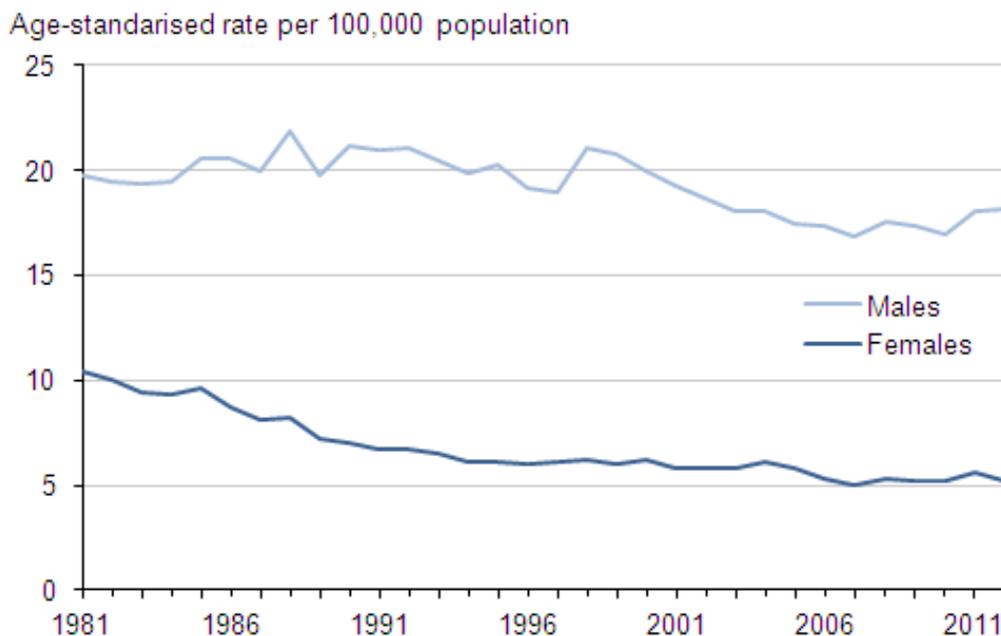
in Wales, is presented. A discussion of registration delays in relation to suicide statistics in the UK is also included.

In 2012, a total of 5,981 suicides in people aged 15 and over were registered in the UK. Suicide rates for 2012 were not significantly different to those in 2011. They were significantly higher than five years before, but significantly lower than 20 years before.

Of the total number of suicides registered in 2012 in the UK, 4,590 were males and 1,391 were females. Suicide rates have been consistently lower in females than in males throughout the time series. Although suicide rates for both males and females have fallen significantly in this time, the fall has been faster among females, from 10.1 deaths per 100,000 population in 1982 (37% of all suicides) to almost half that, at 5.2 deaths per 100,000 population in 2012 (23% of all suicides). In comparison, the suicide rate among males fell from 19.4 deaths per 100,000 population in 1982 (63% of all suicides) to 18.2 (77% of all suicides) in 2012. In 2012, the male suicide rate was more than three times the rate for females.

Figure 1: Age-standardised suicide rates: by sex, deaths registered in each year from 1981 to 2012

United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Notes:

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Rates per 100,000 population, standardised to the 1976 European Standard Population.

4. Figures include deaths of non-residents.
5. Figures are for deaths registered in each calendar year.

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Suicides in the United Kingdom 1981 to 2012 Registrations

Males

There were 4,129 male suicides registered in the UK in 1981 (an age-standardised mortality rate of 19.8 deaths per 100,000 population). In 2012 the number of suicides registered was higher at 4,590, but the suicide rate was significantly lower, at 18.2 deaths per 100,000 population. The suicide rate did not decline consistently over this period, but fluctuated from year to year.

Male suicide rates increased in the 1980s, and peaked at 21.9 deaths per 100,000 population in 1988. Suicide rates tended to decrease between 1988 and 2010, though there were some notable annual rises, such as between 1989 and 1990 when the suicide rate rose significantly from 19.8 to 21.2 deaths per 100,000 population, and again between 1997 and 1998 when they rose significantly from 19.0 to 21.1 deaths per 100,000 population. Male suicide rates then fell each year between 2000 and 2007, rose slightly in 2008 and continued to fall until 2011, when the rate increased significantly from 16.9 to 18.1 deaths per 100,000 population. The increase between 2011 and 2012 (to 18.2 deaths per 100,000 population) is not significant.

Females

In 1981 there were 2,466 female suicides registered in the UK (an age-standardised mortality rate of 10.4 deaths per 100,000 population). This was the highest rate of female suicide seen in the 32-year period covered by this bulletin. By 2012 the number of female suicides had fallen by almost 44% to 1,391 (5.2 deaths per 100,000 population). However, as with males, there have not been consistent year-on-year decreases in female suicides.

The female suicide rate declined steadily between 1981 and 1994 from 10.4 to 6.1 deaths per 100,000 population, and then remained relatively stable between 1994 and 2004. The rate then declined for three years in a row, to reach a low of 5.0 suicides per 100,000 population in 2007. Female suicides increased slightly to 5.3 deaths per 100,000 population in 2008 and remained fairly stable until 2011 when they rose to 5.6 deaths per 100,000 population before falling back to 5.2 deaths per 100,000 population in 2012. There has been no significant change in female suicide rates since 2004, when the rate was 6.1 deaths per 100,000 population.

Coding Changes

Several changes were introduced in 2011 that could have affected suicide statistics. In respect of narrative verdicts, an advice note was issued to coroners explaining what information is required in a narrative verdict to help ONS code cause of death using the International Classification of Diseases. Also, additional guidance was given to the ONS coding team to improve coding of narrative verdicts. Finally, an update of the ICD-10 software (version 2010) was introduced in the UK, which included a rule change that affected deaths coded as an event of undetermined intent. These changes were outlined in more detail in the statistical bulletin [Suicides in the UK, 2011](#), which is available on the ONS website.

Age-specific Suicide Rates in the United Kingdom

Males

Looking at five-year age groups, there were no significant changes in the male suicide rates between 2011 and 2012. As in 2011, the highest rate in 2012 was among men aged 40 to 44, at 25.9 deaths per 100,000 population, although this was slightly lower than in 2011 when the rate for this age group was 26.8 deaths per 100,000 population. The lowest rate was among younger men, those aged 15 to 19, at 6.4 deaths per 100,000 population. [Table 6 \(647 Kb Excel sheet\)](#) of the reference tables available for download presents suicide rates in the UK by sex and five year age groups.

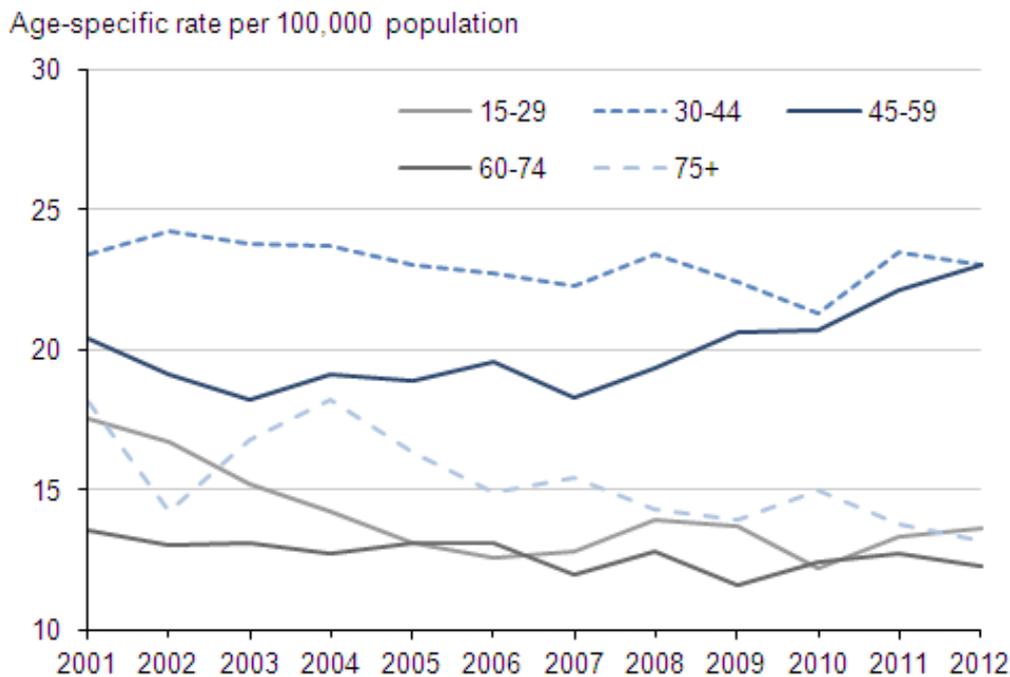
Looking at broader age groups over the last 10 years, very different trends have been observed. Male suicide rates have fluctuated among all age groups, and although all age groups except one saw lower suicide rates in 2012 than in 2003, these changes weren't significant. The exception was the age group 45 to 59, which saw a suicide rate of 23.0 deaths per 100,000 population in 2012. This was significantly higher than in 2003 when the rate was 18.2 deaths per 100,000 population. This age group had the joint highest suicide rate in 2012, along with men aged 30 to 44, who have consistently had the highest suicide rates over the last 10 years. See [Table 10 \(647 Kb Excel sheet\)](#) of the reference tables available for download.

Suicide is the leading cause of death in England and Wales for men aged between 20 and 34 years of age (26% of all deaths in 2012), followed by accidental poisoning (12%), and then land transport accidents (10%). Suicide remains the leading cause of death among men aged 35 to 49 years (13% of all deaths in 2012). Further information about [leading causes of death](#) can be found on the ONS website.

The latest suicide prevention strategy for England (Department of Health, 2012) identified middle-aged men as one of the high-risk groups who were a priority for suicide prevention. A recent [report by the Samaritans](#) suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life (Samaritans, 2012).

Figure 2: Age-specific suicide rate: males, deaths registered each year from 2001 to 2012

United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Notes:

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Age-specific suicide rate per 100,000 population.
4. Figures include deaths of non-residents.
5. Figures are for deaths registered in each calendar year.

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Females

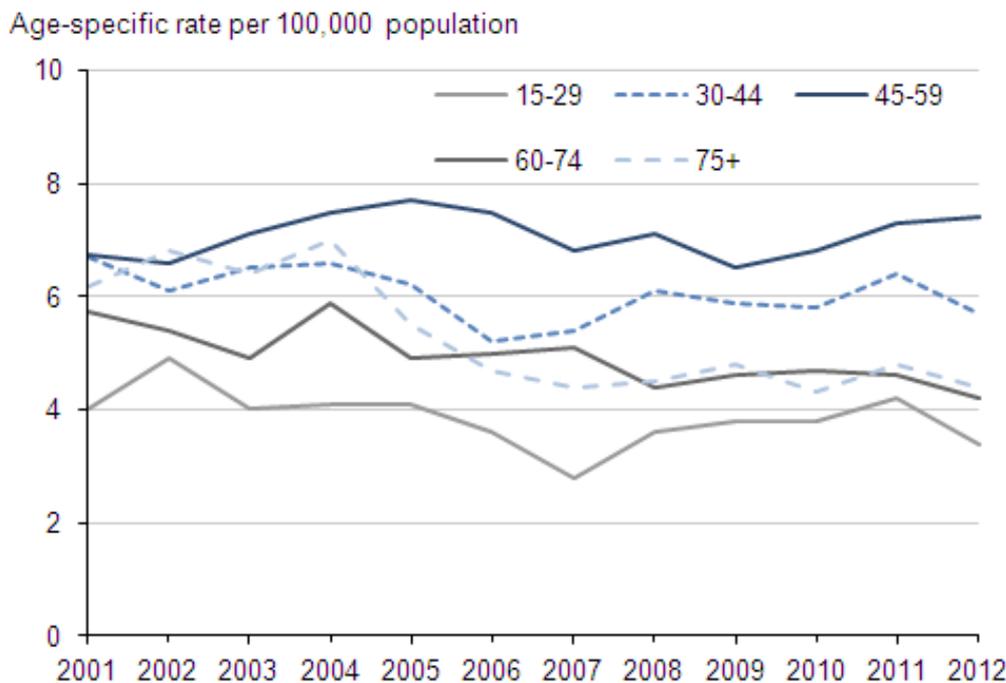
In 2012 the highest female suicide rate was in 50 to 54-year-olds, at 8.0 deaths per 100,000 population, and the lowest suicide rate was in 15 to 19-year-olds, at 1.9 deaths per 100,000 population. As with males, none of the changes in female suicide rates between 2011 and 2012 were significant. [Table 6 \(647 Kb Excel sheet\)](#) of the reference tables available to download shows suicide rates in the UK by sex and five-year age groups.

Looking at broader age groups over the last 10 years, female suicide rates have fluctuated for all age groups, but rates in 2012 were only significantly different to rates in 2003 for the age group 75 years and over, having fallen from 6.4 to 4.4 deaths per 100,000 population.

As with men, suicide is the leading cause of death among women aged between 20 and 34 years of age, accounting for 13% of all deaths registered in this age group in 2012. Further information about [leading causes of death](#) can be found on the ONS website.

Figure 3: Age-specific suicide rate: females, deaths registered in each year from 2001 to 2012

United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Notes:

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Age-specific suicide rate per 100,000 population.
4. Figures include deaths of non-residents.
5. Figures are for deaths registered in each calendar year.

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Suicides in England and Wales

England

There were 4,507 suicides among people aged 15 and over registered in England in 2012, just two fewer than in 2011. Of these, more than three-quarters (77.3%) were male (3,483 deaths). There were 1,024 female suicides (22.7%). Overall, the age-standardised suicide rate did not change between 2011 and 2012, remaining at 10.4 deaths per 100,000 population.

In 2012/13 there were almost 110,000 inpatient hospital admission episodes in NHS hospitals in England for intentional self-harm or an event of an undetermined intent. This is a fall of around 4% compared with 2011/12 when there were just over 114,000 [inpatient admission episodes](#).

Wales

There were 334 suicides in those age 15 and over in Wales in 2012. Between 2011 and 2012 the number of male suicides fell from 270 to 257, while the number of female suicides rose from 71 to 77.

Between 1981 and 1990 the male suicide rates were fairly similar in England and Wales, but from 1991 onwards the rate has been higher in Wales (23% higher in 2012). However, a different picture is seen for females: between 1981 and 1996, the female suicide rate tended to be lower in Wales than in England, but from 1997 onwards there has been no consistent pattern.

In 2012/13 there were just over 9,600 admissions in NHS hospitals in Wales for intentional self-harm or an event of an undetermined intent. This is a fall of almost 11% compared with 2011/12 when there were almost 10,750 [inpatient admission episodes](#).

English regions

In 2012 the suicide rate was highest in the North West at 12.4 deaths per 100,000 population and lowest in London at 8.7 per 100,000 (see Table 1).

[Reference Table 5 \(647 Kb Excel sheet\)](#) shows that over the last 10 years (2003 to 2012) male suicide rates have tended to be highest in the North East and the North West and lowest in London and the East of England. Female suicide rates have tended to be highest in the North West and the South West, and lowest in Yorkshire and The Humber and the West Midlands.

Table 1: Number of deaths and age-standardised suicide rate: by sex, deaths registered in 2012

England, regions in England and Wales

	Male		Female		Persons	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
England	3,483	16.4	1,024	4.5	4,507	10.4
North East	198	19.8	48	4.4	246	12.0
North West	552	19.8	152	5.2	704	12.4
Yorkshire and The Humber	381	18.2	100	4.5	481	11.3
East Midlands	302	16.5	72	3.6	374	9.9
West Midlands	357	16.3	96	4.0	453	10.1
East of England	330	14.3	110	4.4	440	9.3
London	434	13.4	142	4.2	576	8.7
South East	537	15.7	177	4.8	714	10.2
South West	392	18.1	127	5.6	519	11.8
Wales	257	21.4	77	5.8	334	13.5

Table source: Office for National Statistics**Table notes:**

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Rates per 100,000 population, standardised to the 1976 European Standard Population.
4. Figures exclude the deaths of non-residents.
5. Figures are for deaths registered in 2012.
6. Based on boundaries as of August 2013.

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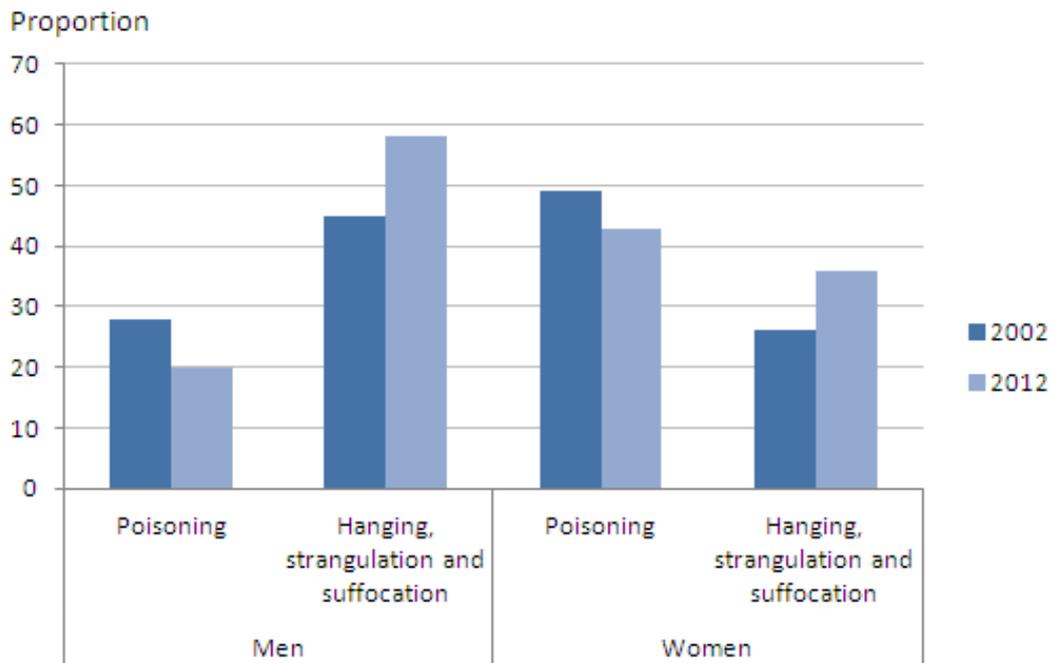
Methods of Suicide

The two most common methods of suicide among men in the United Kingdom are hanging, strangulation and suffocation, followed by poisoning. The reverse is true among women: the most

common method of suicide is poisoning, followed by hanging, strangulation and suffocation. For both men and women, the proportion of deaths from poison has fallen over the last 10 years, from 28% in 2002 to 20% in 2012 for men, and from 49% in 2002 to 43% in 2012 for women. Conversely, the proportion of suicides from hanging, strangulation and suffocation has increased over the same period, from 45% in 2002 to 58% in 2012 for men, and from 26% in 2002 to 36% in 2012 for women.

Figure 4: Proportion of suicide deaths: method and sex, deaths registered in 2002 & 2012

United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Notes:

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Figures include deaths of non-residents.
4. Figures are for deaths registered in each calendar year.

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A [study by the World Health Organisation \(WHO\)](#) in 2008, which compared methods of suicide by country, found that methods of suicide vary between countries, and that this difference is driven primarily by availability of means. For example, while hanging (suffocation) was the most common method in the majority of countries, suicide by firearm was the most common method in the United States, and jumping from a height was the most common method in Hong Kong. The

report also highlighted the difference in method between the sexes; men tend to choose a more violent mechanism, such as hanging or suicide by firearm, whereas women choose less violent mechanisms such as poison.

Results for Scotland and Northern Ireland

Suicide figures for Scotland are produced by [National Records of Scotland](#) (formerly the General Register Office for Scotland) and can be found on their website.

Suicide figures for Northern Ireland are produced by the [Northern Ireland Statistics and Research Agency](#) and can be found on their website.

Narrative Verdicts in England and Wales

Annually, there are around 30,000 coroner's inquests held in England and Wales that conclude with a verdict. Around 90% of these inquests conclude with a 'short form' verdict such as accident, misadventure, natural causes, suicide or homicide. Narrative verdicts can be used by a coroner or jury instead of a short form verdict to express their conclusions as to the cause of death following an inquest.

A narrative verdict can be given in a range of different circumstances, and for a variety of causes of death. Table 2 shows that the underlying cause of death for around half (49%) of all narrative verdicts in England and Wales in 2012 was a disease of some kind, most commonly a circulatory disease or a type of cancer (a neoplasm). An example of when a narrative verdict would be used for a death from a disease is some cases of mesothelioma. Mesothelioma is an industrial disease often associated with exposure to asbestos in the workplace; a narrative verdict is sometimes given when the source of exposure to asbestos could not be determined. Other examples of narrative verdicts include instances where the deceased may have suffered an accidental fall as a result of an underlying health condition, or where the deceased died whilst having medical treatment for an underlying health condition.

Table 2: Number of narrative verdicts: by underlying cause of death, deaths registered in 2012

England and Wales

Underlying cause of death	Hard-to-code narrative verdict	Other type of narrative verdict	All narrative verdicts
All causes	2,024	1,421	3,445
Diseases	1,017	676	1,693
Neoplasms	210	159	369
Circulatory	219	194	413
Respiratory	114	59	173
Digestive system	104	76	180
Other disease or condition	370	188	558
External causes	1,007	745	1,752
Transport accidents	148	17	165
Other accidents	798	226	1,024
Intentional self-harm	0	163	163
Undetermined intent	0	260	260
Other external cause	61	79	140

Table source: Office for National Statistics**Table notes:**

1. Underlying cause of death was defined using the International Classification of Diseases, Tenth Revision (ICD–10).
2. Figures include deaths of non-residents.
3. Figures are for deaths registered in 2012.

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In 2012, 51% of narrative verdicts in England and Wales resulted from an external cause of death (an injury or poisoning) rather than a disease. Some of these narrative verdicts clearly state the intent (for example, accidental) and mechanism (for example, hanging, poisoning) of death. However, in some cases, the coroner may not indicate clearly whether the fatal injury was accidental or if there was deliberate intent to self-harm, or if intent could not be determined. ONS defines deaths where the intent has not been specified as 'hard-to-code'.

The way ONS applies the rules of coding cause of death means that where no indication of intent has been given by the certifier, deaths from injury or poisoning must be coded as accidents. Table 2 shows that more than a third (35%) of narrative verdicts were assigned an accidental cause of death in 2012.

Table 3: Hard-to-code narrative verdicts and all narrative verdicts (for 2011 and 2012 only) as a percentage of all inquest verdicts: deaths registered in each year from 2006 to 2012

England, regions in England, and Wales

	Hard-to-code narrative verdict							All narrative verdicts	
	2006	2007	2008	2009	2010	2011	2012	2011	2012
England	6	8	9	10	12	6	7	10	12
North	4	6	6	7	8	2	3	4	6
East									
North	5	8	11	13	15	6	7	11	12
West									
Yorkshire and The Humber	7	9	8	10	10	9	11	13	14
East Midlands	4	6	6	8	11	5	8	10	14
West Midlands	15	17	17	16	20	8	8	12	13
East of England	5	7	8	13	13	10	11	15	18
London	5	6	8	8	8	6	6	9	10
South East	5	6	7	6	8	5	5	8	9
South West	4	6	7	8	8	5	6	7	10
Wales	3	7	9	8	8	4	5	8	9

Table source: Office for National Statistics

Table notes:

1. Number of narrative verdicts defined by ONS as hard-to-code.
2. Figures exclude deaths of non-residents.
3. Based on boundaries as of August 2013.
4. Figures are for deaths registered in each calendar year.

5. Percentages are calculated as the number of hard-to-code narrative verdicts as a percentage of all inquest verdicts. Figures are also provided for all narrative verdicts for 2011 and 2012 only, as prior to 2011, ONS were only able to identify hard-to-code narrative verdicts in our mortality database.

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Between 2001 and 2010 there were large year-on-year increases in the number of narrative verdicts returned by coroners in England and Wales ([Reference Table 13 \(647 Kb Excel sheet\)](#)). The number of narrative verdicts registered in England in 2010 (3,170) was almost double the number registered in 2006 (1,592). In Wales, the number increased almost three-fold over the same period, from 52 in 2006 to 147 in 2010. This trend is supported by figures from the Ministry of Justice showing that the number of unclassified verdicts (including narrative verdicts) in England and Wales increased from 2,406 in 2006 to 4,400 in 2011.

Moreover, there is considerable variation in the use of narrative verdicts between coroners. Until 2011 the region with the highest proportion of narrative verdicts (out of all inquests that returned a verdict) was the West Midlands. In 2010 around 20% of inquests in the West Midlands resulted in a hard-to-code narrative verdict compared with only 8% in the following regions: South West, North East, South East, London and Wales. This regional variation led to concerns that if the use of narrative verdicts continued to increase, it could affect the reliability of ONS suicide statistics – especially at a sub-national level.

To help improve the accuracy of suicide statistics, in January 2011 additional guidance was given to the ONS coding team in order to improve the coding of narrative verdicts. ONS also provided advice to coroners on the types of narrative verdicts that are hard to code, elements of which the Local Government Committee of the Coroners Advisory Group incorporated into an advice note issued in October 2011.

Prior to 2011, ONS could only identify hard-to-code narrative verdicts within our mortality database, so figures for the years 2001 to 2010 reported in [Reference Table 13 \(647 Kb Excel sheet\)](#) do not show the total number of narrative verdicts. In 2011 ONS made changes to the database to make it possible to identify all narrative verdicts. [Reference Table 13 \(647 Kb Excel sheet\)](#) shows that between 2011 and 2012 the total number of narrative verdicts increased by just over 16% in England to 3,248. In Wales, there was an increase of 20% between 2011 and 2012 (from 155 to 186 narrative verdicts).

Between 2010 and 2011 the number of hard-to-code narrative verdicts decreased by 46% in England (from 3,170 to 1,727) and by 49% in Wales (from 147 to 75), which would suggest that the additional guidance given to ONS coders and coroners had significantly reduced the number of hard-to-code narrative verdicts. However, between 2011 and 2012 the number of hard-to-code narrative verdicts increased by 12% in England (from 1,727 to 1,928 hard-to-code narrative verdicts) and by 24% in Wales (from 75 to 93 hard-to-code narrative verdicts). Most regions in England showed an increase in the number of hard-to-code narrative verdicts in 2012 compared to 2011. The largest increase was in the East Midlands (64%) and the smallest increase was in London, which

saw a 2% increase. In spite of these increases, the number of hard-to-code narrative verdicts in England and Wales in 2012 remains considerably lower than before the advice was issued.

In 2013 a number of reforms were implemented in the coroners' service, as a result of part one of the Coroners and Justice Act 2009. These include minor changes affecting the death registration and mortality statistics processes, for example, verdicts will be replaced by investigation conclusions. Other changes include the introduction of a Chief Coroner. More details about the work of the Office of the Chief Coroner can be found on the Judiciary of England and Wales website. These changes will affect deaths registered in 2013 and will be reported in more detail in the next edition of this bulletin.

Narrative Verdict Simulations for England and Wales

An analysis to assess the impact of narrative verdicts on suicide rates in England and Wales was undertaken by ONS in 2011 (Hill and Cook, 2011). Simulated age-standardised suicide rates were calculated for the years 2001 to 2009 using two different assumptions:

Scenario 1: suicide rates were calculated assuming all deaths where a hard-to-code narrative verdict meant that the death been coded as an accidental hanging (ICD-10 codes W75–W76) or accidental poisoning (ICD-10 codes X40–X49) were intentional self-harm.

Scenario 2: suicide rates were calculated assuming that half of these deaths were intentional self-harm.

Hangings and poisonings were used as these are the two most common methods of intentional self-harm in England and Wales.

The results showed that between 2001 and 2009 there were no statistically significant differences between the published and simulated suicide rates at national level. ONS has now repeated the Scenario 1 analysis using the latest figures for regions of England, and for Wales (see Background Note 6).

Table 1 shows the existing suicide rates for regions of England, and Wales, for 2012. In comparison, Table 4 shows results of combining all accidental hangings and accidental poisonings from hard-to-code narrative verdicts with existing suicide rates (Scenario 1), for regions of England, and Wales, for 2012.

Table 4: Simulated suicide rates: by sex, deaths registered in 2012

England, regions in England, and Wales

	Males		Females		Persons	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
England	3,620	17.1	1,110	4.9	4,730	10.9
North	205	20.6	53	4.9	258	12.6
East						
North	579	20.8	168	5.7	747	13.2
West						
Yorkshire and The Humber	399	19.1	110	4.9	509	12.0
East Midlands	319	17.5	76	3.8	395	10.5
West Midlands	372	17.0	109	4.5	481	10.7
East of England	344	15.0	120	4.8	464	9.8
London	446	13.8	155	4.6	601	9.1
South East	550	16.1	182	4.9	732	10.4
South West	406	18.8	137	6.1	543	12.3
Wales	267	22.3	80	6.1	347	14.0

Table source: Office for National Statistics**Table notes:**

1. Underlying cause of death was defined using the International Classification of Diseases, Tenth Revision (ICD-10).
2. Suicide rates were calculated assuming all deaths where a hard-to-code narrative verdict meant that the death been coded as an accidental hanging (ICD-10 codes W75–W76) or accidental poisoning (ICD-10 codes X40–X49) were intentional self-harm. These deaths were then added to the number of suicides (see 'Suicide definition' section) in order to calculate simulated suicide rates.
3. Figures are for persons aged 15 years and over.
4. Rates per 100,000 population, standardised to the 1976 European Standard Population.
5. Figures exclude deaths of non-residents.
6. Figures are for deaths registered in 2012.
7. Based on boundaries as of August 2013.

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Although there were apparent increases in simulated suicide rates, and small changes in the rank ordering of regions, it is important to note that none of simulated suicide rates were significantly higher than the actual suicide rates. Moreover, the simulated suicide rates presented above represent a 'worst-case scenario', as not all accidental hangings and poisonings are suicides. In addition, events of undetermined intent are also included in ONS suicide statistics, and not all of these deaths are caused by self-inflicted harm. Therefore, ONS suicide statistics still provide a reliable estimate of national suicide trends, despite the issues surrounding hard-to-code narrative verdicts.

When hard-to-code narrative verdict deaths with an underlying cause of accidental hanging or accidental poisoning were added to existing suicides, the male suicide rate in England in 2012 increased from 16.4 to 17.1 deaths per 100,000 population (a 4% increase). The corresponding female suicide rate rose from 4.5 to 4.9 per 100,000 (an 8% increase). In Wales the suicide rate increased from 21.4 to 22.3 per 100,000 in males (a 4% rise); and from 5.8 to 6.1 per 100,000 in females (a 5% rise).

Within the regions in England, the largest increases in suicide rates as a result of this simulation were in the East Midlands for males (a 6% increase) and the West Midlands for females (a 13% increase). The actual suicide rate was highest in the North East and the North West for males at 19.8 deaths per 100,000 population. The simulated suicide rates shows a slightly higher suicide rate in the North West, at 20.8 deaths per 100,000 population, compared with 20.6 in the North East. There was no other change in the rankings for males. For females, there was no change at the top and bottom of the rankings. Yorkshire and The Humber and the North East, which are fourth and fifth out of nine regions in the actual suicide rates rankings, rank as joint third when looking at the simulated suicide rates, along with the South East, all at 4.9 deaths per 100,000 population.

Population Estimate Revisions and their Impact on Suicide Statistics for 2002 to 2012

Population estimates for mid-2002 to mid-2010 for England and Wales were revised in December 2012 to take account of the results of the 2011 Census to ensure a consistent time series over the decade. Population estimates for the UK for mid-2002 to mid-2011 were also revised in December 2013. Therefore, suicide rates in this bulletin from 2002 on have been re-calculated using the latest population estimates.

Differences Between the 2011 Census and 2011 Population Estimates Based on the 2001 Census and Impact on 2002 to 2010 Revisions

A [high level reconciliation report \(361.9 Kb Pdf\)](#) explaining national level differences between 2011 Census estimates and population estimates for March 2011 rolled forward from the 2001 Census, was published alongside the first release of 2011 Census data in July 2012. The rolled forward

estimates were 476,000 lower than the 2011 Census estimate for England and Wales which splits down into 144,000 males and 332,000 females.

Comparison of the rates presented for the period 2002 to 2010 in this bulletin, using the revised population data, compared with those presented last year, shows that none of the rates have changed significantly. The biggest change was in 2010 among men aged 30 to 34 years in Wales, where the rate fell from 29.2 to 27.0 deaths per 100,000 population. The biggest increase was also in 2010 among men aged 85 years and over, again in Wales, where the rate increased from 28.2 to 30.1 deaths per 100,000 population.

Impact of Registration Delays on Suicide Statistics

In England and Wales all suicides 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, and ONS is not notified that a death has occurred until it is registered. The only exception to this is when someone will be charged in relation to the death. In this instance the coroner must adjourn the inquest, and they may carry out an accelerated registration. The full details of these deaths are not recorded until the inquest is completed, but the majority are eventually coded as assaults.

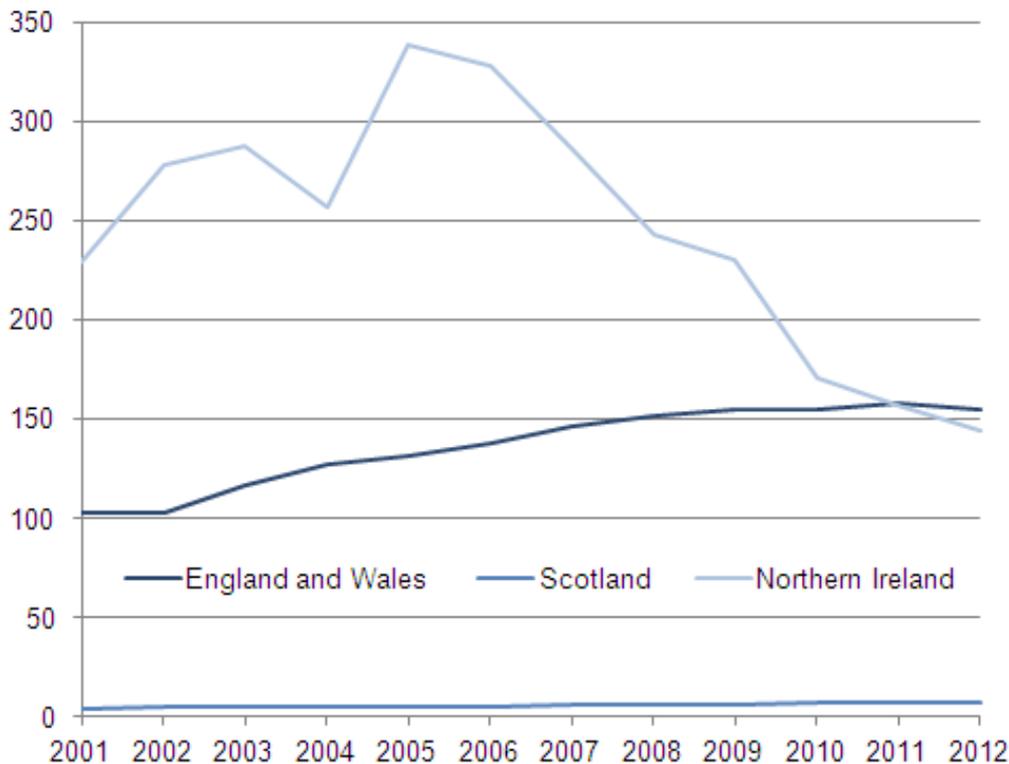
The death registration system in Northern Ireland is similar to that used in England and Wales, in that all suspected suicides are referred to the coroner. The family of the deceased may ask for an inquest and if one has been held, the registrar will register the death on receipt of the coroner's report. If there is no inquest the General Register Office (GRO) will write to the deceased's family (or other informant) to ask them to register the death. However, if the death is not registered within a year of its occurrence, GRO are able to register the death on the authority of the Registrar General.

In Scotland a death must be registered within eight days. The Procurator Fiscal has a duty to investigate all sudden, suspicious, accidental, unexpected or unexplained deaths and any death occurring in circumstances that give rise to serious public concern, and a Fatal Accident Inquiry may follow. If the results of toxicological tests or a post mortem are not yet known, the cause of death can be given as "unascertained, pending investigations", and the actual cause of death will be entered at a later date. Therefore National Records of Scotland (NRS) receive notification of deaths more quickly than ONS and the Northern Ireland Statistics and Research Agency (NISRA). However, although NRS may know what caused the death (for example, hanging, poisoning), they may not be told whether it was due to an accident, assault or intentional self-harm until after the statistical database has been 'frozen' for the year. So NRS may have to code the death as an event of undetermined intent, which would be counted as a probable suicide. Consequently, Scotland has proportionally more deaths coded as being due to events of undetermined intent (and hence as probable suicides), compared with England, Wales and Northern Ireland.

Figure 5: Median registration delay for suicides: deaths registered in each year between 2001 and 2012

United Kingdom

Median delay (days)



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

Notes:

1. The National Statistics definition of suicide is given below under 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. The registration delay is calculated as the difference between the date each death occurred and the date it was registered, measured in days. Additional information on the calculation of registration delays is provided Background Note 7 of the UK suicides bulletin.
4. Figures are for deaths registered in each calendar year.
5. Figures include deaths of non-residents.

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(43 Kb)

In common with most other UK mortality statistics, suicide figures 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 have to be delayed in order to allow enough

time for the majority of the deaths that occurred in a given year to be registered. Even allowing for a reasonable delay, it is probable that some deaths occurring in a given year would not be registered in time for the publication. Table 2 of the publication [Mortality Metadata](#) presents figures on the number of late registrations (all deaths) that are not included in the relevant occurrence dataset. Moreover, it would be inconsistent with other ONS mortality figures (for example, those published annually in 'Deaths registered in England and Wales').

Due to the length of time it takes to hold an inquest, figures presented in this bulletin for England and Wales and Northern Ireland are based on deaths that may have occurred months or even years before 2012. Figure 5 shows that in 2012 the average registration delay for suicides in England and Wales was 155 days. Out of the 4,881 suicides registered in 2012, just under half (46%) occurred before 2012. In England and Wales the average registration delay has gradually increased over time, but the increase has slowed since 2008, which suggests that the upward trend is levelling off. In 2001 the average registration delay was 103 days, and by 2008 it was 152 days (an increase of 48%). Between 2008 and 2011 the average registration delay increased by around just 4% (to 158 days,) and between 2011 and 2012 the average delay fell by a further 2% to 155 days.

Suicide statistics in Northern Ireland are also affected by registration delays, although the trend over time has been more variable than in England and Wales. In Northern Ireland average registration delays for suicides peaked in 2005 at 339 days, but had decreased sharply to 144 days by 2012. Prior to 2004 there were seven coroner's districts in Northern Ireland. Following a review of the coroner's service, the separate districts were amalgamated into one centralised coroner's service. This reorganisation of the coroner's service may explain the reduction in registration delays in Northern Ireland since 2005. Around 50% of suicides registered in Northern Ireland in 2012 also occurred in 2012.

In 2012 the average registration delay in Scotland was just seven days. Although the registration delay has increased slightly since 2001, 96.6% of suicides registered in Scotland in 2012 also occurred in 2012.

The differences in the death registration systems in England and Wales, Scotland and Northern Ireland have implications for the comparability of mortality statistics across the UK. That is, the UK suicide figures for deaths registered in 2012 will comprise deaths occurring in different time periods for different countries of the UK. However, as suicide trends tend to change relatively slowly over time, this is unlikely to have a great impact on the usability of UK suicide statistics.

Additional information on registration delays for suicides, including separate figures for males and females, and an indication of the range of registration delays (the lower and upper quartile) can be found in Reference [Table 15 \(647 Kb Excel sheet\)](#). Information on registration delays for a range of causes in England and Wales in 2011 can be found on the [ONS website](#).

Data Available on the Office for National Statistics Website

Suicide figures for the UK, England and Wales, England, Wales, and regions of England, and results from the analysis of the impact of hard-to-code narrative verdicts returned by coroners in England and Wales, can be found in a [Microsoft Excel workbook \(647 Kb Excel sheet\)](#) on the Office for National Statistics website.

The workbook contains:

- Age-standardised suicide rates per 100,000 population (with 95% confidence limits) and numbers of suicides: by sex, for the UK, England and Wales, England, regions of England and Wales, deaths registered in each year from 1981 to 2012,
- Age-specific suicide rates per 100,000 population (with 95% confidence limits) and numbers of suicides: by sex and five-year age group, for the UK, England and Wales, England, and Wales, deaths registered in each year from 1981 to 2012,
- Age-specific suicide rate for broad age groups (with 95% confidence intervals): for males and females, United Kingdom, deaths registered in each year from 1981 to 2012,
- Number of narrative verdicts: by underlying cause of death, England and Wales, deaths registered in 2012,
- Number of narrative verdicts: by sex, for England and Wales and regions of England, deaths registered in each year from 2001 to 2012,
- Simulated age-standardised suicide rates per 100,000 population (with 95% confidence limits): by sex, for England and Wales and regions of England, deaths registered in each year from 2001 to 2012,
- Median registration delays (and the lower and upper quartiles) in England and Wales, Scotland and Northern Ireland, deaths registered in each year from 2001 to 2012.

Context of Suicide Statistics

Use of the statistics

Suicide statistics provide an indicator of mental health and are important for monitoring trends in deaths resulting from intentional (and probable) self-harm. The statistics are widely used to inform policy, planning and research in both the public and private sector and they enable policy makers and support services to target their resources most effectively. Key users include the Department of Health and devolved health administrations, public health observatories, local and health authorities, academics, and charity organisations.

Policy context

Each constituent country of the UK has a suicide prevention strategy in place which aims to identify risk factors, take action via cross-sector organisations, and ultimately reduce suicide rates.

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 and was informed by an earlier consultation on preventing suicide in England. The new strategy outlines six areas for action including: reducing the risk of suicide in key high-risk groups (for example, people in the care of mental health services, people with a history of self-harm, people in contact with the criminal justice system, and men aged under 50); reducing access to the means of suicide; and supporting research, data collection and monitoring.

Following a public consultation in 2009, the Welsh Assembly Government published '[Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales, 2009–2014](#)'. This is based on a strategic aim to:

'deliver co-ordinated action across all sectors of society for improving the mental health and well-being of the population of Wales, promoting resilience within individuals and communities, delivering timely and effective services to those people identified as being at risk and thereby reducing the rate of suicide and self-harm in Wales'.

The aim is underpinned by seven objectives, which include promoting mental health and well-being, delivering early intervention, improving information on suicide and suicide prevention, and restricting access to the means of suicide. The Action Plan also highlights a suicide prevention health gain target that has been in place since 2002 to reduce the European age-standardised rate by 10% by 2012. Progress towards this target was most recently reported in the [Chief Medical Officer for Wales Annual Report 2011](#).

In Scotland, a 10-year '[Choose Life](#)' suicide prevention strategy and action plan was launched in 2002 with the overarching aim to reduce suicide in Scotland by 20% by 2013 (Scottish Executive, 2002). A summary of progress to date and recommended objectives (which are similar to those in England and Wales) for the final phase of the strategy are reported in '[Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland](#)', published by the Scottish Government in 2010. This forms part of the national policy framework, 'Towards a Mentally Flourishing Scotland (2009–11)'

In 2006, the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPS) published '[Protect Life: A Shared Vision – The Northern Ireland Suicide Prevention Strategy and Action Plan, 2006–2011](#)'. The strategy includes two targets:

1. to obtain a 10% reduction in the overall suicide rate by 2008
2. to reduce the overall suicide rate by a further 5% by 2011

The aim, objectives and approach are similar to those in other UK countries and specific actions focussing on both the general population and the target population are also highlighted. In 2012 the strategy was refreshed to cover the period 2011 to March 2014 and the DHSSPS published an evaluation of the original 'Protect Life' strategy.

People with mental illness have a higher suicide risk than the general population (Windfur and Kapur, 2011). A National Confidential Inquiry into Suicide and Homicide by People with Mental Illness was set up to help reduce this risk. The recommendations of this project could assist health professionals and policymakers improve patient safety and reduce the suicide risk of individuals who are in contact with mental health services. The most recent annual report from the [Confidential Inquiry](#) was published in July 2013.

Suicide Definition

The National Statistics definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. In England and Wales it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the

harm was self-inflicted, but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves (Adelstein and Mardon, 1975). This convention has been adopted across the UK. However, this cannot be applied to children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. Therefore, only persons aged 15 years and over are included in the UK suicide figures.

In the UK, deaths are currently coded using the International Classification of Diseases, Tenth Revision (ICD-10 World Health Organisation, 2010). The codes used to define the suicide figures presented in this bulletin are shown below:

International Classification of Diseases, Tenth Revision codes used to define suicide in the United Kingdom

ICD-10 code	Description
X60–X84	Intentional self-harm
Y10–Y34 ¹	Injury/poisoning of undetermined intent
Y87.0 / Y87.2 ²	Sequelae of intentional self-harm / injury / poisoning of undetermined intent

Table notes:

1. Excluding Y33.9 where the coroner's verdict was pending in England and Wales, up to 2006. From 2007, deaths which were previously coded to Y33.9 are coded to U50.9.
2. Y87.0 and Y87.2 are not included for England and Wales.

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Comparison with Other Countries

It is not always possible to compare UK suicide statistics with those of other countries because of differences in the way suicide is defined and recorded. For example, deaths from injuries and poisonings of undetermined intent are included in UK suicide figures, (as well as deaths from intentional self-harm). This is because in the UK we assume that these deaths were self-inflicted, but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves (Adelstein and Mardon, 1975). This cannot be assumed for child deaths, and so UK suicide figures routinely only include persons aged 15 years and over (although data for children aged ten and over are available on request). However, many other countries, including [Canada](#), [United States](#), and [France](#), use a narrower definition that does not include deaths from injuries and poisonings of undetermined intent, and do report on deaths of children aged between 10 and 14. The [Australian Bureau of Statistics](#) uses a similar definition to these countries but does not routinely report on suicides of children under the age of 15.

Suicide figures published by [Eurostat](#) for European countries are based on a broadly comparable definition of deaths from intentional self-harm only. These are available for all ages and rates for

males and females are age-standardised to the European Standard Population. Age-specific (or 'crude') rates for particular age groups are also available.

Suicide figures published by the [World Health Organization](#) (WHO) use official figures made available to WHO by its member states. These are based on actual death certificates signed by legally authorised personnel, usually doctors and, to a lesser extent, police officers. Although they are not all directly comparable or timely, the suicide figures published by the WHO give an overall perspective of the extent of suicide deaths around the world.

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Background notes

1. Sources of data

The Office for National Statistics holds mortality data for England and Wales. Figures for the UK include data kindly provided by [National Records of Scotland](#) (formerly the General Register Office for Scotland) and the [Northern Ireland Statistics and Research Agency](#).

2. Mortality metadata

Information about the underlying mortality data, including details on how the data is collected and coded are available in the [mortality metadata](#).

3. Calculation of UK suicide rates

This bulletin presents age-standardised (also known as 'directly-standardised') rates, standardised to the 1976 European Standard Population (ESP). These are presented as suicides per 100,000 population. Age-standardised rates make allowances for differences in the age structure of the population, over time and between sexes. The age-standardised rate for a particular cause of death is that which would have occurred if the observed age-specific rates for that cause had applied in the given standard population. Suicide rates for particular age groups (for example, Figures 2 and 3) are age-specific rates. A template demonstrating how to calculate age-standardised rates using both the [1976 ESP](#) and the [2013 ESP](#) can be found on the ONS website.

4. Confidence Intervals

Within this bulletin, a difference which is described as 'statistically significant' has been assessed using 95% confidence intervals. Confidence intervals are a measure of the statistical precision of an estimate and show the range of uncertainty around the estimated figure. Calculations based on small numbers of events are often subject to random fluctuations. As a general rule, if the confidence interval around one figure overlaps with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures. Within this statistical bulletin, a difference which is described as 'significant' means 'statistically significant', assessed by examining the confidence intervals.

5. Coroners statistics

[Coroners' statistics](#) (including statistics on the verdicts returned at inquests) are available from the Ministry of Justice.

6. Regional analysis of narrative verdicts

The analysis of regional variations in the use of narrative verdicts, and the calculation of regional simulated suicide rates were based on the country/region of usual residence of the deceased. Please note that boundaries for coroner district areas are not aligned with regional boundaries (that is, they are not coterminous), so it is possible that narrative verdicts returned by an individual coroner may fall within more than one region.

7. Calculation of registration delays

Figure 5 presents data on the length of time taken to register a death (also known as the registration delay) for suicides. This is calculated as the difference between the date each death occurred and the date it was registered, measured in days. Data where the exact date of death was unknown or the date of death was more than 11 years before date of registration or where either the date of death or date of registration was clearly recorded incorrectly (that is, the death appeared to have been registered before it occurred) were excluded from this analysis. Approximately 0.01% of the data were excluded for these reasons.

Analysis showed that the data was positively skewed, and contained some deaths with very long registration delays. Therefore the registration delay has been presented using the median value, as this is not influenced by extreme values. The median is defined as is the middle value if the delays were sorted by size. The lower and upper quartile are also presented in the [Reference Table 15 \(647 Kb Excel sheet\)](#) to give an indication of the spread of registration delays that are found with suicides. The lower quartile is the smallest values below which 25% of the values lie; the upper quartile is the smallest values below which 75% of the values lie. In 2012, 25% of registration delays for suicides in England and Wales were less than 96 days, and 75% were less than 245 days.

8. Cause of death categories for narrative verdicts

International Classification of Diseases, tenth revision (ICD-10) codes used to define the cause of death categories in Table 2

Cause	ICD-10 Code
All causes	A00–R99, U50.9, V00–Y89
Diseases	A00–R99
Neoplasms	C00–D48
Circulatory	I00–I99
Respiratory	J00–J99
Digestive system	K00–K93
Other disease or condition	All other codes in the range A00–R99 not included above
External causes	V00–Y89, and U50.9
Transport accidents	V00–V99
Other accidents	W00–X59
Intentional self-harm	X60–X84
Undetermined intent	Y10–Y34
Other external cause	All other codes in the range V00–Y89, and U50.9 not included above

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9. Health and Life Events user feedback

As a user of our statistics, we would welcome your feedback on this publication.

Please get in touch either via email at mortality@ons.gsi.gov.uk or telephone on +44 (0)1633 455898.

10. Special extracts

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

Mortality Analysis Team, Life Events and Population Sources Division

Office for National Statistics

Government Buildings

Cardiff Road

Newport

Gwent NP10 8XG

Tel: +44 (0)1633 455898

E-mail: mortality@ons.gsi.gov.uk

The ONS charging policy is available on the [ONS website](#).

11. Revisions

The ONS revisions policy is available on our [website](#).

12. Pre-release access

A list of the names of those given pre-publication access to the statistics and written commentary is available in this [pre-release access list](#) for Suicides in the United Kingdom, 2012. The rules and principles which govern pre-release access are featured within the [Pre-release Access to Official Statistics Order 2008](#).

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

Statistical contacts

Name	Phone	Department	Email
Joanne Evans	+44 (0)1633 455898	Life Events and Population Sources Division	mortality@ons.gsi.gov.uk

Issuing Bodies:

National Records of Scotland
Northern Ireland Statistics and Research Agency
Office for National Statistics

Media Contact Details:

Telephone: 0845 604 1858
(8.30am-5.30pm Weekdays)

Emergency out of hours (limited service): 07867 906553

Email:

media.relations@ons.gsi.gov.uk