Office for National Statistics

Statistical bulletin

# Prevention of Future Death reports for suicide in children in England and Wales: January 2015 to November 2023

Emerging themes resulting from qualitative analysis of Prevention of Future Death reports, submitted by coroners in England and Wales from January 2015 to November 2023.

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# 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; this analysis of 37 PFD reports submitted by coroners in England and Wales from January 2015 to November 2023 in relation to suicide in children is the first of its kind in the Office for National Statistics (ONS).

- Reports are sent to organisations where action could be taken and contain a "coroner's concerns" section; in this analysis, a total of 145 concerns (across 37 reports) were raised with an average of four concerns per report.

- The most commonly raised concern related to service provision that may have resulted in a death; in particular, standard operating procedures not being followed or being inadequate.

- Staffing and resourcing were also raised in the reports, including missing and inadequate training for staff or inadequate levels of staff to meet demand, and a lack of funding for staff.

- Reports also mentioned issues in communication between services and families, disconnection between multiple services involved in a child's care and difficulties in accessing services, including delayed referrals, long waiting times and rejected referrals.

- A diagnosis of Asperger's or autism was reported in 25% of all PFD reports included in this analysis.

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 Samaritans for free on 116 123 (UK and ROI) or contact other sources of support, such as those listed on the NHS' Help for suicidal thoughts webpage. Support is available round 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.

# 2 . Background to 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 identifying 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 bulletin presents qualitative analysis conducted on PFD reports submitted between January 2015 and November 2023, categorised as suicides and a child death (aged 18 years and under). We used thematic analysis to identify themes and sub-themes from concerns raised in the PFD reports, to provide insight into areas for improvement to prevent future deaths, inform subsequent research and provide an evidence base for policies around suicide prevention.

A total of 37 PFD reports were identified using our search criteria and made available, covering 36 children. A total of 145 concerns were identified, with an average of four concerns per report (range: 1 to 12). The average number of days between the date of death and the publication of a report was 626 days (range: 152 to 1,788 days). Reports covered deaths occurring between 2012 and 2022. Of the 36 reports, where age and sex information were provided, 44% of the deceased were male and 53% were female, and the average age at date of death was 16 years (range: 12 years to 18 years).

A diagnosis of a health condition was reported in 89% of the PFD reports, with 25% reporting the deceased had a diagnosis of Asperger's or autism, and 19% having a mood disorder. Of the deceased, 64% were known to Child and Adolescent Mental Health Services (CAMHS) and 42% had a history of previous suicide attempts or suicidal thoughts.

# 3 . Addressees by organisation type

Government departments or ministers and the NHS (including health boards, trusts, clinical commissioning groups, primary care services, health and care partnerships and ambulance services), were the most frequent recipient organisations (see Table 1) across most primary themes. Further information on addressees can be found in our accompanying Prevention of Future Death reports for suicide in children in England and Wales dataset.

Table 1: The number of reports per addressee organisation in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Addressee | No of reports | % |
|---|---|---|
| **Government department or minister** | 15 | 41 |
| **NHS Trust or CCG** | 15 | 41 |
| **Professional body** | 12 | 32 |
| **Local council** | 8 | 22 |
| **Other** | 10 | 27 |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

Notes

1. Prevention of Future Death (PFD) reports can be addressed to multiple organisations; therefore the percentages do not sum to 100%.

2. “Other” includes rail or road company, police (including British Transport Police), private companies, and hospital or Child and Adolescent Mental Health Services (CAMHS).

# 4 . Coroners’ concerns

We coded coroners' concerns into six primary themes:

- service provision
- staffing and resourcing
- communication
- multiple services involved in care
- accessing services
- access to harmful content and environment

Within these primary themes, 23 sub-themes were identified, which are defined in our accompanying dataset.

## Service provision

The concerns raised for the primary theme of "service provision" were identified from 28 Prevention of Future Death (PFD) reports (76% of all analysed reports), with "standard operating procedures [or] processes not followed or adequate" (40 mentions) being the most common sub-theme (see Table 2). This sub-theme included reports of missing processes or protocols, lack of escalation routes and ineffective monitoring and reporting.

Concerns under the sub-theme "specialist services" (22 mentions) included reports of a lack of available services, inappropriate support with children being placed in adult services and no case or key workers for children with additional needs such as autism.

Since September 2022, NICE guidelines state that risk assessment tools should not be used in the prediction of future suicide or repetition of self-harm. Whilst 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 that these reports were written.

Table 2: The number of mentions classified under the “service provision” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-themes) | Number of mentions |
|---|---|---|
| **Service provision** | Standard operating procedures or processes not followed or adequate | 40 |
| | Specialist services (crisis, autism, beds) | 22 |
| | Risk assessment | 20 |
| | Discharge from services | 8 |
| | Diagnostics | 4 |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

## Staffing and resources

The concerns raised for the primary theme of "staffing and resources" came from 19 PFD reports (51% of all analysed reports). Sub-themes included "training missing, inadequate or not mandatory" (17 mentions), "inadequate staffing" (10 mentions) and "lack of funding" (10 mentions) (see Table 3).

Analysis identified that reports raised a lack of training available for staff working with children with additional needs such as autism, and staff not having the qualifications to support the children involved. There were also mentions of high caseloads leading to delays in support and funding not increasing for services despite the number of referrals to services increasing.

Table 3: The number of mentions classified under the “staffing and resources” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-themes) | Number of mentions |
|---|---|---|
| **Staffing and resourcing** | Training missing, inadequate or not mandatory | 17 |
| | Inadequate staffing | 10 |
| | Lack of funding | 10 |
| | Recruitment and retention problems | [c] |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

Notes

1. Number of mentions which are confidential (c) indicate categories where counts of three and under may result in statistical disclosure.

## Communication

The concerns raised for the primary theme of "communication" came from 24 PFD reports (65% of all reports). Sub-themes included a "lack of communication between services" (19 mentions) and "lack of communication with patient and family" (nine mentions) (see Table 4). Reports revealed a lack of communication between health and non-health organisations such as transport services, information not being passed onto children and families, and families not being given the opportunity to provide additional contexts and information which could have helped to support an individual prior to their death.

Table 4: The number of mentions classified under the “communication” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-theme) | Number of mentions |
|---|---|---|
| **Communication** | Lack of communication between services | 19 |
| | Lack of communication with patient and family | 9 |
| | Confidentiality risk not communicated | [c] |
| | Within services communication is poor | [c] |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

Notes

1. Number of mentions which are confidential (c) indicate categories where counts of three and under may result in statistical disclosure.

## Multiple services involved in care

The concerns raised for the primary theme of "multiple services involved in care" came from 18 PFD reports (49% of all reports). Sub-themes included "integration of care was disconnected" (16 mentions), and "issues with local authority (including child services, schools)" (11 mentions) (see Table 5). The detail in the reports indicated care became ineffective and needs went unmet. The reports also suggested services were not taking on learning from previous suicides and not having mitigations in place for future risks.

Table 5: The number of mentions classified under the “multiple services involved in care” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-theme) | Number of mentions |
|---|---|---|
| **Multiple services involved in care** | Integration of care was disconnected | 16 |
| | Issues with Local Authority (including child services, schools) | 11 |
| | Transition from Child and Adolescent Mental Health Services to adult services ineffective | 4 |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

## Accessing services

The concerns raised for the primary theme of "accessing services" came from 16 PFD reports (43% of all reports). Sub-themes included "delays in referrals and waiting times" (13 mentions) (see Table 6), relating to long waiting times and lack of beds available in services. In addition, delays in receiving diagnoses for conditions such as autism and access to specialist services for these conditions resulted in delays to support and inappropriate support.

Table 6: The number of mentions classified under the “accessing services” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-theme) | Number of mentions |
|---|---|---|
| **Accessing services** | Delays in referrals and waiting times | 13 |
| | Referrals rejected | 5 |
| | Patient engagement lacking | 5 |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

## Access to harmful content and environment

The concerns raised for the primary theme of "access to harmful content and environment" came from 11 PFD reports (30% of all analysed reports). Sub-themes included "internet content and controls" (nine mentions) (see Table 7), which referred to concerns over lack of parent controls, social media use and inappropriate content being viewed, which contributed towards a death from suicide.

Table 7: The number of mentions classified under the “access to harmful content and environment” primary theme and related sub-themes in Prevention of Future Death reports categorised as suicides in children in England and Wales, January 2015 to November 2023

| Concern (Primary theme) | Concern (Sub-theme) | Number of mentions |
|---|---|---|
| **Access to harmful content and environment** | Internet content and controls | 9 |
| | Safeguarding from sensitive material | 5 |
| | Access to harmful items or substances | 4 |
| | Access to Trainlines | [c] |

Source: Analysis of Prevention of Future Death reports from the Office for National Statistics

# 5 . Data on Prevention of Future Death reports for suicide in children in England and Wales

Prevention of Future Death reports for suicide in children in England and Wales
Dataset | Released 27 February 2025
Prevention of Future Death reports for suicide in children using data submitted by coroners in England and Wales, including number of reports, diagnosis and place of death.

# 6 . Glossary

## Coroners' concerns

Coroners' concerns, also referred to as "concerns" for the purpose of this research, are points highlighted on the Prevention of Future Death 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 usually used in the analysis of text and involves extracting and interpreting common themes that appear frequently in the data.

# 7 . Data sources and quality

## Prevention of Future Death reports

Prevention of Future Death (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.

Coroners have a duty to make a report detailing actions which 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 are sent to the Chief Coroner and can also be sent to persons, organisations, local authorities, government departments or agencies.

Reports typically follow a standard structure comprising of multiple sections. Some parts of the PFD reports are redacted for public safety and privacy purposes, and this content could not be included in our analysis.

## Analysis

We identified PFD reports where the death was categorised as "suicide (from 2015)" or "mental health related death" and "child death (from 2015)".

Reports were imported into QSR NVivo 14 qualitative analysis software for an inductive thematic analysis. Inductive thematic analysis is where researchers have no preconceptions of themes. All 37 reports were manually coded by a single researcher, and then this same researcher re-reviewed the coding structure to refine the codes further.

Following this, a second researcher independently re-analysed all 37 reports. Initial agreement between the two researchers was 66% (calculated by the number of agreed codes divided by the total number of codes).

Where researchers disagreed with codes created, the researchers discussed their views and came to a consensus for 99% of codes. For the remaining 1% of codes, the initial coding decision from the lead researcher was used.

## Strengths and limitations

The main strengths of this study are that:

- it provides a high level of detail from inquests and individual circumstance which cannot be achieved through quantitative analysis alone
- it utilises PFD reports, which are valuable information provided by coroners that are not frequently used in analysis
- the method of analysis was followed according to well established qualitative analysis methodology

The main limitations of this study are that:

- findings relate to specific circumstances for cases where PFD reports were produced, therefore may not be reflective of all concerns across all suicide deaths
- the categorisations for "child death (from 2015)" and "suicide (from 2015)" were only introduced in 2015, therefore there may be reports published earlier that have not been included in the study
- there may be relevant reports where only one or no categorisations have been applied and were therefore not included
- age is not always noted on reports, therefore there may have been reports relating to a child which have not been categorised and therefore excluded from the analysis
- the coronavirus (COVID-19) pandemic is likely to have had an impact on the publication of PFD reports, with long delays between a death occurring and the publication of the report
- it is possible that in the coming years, more PFD reports will be published covering the coronavirus pandemic period, which may raise different concerns and themes not included in this study
- the PFD reports are only issued for a small number of cases; the latest Office for National Statistics (ONS) statistics show that 6,069 suicides were registered in England and Wales in 2023
- the important themes identified in our analysis are restricted to the content published in the PFD reports and therefore are not exhaustive of all potential issues related to suicide prevention

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# 8 . Related links

Risk factors for suicide in children and young people in England: 2011 to 2022
Digital content article | Released 27 February 2025
The differences in risk of suicide between sociodemographic groups and analysis of Special Educational Needs (SEN) as a risk factor for suicide.

Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022
Bulletin | Released 29 March 2023
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

Suicides in England and Wales: 2023 registrations
Bulletin | Released 29 August 2024
Registered deaths in England and Wales from suicide analysed by sex, age, area of usual residence of the deceased, and suicide method.

Sociodemographic inequalities in suicides 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 statistical bulletin

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