SUICIDE STATISTICS IN NORTHERN IRELAND:

Impact of Time Taken to Investigate the Death

Introduction

Mortality Statistics in Northern Ireland are based on deaths which have been certified and registered by a District Registrar under the Births & Deaths Registration (Northern Ireland) Order, 1976. Deaths must be registered within five days of the death occurring, but there are some situations where the registration of the death can be delayed, specifically where the death has been accidental, unexpected or suspicious. Under the provisions of Section 7 of the Coroner's Act (Northern Ireland) 1959, where a deceased person has died from any cause other than natural illness for which they have been seen and treated by a registered medical practitioner within 28 days prior to the death, the death must be referred to the Coroner. A death which is suspected to be suicide must therefore be referred to the Coroner and can only be registered after the Coroner has completed his/her investigation. The time taken to carry out such an investigation can result in a delay in registration.

Suicide death statistics and mortality statistics in general are published by the Northern Ireland Statistics & Research Agency (NISRA) as the number of deaths *registered* within a calendar year, as opposed to the number of deaths that actually occurred in that period. This method ensures timely data, but introduces a limitation to the statistics within a policy context.

This paper discusses the registration process for suicide deaths and the impact of the time taken to investigate the death on official suicide death statistics.

Definition of Suicide

Suicide deaths in Northern Ireland are defined using the UK definition which includes deaths from Self-inflicted Injury (ICD10 codes X60-X84, Y87.0) as well as Events of Undetermined Intent (ICD10 codes Y10-Y34, Y87.2).

Suicide Statistics

There are approximately 14,000 deaths registered in Northern Ireland each year and of this around 2% are recorded as suicide. In 2011, the total number of deaths registered as suicide was 289. This equates to a suicide rate of 16 per 100,000 population. Further statistics are available at http://www.nisra.gov.uk/demography/default.asp31.htm.

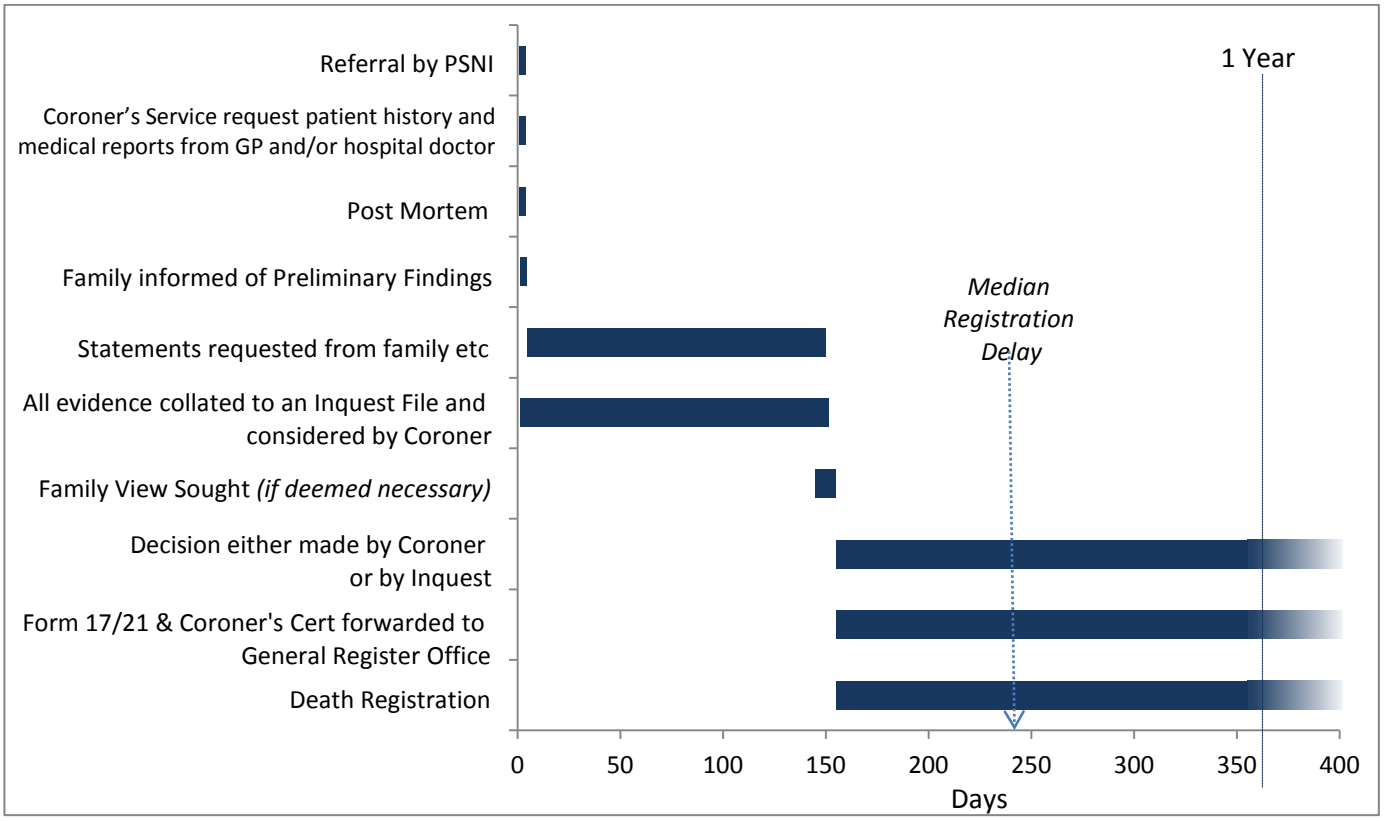
Context of Suicide Statistics

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 sectors and they enable policy makers and support services to target their resources most effectively. Key users include the Department of Health, Social Services and Public Safety (DHSSPS), the Public Health Agency (PHA), academics, and charitable organisations.

Registration Process for Suicide Deaths

If the Police Service of Northern Ireland, or a registered medical practitioner suspect that a death has occurred from intentional self-harm they are legally required to refer the case to the Coroner. This referral signals the start of a 10 stage process, detailed in Figure 1 below.

Figure 1: Death Registration Process for Suicides, Northern Ireland



The first four stages are generally completed within 24 – 36 hours of the death. In most cases of suspected suicide the Coroner will direct a post mortem examination to ascertain the cause of death. The final post mortem report may take up to five months to complete particularly if the case is complex e.g. when toxicology is required or if additional specialist input is required (neuropathology, odontology etc).

The PSNI Investigating Officer must then collate an inquest file on behalf of the Coroner. This should include statements from all relevant witnesses, a witness address list, photographs, expert reports, copies of any notes left by the deceased and computers and mobile telephones should all be checked for relevant evidence.

Throughout the process the family are advised of case progression by a named Coroners Liaison Officer.

Once the inquest file is complete and has been considered fully, the Coroner in certain circumstances may ask for family views regarding the holding of an inquest. The family is also invited to bring any concerns they may have about the circumstances surrounding the death to the coroner's attention before any decision is made about the holding of an inquest.

Once the details required to register the death have been determined, either through the Coroner's investigation or following an inquest, Form 17 or Form 21 is forwarded along with the Coroner's Certificate to a District Registration Office, hence commencing the death registration process.

Where an inquest has been held the Registrar will register the death on receipt of Form 21. If there has been no inquest the Registrar 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, the General Register Office is able to authorise the registration of the death on the authority of the Registrar General.

Time Taken to Investigate and Register a Suicide Death

As discussed above, registration of a suicide death can take many months or even years. NISRA are not notified that a death has occurred until it is registered, therefore a significant number of suicide deaths registered in any year have occurred in earlier years. For example, of the 289 such deaths registered in 2011, 120 actually occurred in 2011, 131 occurred in 2010, 12 occurred in 2009, with the remaining 26 occurring in 2008 or earlier.

Figure 2: Suicide Deaths by Year of Registration and Year of Occurrence, 2001-2011

Registration Year \ Year of Occurrence	2000 or earlier	2001	2002	2003	2004	2005	2006	2007	2008	2009*	2010*	2011*	Published Figure
2001	114	**44**											158
2002	0	97	**55**										183
2003	5	18	92	**29**									144
2004	2	7	24	64	**49**								146
2005	7	7	15	36	107	**41**							213
2006	4	3	7	23	52	130	**72**						291
2007	0	5	3	5	12	35	102	**80**					242
2008	1	1	2	3	8	13	24	132	**98**				282
2009	0	1	3	1	4	7	13	30	115	**86**			260
2010	1	0	0	2	4	3	7	7	21	127	**141**		313
2011	1	0	1	1	1	0	2	5	15	12	131	**120**	289
Total		*183*	*202*	*164*	*237*	*229*	*220*	*254*	*249*	*225*	*272*	*120*	*2,521*

NOTES:

* *Occurrence data for 2009, 2010 and 2011 should be treated with caution as they may be subject to significant change as more cases referred to the Coroner are investigated and registered.*

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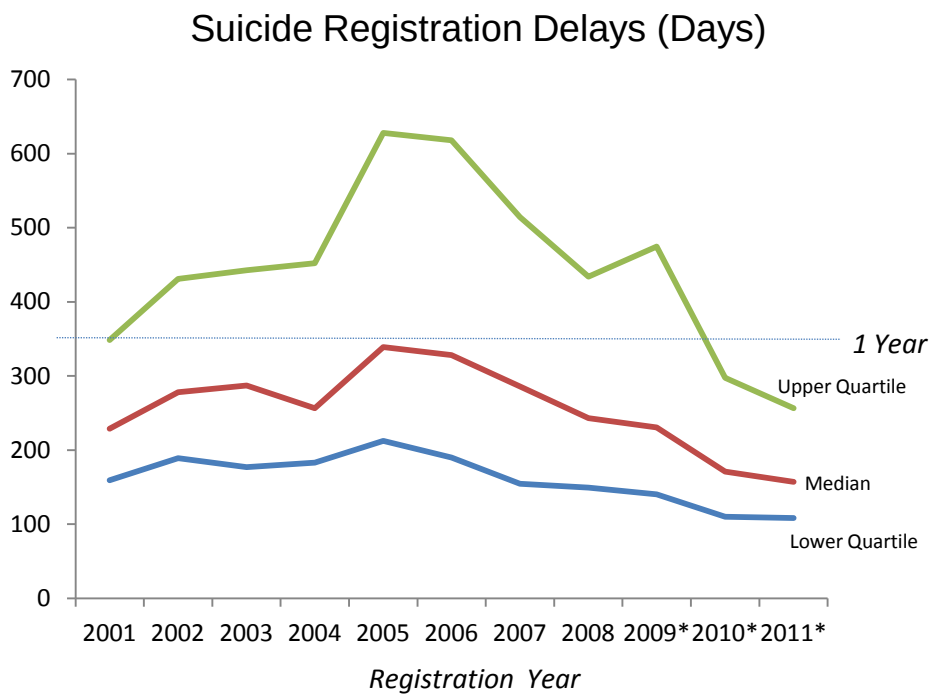
Figure 2 shows a breakdown of registered suicide deaths by the year they occurred from 2001. For those registered in 2011, 60 per cent were registered within six months and 83 per cent were registered within one year of the date of death.

Figure 3 shows that median registration delay (the middle value if the delays were sorted by length of delay), for suicides peaked in 2005 at 339 days, but this number has been declining since, reaching 157 days in 2011. Prior to April 2006, 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 which coincides with the reduction in registration delays illustrated in Figure 3.

Figure 3: Median registration delay for suicide deaths registered between 2001 and 2011, Northern Ireland



Source: Demography & Methodology Branch, Northern Ireland Statistics & Research Agency

NOTES:

1. *The suicide registration delay is calculated as the difference between the date each suicide death occurred and the date it was registered, measured in days. Additional information on the calculation of suicide registration delays is provided in Background Note 1.*
2. *Figures are for deaths registered in each calendar year.*
3. *Figures include deaths of non-residents.*

* *Data for 2009, 2010 and 2011 should be treated with caution as they will be subject to significant change as more cases referred to the Coroner are investigated and registered.*

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Quality of Suicide Statistics

Vital statistics, which include deaths due to suicide, were subject to a National Statistics Assessment in 2011/12 by the United Kingdom Statistics Authority. These statistics were designated as National Statistics in accordance with the Statistics and Registration Service Act (2007) and the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics; are produced according to sound methods; meet identified user needs; are well explained; are readily accessible and are managed impartially and objectively in the public interest. Further information on the quality assurance of Vital Statistics is detailed in the Vital Statistics Quality Assurance Procedures paper available at www.nisra.gov.uk.

Comparisons across the UK

While death registration systems are broadly comparable across the United Kingdom, there are some significant differences in the coronial and registration processes which affect comparison of suicide statistics.

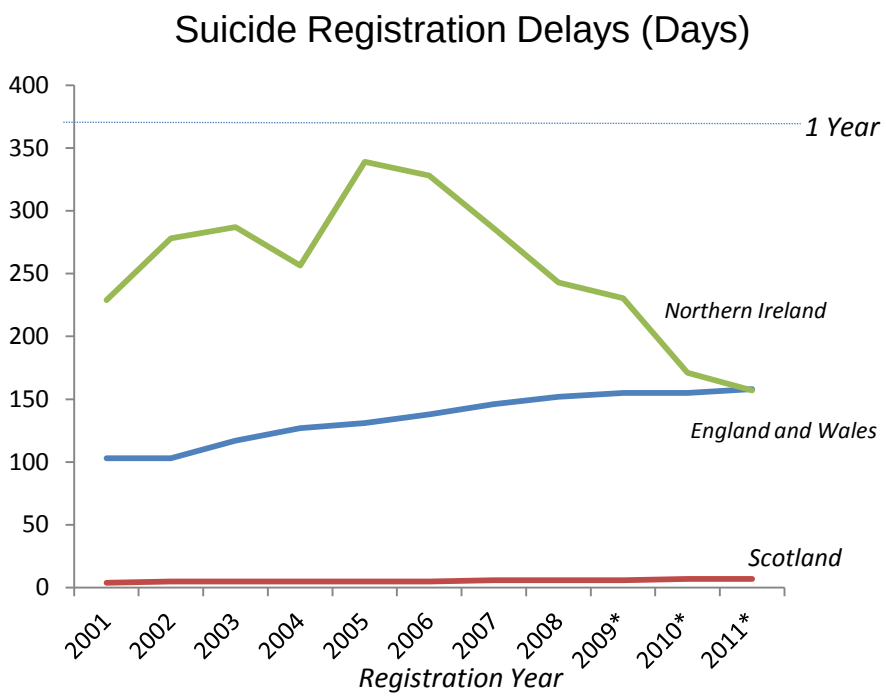
As already discussed all suspected suicides in Northern Ireland are referred to a coroner. Inquests are only held in complex cases or if the family request it, so a Registrar will register the death on receipt of the Coroner's report. If there has been no inquest a Registrar awaits the deceased's family to register the death. If there has not been an inquest and the death has not been registered within a year of the death occurring, the General Register Office (GRO), are able authorise the registration of the death on the authority of the Registrar General.

In England and Wales inquests are held for all suspected suicides. Suicides are then certified by a Coroner once the inquest has taken place. The death cannot be registered until the inquest is completed. 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.

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 the Office for National Statistics (ONS) and 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 4 shows that the median registration delay for suicide deaths is now virtually the same in Northern Ireland as in England and Wales – both just over five months. Scotland's figures have remained steady at under 10 days, for reasons already discussed.

Figure 4: Median registration delay for suicide deaths registered between 2001 and 2011, United Kingdom



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

Notes:

1. *The suicide registration delay is calculated as the difference between the date each suicide death occurred and the date it was registered, measured in days. Additional information on the calculation of suicide registration delays is provided in Background Note 1.*
2. *Figures are for deaths registered in each calendar year.*
3. *Figures include deaths of non-residents.*

* *Northern Ireland data for 2009, 2010 and 2011 should be treated with caution as they may be subject to significant change as more cases referred to the Coroner are investigated and registered.*

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Conclusion

There is a period of time between when a suicide occurs and when the death is registered. The median suicide registration delay in Northern Ireland peaked in 2005 but has declined since.

Suicide statistics are published on a registration date basis and are clearly labelled as such. While the number of deaths from suicide registered in any given year will not change, caution should be exercised when using these figures as an indicator for the number of suicides occurring. Statistics published by registration year will include deaths which occurred some time ago and will not include deaths which occurred but have yet to be registered.

Separate figures based on occurrence date are also published. NISRA are satisfied that the majority of suicide cases have been registered within two years, and almost all within three years of the date of occurrence but due to the time taken for the coronial process, caution should be exercised when examining recent years occurrence figures as they are subject to change as more suicides are registered.

Demography & Methodology Branch, NISRA

March 2013

Background Notes

1. *Calculation of registration delays*

   Figure 3 and Figure 4 present 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.

   Analysis has shown 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 the middle value if the delays were sorted by length of delay. The lower and upper quartiles are also presented to give an indication of the spread of registration delays that are found with suicides. The lower quartile is the value below which 25% of the values lie; the upper quartile is the value below which 75% of the values lie. So in 2011, 25% of registration delays for suicides in Northern Ireland (Figure 3) were less than 109 days and 75% were less than 257 days.

2. The Police Service for Northern Ireland and the Public Health Agency have developed an early warning system for monitoring suspected suicide. This is used to give public authorities unofficial early evidence of clusters of suspected suicide and helps direct support services to families. There are no statistics published from this source and no indication of the proportion of these cases which are subsequently confirmed as suicide.

3. Further information on the latest suicide statistics for the UK are available in the latest report *Suicides in the United Kingdom, 2011*.

   For mortality data for across the UK please see statistics on deaths in Scotland and statistics on deaths in England and Wales.

4. *Useful Links*

   Minding Your Head - find out more about mental health and the issues that can affect it; early warning signs that a mental health issue may be developing; tips on how to maintain good mental health.
   Website http://www.mindingyourhead.info/

   Lifeline - a confidential service, where trained counsellors will listen and help immediately on the phone and follow up with other support if necessary.
   Phone 0808 808 8000 Website http://www.lifelinehelpline.info

5. We welcome feedback on the content, format and relevance of this paper. If you have any queries or wish to offer any feedback on this release please contact our Customer Services Section at:

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