Office for National Statistics

Article

Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022

Emerging themes resulting from qualitative analysis of Prevention of Future Death reports, submitted by coroners in England and Wales from January 2021 to October 2022.

Contact:
Emma Wallace, Lauren Revie, Emma Sharland and David Mais
health.data@ons.gov.uk
01329 444110

Release date:
29 March 2023

Next release:
To be announced

Table of contents

1. Main points

2. Overview of the research

3. Addressees by organisation type

4. Coroners' concerns

5. Qualitative analysis of Prevention of Future Death reports for suicide submitted by coroners in England and Wales data

6. Glossary

7. Data sources and quality

8. Related links

9. Cite this article

1 . Main points

- Coroners have a duty to issue a Prevention of Future Death (PFD) report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths; the analysis of Prevention of Future Death reports submitted by coroners is the first of its kind in the Office for National Statistics (ONS).

- A total of 164 PFD reports were available for analysis (96 (59%) from 2021 and 68 (41%) from 2022; for context, around 5,000 suicides are registered in England and Wales each year.

- Reports contain a "Coroner's concerns" section, and are sent to organisations where action could be taken; in this analysis, a total of 485 concerns (across 164 reports) were raised, with an average of three concerns per report.

- The most commonly raised primary concern related to the processes followed, particularly inadequate documentation and monitoring (such as a lack of clinical note taking) that may have prevented a death; 54% of the PFD reports analysed included at least one concern relating to processes.

- Staffing of services was also mentioned across health and public services and communal establishments; this included inadequate volumes of staff or lack of qualified staff to meet demand, inadequate training of staff in services and problems with recruitment and retention of qualified staff.

- Results also found issues in accessing services that may have resulted in their death (32% of reports), as well as issues with communication (34% of reports).

- The NHS (including health boards, trusts, clinical commissioning groups, primary care services, health and care partnerships and ambulance services) were the most frequent recipient of PFD reports (42% of all reports).

If you are a journalist covering a suicide-related issue, please consider following the Samaritans' media guidelines on the reporting of suicide because of the potentially damaging consequences of irresponsible reporting. In particular, the guidelines advise on terminology to use and include links to sources of support for anyone affected by the themes in the article.

If you are struggling to cope, please call the Samaritans for free on 116 123 (UK and ROI) or contact other sources of support, such as those listed on the NHS's help for suicidal thoughts webpage. Support is available around the clock, every single day of the year, providing a safe place for anyone struggling to cope, whoever they are, however they feel, whatever life has done to them.

Statistician's comment

"This is our first analysis of Prevention of Future Death reports. It highlights the range of concerns raised by coroners following a suicide, including processes not being followed, and inadequate documentation and monitoring, that may have prevented a death. We also saw concerns relating to a lack of communication between services who were looking after individuals before they took their own life, and reports were also raised that training was inadequate for staff involved in the care of at-risk individuals. Every death by suicide is a tragedy and has a devastating impact on family, friends and communities and we hope today's analysis will provide valuable insight for those concerned with suicide prevention."

James Tucker, Head of Analysis in the Data and Analysis for Social Care and Health Division, Office for National Statistics.

Follow James Tucker on Twitter @ONSJames.

2 . Overview of the research

Coroners can issue a Prevention of Future Death (PFD) report to individuals or organisations where they feel action should be taken to prevent future deaths. The role of the coroner is to identify areas of concern, rather than identify specific solutions. PFD reports are sent to a wide range of organisations, including the NHS, government departments, professional bodies, and public services. The report is also sent to the deceased's family and is made available on the Courts and Tribunals Judiciary website.

This article presents qualitative analysis conducted on PFD reports submitted between January 2021 and October 2022, categorised as suicides. The aim was to identify themes from concerns raised in the PFD reports that may inform future research or policies for suicide prevention, including a new Suicide Prevention Strategy.

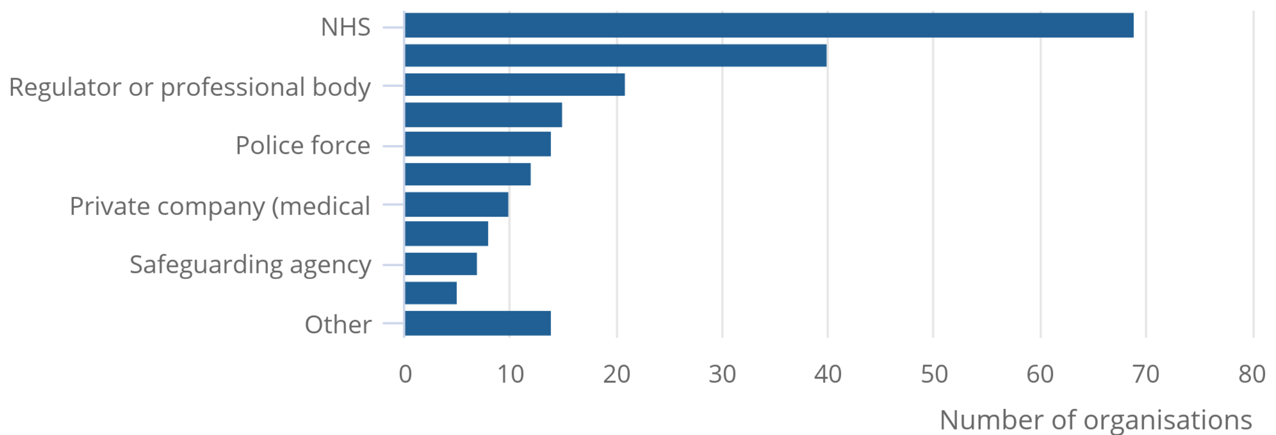
A total of 164 PFD reports were available (96 (59%) from 2021 and 68 (41%) from 2022). For context, around 5,000 suicides are registered in England and Wales each year, so PFD reports are only issued for a small number of cases. A total of 485 concerns were identified, with an average of three concerns per report (range: 1 to 12). Of the 164 reports, around 62% of the deceased were male, 37% were female, and the gender of the deceased was unknown for a small proportion of the reports. The average age at date of death was 36.4 years (range: 14 years to 81 years).

3 . Addressees by organisation type

The NHS (including health boards, trusts, clinical commissioning groups, primary care services, health and care partnerships and ambulance services), was the most frequent recipient organisation of Prevention of Future Death (PFD) reports (see Figure 1: 69 PFD reports, 42% of all reports) across most primary themes. This was followed by government departments. Further information on addressees can be found in [our accompanying dataset](#).

Figure 1: The number of reports per addressee organisation in Prevention of Future Death reports, categorised as suicides, submitted between January 2021 and October 2022

Figure 1: The number of reports per addressee organisation in Prevention of Future Death reports, categorised as suicides, submitted between January 2021 and October 2022



Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes:

1. PFD reports can be addressed to multiple organisations.

2. “Other” category includes organisation type where number of mentions have been grouped, as they may result in individual statistical disclosure. They include: private company (prison), university, army, care home, charity, private company (internet and social media), private company (care home) and solicitors.

4 . Coroners’ concerns

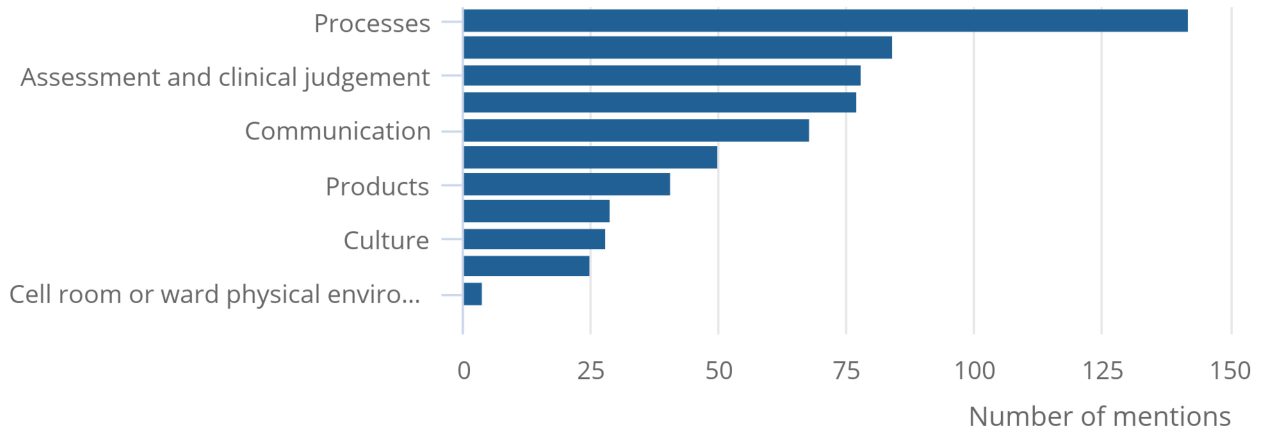
We coded coroners' concerns into 12 primary themes:

- processes
- access to services
- assessment and clinical judgement
- policy
- communication
- products
- training
- culture
- improvements not being implemented
- care plan
- room, cell, or ward physical environment
- general risk factor

Within these primary themes, 83 sub-themes were identified, that are defined in our accompanying dataset.

Figure 2: Primary themes by number of mentions from Prevention of Future Death reports classified as suicides, submitted between January 2021 and October 2022

Figure 2: Primary themes by number of mentions from Prevention of Future Death reports classified as suicides, submitted between January 2021 and October 2022



Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes:

1. “General risk factor” includes broad larger scale societal factors that could lead to future deaths. Number of mentions is not presented on the figure as counts were low and could result in statistical disclosure.

Processes

A total of 142 concerns from 89 PFD reports (54% of all reports) related to "processes", with "inadequate monitoring and documenting of processes" (32 mentions) being the most common sub-theme (see Table 1). This sub-theme related to processes not being recorded or standard operating procedures not being followed, thus potentially contributing to a death. For concerns under the sub-theme "no processes in place" (29 mentions), evidence demonstrated that there were no processes or standard operating procedures, and if they had been in place a death may have been prevented.

Table 1: The number of mentions classified under the “processes” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, January 2021 to October 2022

Concern (Primary theme)	Concern (Sub-themes)	Number of mentions
Processes (142)	Inadequate monitoring and documenting of processes	32
	No processes in place	29
	Inadequate safeguarding or care processes	18
	Processes not followed due to inadequate staffing	18
	Delays in commencing or escalating processes	15
	Processes not clear	14
	Other	10
	Engagement and information relay to deceased	9
	Inadequate review or investigation after incident	9
	Processes impacted by limitation in technology used	9
	Inadequate observation processes	8
	Processes lack independence or risks to disclosing information	4

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.

2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.

3. “Other” includes sub-themes where number of mentions have been grouped, as they may result in statistical disclosure individually, including “leave process inadequate”, “Mental Health Act (MHA) assessment not carried out”, “no family or service involvement in care” and “processes impacted by coronavirus (COVID-19)”.

4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Access to services

There were 84 concerns relating to "Access to services" in 52 PFD reports (32% of all reports). Sub-themes included "delays in accessing services" (21 mentions), "inadequate staffing" (17 mentions) and "services not being appropriate" (16 mentions) (see Table 2). Analysis identified that delays were because of increased demand for services leading to lengthy wait times, and in some instances, services were not appropriate for patients requiring specialist care. There was also inadequate staffing with too little staff, or not enough qualified staff.

Table 2: The number of mentions classified under the “access to services” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, January 2021 to October 2022

Concern (Primary theme)	Concern (Sub-themes)	Number of mentions
Access to services (84)	Delays in accessing services	21
	Inadequate staffing	17
	Service not appropriate	16
	Delays with referrals	13
	No service available	11
	Access impacted by COVID-19	6
	Disengagement from deceased	5
	Multiple services involved impacting access	4
	Requests not fulfilled	4
	Out of area	[c]

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. Number of mentions that are confidential [c] indicate categories where counts of three and under may result in statistical disclosure.
4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Assessment and clinical judgement

There were 78 concerns relating to "assessment and clinical judgement" in 55 PFD reports (34% of all reports). Sub-themes included "risk not correctly assessed" (22 mentions) and "no risk assessment undertaken" (14 mentions) (see Table 3). Risk was not correctly assessed where patient history was not considered or communication between services was poor, preventing the patient from receiving appropriate treatment. Evidence also indicated that services failed to undertake a risk assessment where it was required to maintain patient safety.

Since September 2022, National Institute for Health and Care Excellence (NICE) guidelines state that risk assessment tools should not be used in the prediction of future suicide or repetition of self-harm. While this report does not recommend the use of risk assessments, the sub-theme is included because of the clinical relevance of risk assessments at the time these reports were written.

Table 3: The number of mentions that were classified under the “assessment and clinical judgement” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Assessment and clinical judgement (78)	Risk not correctly assessed	22
	No risk assessment undertaken	14
	Risk assessment not suitable	11
	Processes in assessment	10
	Staffing issues involved in assessment	10
	Error in assessment	7
	Risk not updated	7
	Diagnosis	4
	Assessment impacted by COVID-19	[c]

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. Number of mentions that are confidential [c] indicate categories where counts of three and under may result in statistical disclosure.
4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Policy

There were 77 concerns under "policy" in 45 PFD reports (27% of all reports). Sub-themes included "no policy in place (processes)" (16 mentions), and "inadequate policy" (12 mentions) (see Table 4). "No policy in place" referred to both organisational policy and national policy, and covered areas including discharge, safeguarding and medication. "Inadequate policy" indicated that a policy was present, but it did not mitigate risk and potentially contributed to a death.

Table 4: The number of mentions classified under the “policy” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, January 2021 to October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Policy (77)	No policy in place (processes)	16
	Inadequate policy	12
	Knowledge gaps in existing policy	11
	Policy not used in practice	10
	Review required (incidents and safeguarding)	8
	Other	6
	No policy in place (sharing information)	5
	No records of compliance to policy	5
	Proposal policy made but not implemented	5

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.

2. Figures relate to Prevention of Future Death reports which were categorised as suicides following coroner inquest.

3. “Other” includes sub-themes where number of mentions have been grouped, as they may result in individual statistical disclosure. This includes “policy put in place after incident”, “review required (adherence to the Mental Health Act)” and “unable to provide policy in court.”

4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Communication

There were 55 PFD reports including 68 concerns relating to "communication" (34% of all reports). Sub-themes included "inadequate communication between services" (35 mentions) (see Table 5), meaning information involving the patient was not communicated which may have contributed to failures in care. In addition, "family not involved in care" (12 mentions) highlighted that the family of patients were not engaged, meaning not all possible information was obtained and used to inform services.

Table 5: The number of mentions that were classified under the “communication” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Communication (68)	Inadequate communication between services	35
	Family not involved in care	12
	Medical notes not updated or inadequate	11
	Inadequate communication with deceased	9
	Inadequate communication between staff (within service)	4
	Inadequate communication with professionals closest to deceased	4
	Information on risk not communicated to service	4

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Products

A total of 41 concerns were categorised under the primary theme of "products" from 25 PFD reports (15% of all reports). Sub-themes included "access to medical products (e.g. medication)" (12 mentions) (see Table 6), that referred to the deceased having access to medication, equipment or other medical products that may have contributed to a death.

Table 6: The number of mentions that were classified under the “products” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Products (41)	Access to medical products (e.g. medication)	12
	Other	11
	Access to harmful internet and social media content	8
	Access to area (e.g. railway)	5
	No access to products to save life	5
	Access to substances (e.g. drugs)	4

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.

2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.

3. “Other” includes sub-themes where number of mentions have been grouped, as they may result in individual statistical disclosure. This includes “ability to purchase without regulation”, “access to product (firearms)”, “access to products (general)”, “labelling or product information.”

4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Training

There were 50 concerns from 30 PFD reports related to "training" (18% of all reports). Sub-themes included "current training not adequate" (38 mentions) (see Table 7), that referred to staff training not being mandatory, training not sufficiently covering a topic, training not being applied in practice, or training not being updated following incidents. This was the most frequent sub-theme across all primary themes.

Table 7: The number of mentions that were classified under the “training” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Training (50)	Current training not adequate	38
	Issues with access to training	10
	Other	5
	Training following incident required	4

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. ‘Other’ includes sub-themes where number of mentions have been grouped, as they may result in statistical disclosure individually, including “evidence of training not used in practice”, “impacted by COVID-19”, “re-training required”.
4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Culture

A total of 28 concerns raised from 25 PFD reports related to "culture" within an organisation (15% of all reports). The most frequent sub-theme was "inadequate staffing and/or way of working" (17 mentions) (see Table 8). This refers to issues with recruitment or the retention of suitably qualified staff, as well as the code of conduct among staff in services that are in demand with limited resources. These issues were related to failures of care that may have contributed to death, such as signing-off procedures that had not been completed.

Table 8: The number of mentions that were classified under the “culture” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Culture (28)	Inadequate staffing and/or way of working	17
	Bullying	[c]
	Diagnosing	[c]
	Dismissive culture	[c]
	Incorrect assumptions made	[c]
	Therapeutic environment or relationships	[c]

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. Number of mentions that are confidential [c] indicate categories where counts of three and under may result in statistical disclosure.
4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Improvements not being implemented

There were 25 concerns relating to "improvements not being implemented" from 20 PFD reports (12% of all reports). Sub-themes included "information, guidance, and training for staff" (11 mentions) and "access or CCTV at high-risk areas" within the community (8 mentions) (see Table 9). For both sub-themes, recommendations that have been identified from previous incidents have not been implemented in a timely manner, therefore potentially contributing to future deaths.

Table 9: The number of mentions that were classified under the “improvements not being implemented” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Improvements not being implemented (25)	Information, guidance, and training for staff	11
	Access or CCTV at high-risk areas (community)	8
	Delays in improvements	4
	Hospital room adaptations	[c]
	Medical equipment or clothing	[c]

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.
2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.
3. Number of mentions that are confidential [c] indicate categories where counts of three and under may result in statistical disclosure.
4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Care plan

A total of 29 concerns from 25 PFD reports related to "care plan" (15% of all reports). Sub-themes included "issues with the care plan process" (11 mentions) and "care plan not suitable" (10 mentions) (see Table 10). "Issues with the care plan process" related to failures in updating and communicating care plans with those involved in the patients' care. For concerns under "care plans not suitable", care plans were unclear or omitted details relating to a patient's circumstances and were therefore unable to be followed appropriately.

Table 10: The number of mentions that were classified under the “care plan” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides, submitted between January 2021 and October 2022

Concern (Primary theme)	Concern (Sub-theme)	Number of mentions
Care plan (29)	Issues with care plan process	11
	Care plan not suitable	10
	No care plan in place	8
	Issues with care plan for carers	[c]

Source: Office for National Statistics analysis of Prevention of Future Death reports

Notes

1. Figures refer to the number of mentions classified as belonging to primary and sub-themes following thematic analysis of reports.

2. Figures relate to Prevention of Future Death reports that were categorised as suicides following coroner inquest.

3. Number of mentions that are confidential [c] indicate categories where counts of three and under may result in statistical disclosure.

4. Concerns can be coded to multiple sub-themes where appropriate. Therefore, the sum of the sub-themes may not match the total number recorded for the primary-theme.

Many concerns highlighted in our analysis were categorised under the primary theme of "Processes", where issues in processes or standard operating procedures (including processes being unclear, delayed or not in place) may have contributed to the death. The main sub-themes were "current training not adequate", "inadequate communication between services" and "inadequate monitoring and documenting of processes". These themes highlight concerns across current care and service provision where review and improvement are required to prevent future deaths occurring.

5 . Qualitative analysis of Prevention of Future Death reports for suicide submitted by coroners in England and Wales data

Prevention of Future Death reports for suicide submitted by coroners in England and Wales.
Dataset | Released 29 March 2023
Qualitative analysis of Prevention of Future Death reports for suicide. Includes number of reports coded to primary and sub-themes, number of reports by recipient organisation, as well as diagnosis and place of death. Uses data submitted by coroners in England and Wales.

6 . Glossary

Care plan

A care plan is a document that outlines health and social care requirements of a person, and how those needs will be met through treatment, services, and support. The care plan outlines who will provide the care, the timescale of care and how support will be delivered.

Coroners' concerns

Coroners' concerns, also referred to as "concerns" for the purpose of this research, are points highlighted on the Prevention of Future Death (PFD) reports where the coroner believes action should, or could, have been taken to prevent death.

Thematic analysis

Thematic analysis is a method of analysing qualitative data. It is used in the analysis of text and involves extracting and interpreting common themes from the data that appear frequently.

7 . Data sources and quality

Prevention of Future Death (PFD) reports

PFD reports are publicly available on the Courts and Tribunals Judiciary website and cover both England and Wales. The intention of the PFD report is to benefit the public.

The Courts and Tribunals Judiciary website indicates that coroners have a duty to make a report detailing actions that should be taken to prevent future deaths (see Courts and Tribunals Judiciary, Revised Guidance No.5. Reports to Prevent Future Deaths for further information). These reports can be sent to persons, organisations, local authorities, government departments or agencies. These reports are also sent to the Chief Coroner.

Reports typically follow a standard structure of the following sections: This Report is Being Sent To, Coroner details, Coroner's Legal Powers, Investigation and Inquest, Circumstances of Death, Coroner's Concerns - The Matters of Concern, Action Should be Taken, Your Response and Copies and Publication. Some parts of the PFD reports are redacted for public safety and privacy purposes, and therefore redacted content could not be included in any analysis.

Approach to analysis

Reports were imported into QSR NVivo 12 Qualitative Analysis software for an inductive thematic analysis. Inductive thematic analysis is where researchers have no preconceptions of themes and have not pre-set any themes. All reports (100%, n = 164) were manually coded by a single researcher initially, and then this same researcher re-reviewed the coding structure to refine the codes further. Following this, a second researcher re-analysed 40% (n = 65) of the PFD reports. Initial agreement between the two researchers was 82% (calculated by the number of agreed codes, divided by the total number of codes). Where researchers disagreed with codes created, these researchers discussed their views and came to a consensus (agreement after review = 97%). For the remaining 3% of codes, the initial coding decisions from the lead researcher was taken.

Strengths and limitations

The main strengths of this study are that:

- it provides a high level of detail from inquests and individual circumstance, that cannot be achieved through quantitative analysis alone
- it uses PFD reports, which contain valuable information provided by coroners that are not frequently used in analysis
- the method of analysis was followed according to well-established qualitative analysis practices
- the research was obtained through expert consultation and met policy user needs

The main limitations of this study are that:

- findings relate to specific individual circumstances for cases where PFD reports were produced, therefore may not be reflective of all concerns across all suicide deaths
- this analysis examined PFDs that were uploaded to the coroner's website between January 2021 and October 2022. However, because of the length of time inquests take to conduct, the date of death may be several months prior to this. Therefore, the concerns highlighted in PFD reports may not reflect concerns for cases with a more recent date of death

8 . Related links

Suicides in England and Wales: 2021 registrations
Bulletin | Released 6 September 2022
Registered deaths in England and Wales from suicide analysed by sex, age, area of usual residence of the deceased, and suicide method.

Quarterly suicide death registrations in England: 2001 to 2021 registrations and Quarter 1 (Jan to Mar) to Quarter 3 (July to Sept) 2022 provisional data
Bulletin | Released 9 December 2022
Provisional rate and number of suicide deaths registered in England per quarter. Includes 2001 to 2021 registrations and provisional data for Quarter 1 (Jan to Mar) to Quarter 3 (July to Sept) 2022.

Deaths from suicide that occurred in England and Wales: April to December 2020
Article | Released 14 April 2022
Suicides that occurred between April and December 2020 in England and Wales analysed by sex, age, and suicide method.

Suicides among people diagnosed with severe health conditions, England: 2017 to 2020
Bulletin | Released 20 April 2022
Suicide rates among people diagnosed with severe health conditions, based on mortality records linked to the 2011 Census and Hospital Episode Statistics (HES). Experimental Statistics.

Sociodemographic inequalities of dying by suicide in England and Wales: 2011 to 2021
Bulletin | Released 6 March 2023
A population level analysis comparing the risk of dying by suicide across sociodemographic groups in adults in England and Wales.

9 . Cite this article

Office for National Statistics (ONS), released 29 March 2023, ONS website, article, Prevention of Future Death Reports for suicide submitted by coroners in England and Wales: January 2021 to October 2022