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.

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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; 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.

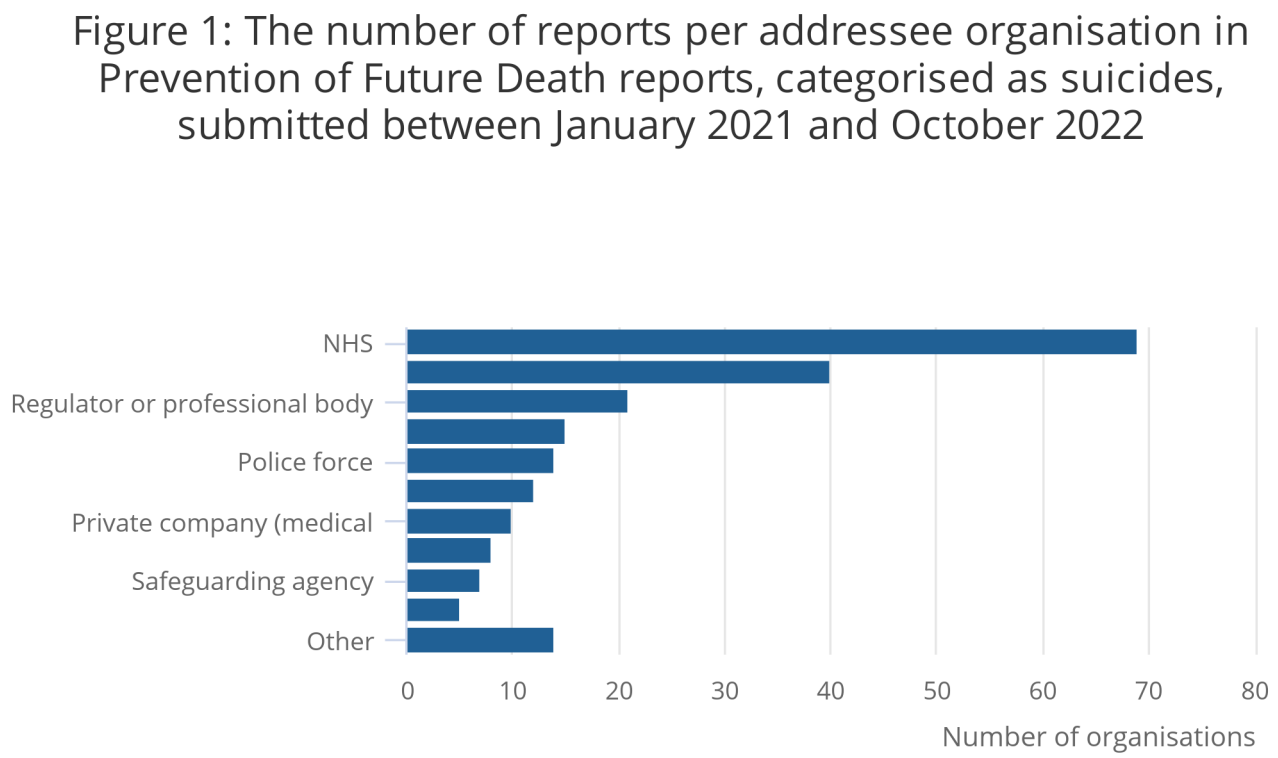
This article presents qualitative analysis conducted on PFD reports submitted between January 2021 and October 2022, categorised as suicides. The aim was to identify themes from concerns raised in the PFD reports that may inform future research or policies for suicide prevention, including a new Suicide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



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: