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Deaths by suspected suicide 2023-2024

Version 1.0 – December 2024

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available in Welsh

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Main Points

1. From 1 April 2023 – 31 March 2024 there were 350 deaths by suspected suicide of Welsh residents who died in or outside of Wales, giving a rate of 12.4 per 100,000 people. The rate in 2022/23 was 12.7 per 100,000.
2. Males accounted for 76% of deaths by suspected suicide. The age-specific rate was highest in males aged 35-44 years (35.6 per 100,000).
3. By regional area of residence, North Wales had the highest rate of death by suspected suicide (14.1 per 100,000), but it was not statistically significantly different to the all-Wales rate.
4. The rates of deaths by suspected suicide in residents in the most deprived areas (15.8 per 100,000) were statistically significantly higher than the all-Wales rate, and the rate of deaths by suspected suicide in residents in the least deprived areas (8.6 per 100,000) was statistically significantly lower than the all-Wales rate.
5. The rate of deaths by suspected suicide in people who were reported to be unemployed was 126.7 per 100,000, which was at least 12 times higher than in any other employment status group.
6. 63% of people were reported to have had a mental health condition, 29% were known to mental health services, and 53% had a history of previous self-harm.
7. 65% of the deaths by suspected suicide were in people previously known to the police.
8. Collecting and sharing data via Real Time Suspected Suicide Surveillance allows action to prevent future deaths by suspected suicide to be taken in a timely way, by providing up to date intelligence to users on national and regional patterns.
9. This is the second year of data collection. Some amendments relating to analysis have been made since the first year (see Technical Information) and will develop as further data are collected. Due to small numbers and the lack of time series data, there are limitations to the RTSSS dataset. These are outlined throughout this report.
10. Deaths by suspected suicide are reported to Public Health Wales before a Coroner's inquest. It is anticipated that the number of deaths by suspected suicide may be higher than the number of suicides as determined by a Coroner, as some deaths by suspected suicide may be found to have a different cause following a Coroner's investigation and inquest.



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Support

If you need support, information on sources of support in Wales can be found here: [Get Help Now - NHS SSHP](#). The Samaritans can be contacted for free day or night, 365 days a year on 116 123 (UK and the Republic of Ireland) or by email at jo@samaritans.org, or visit www.samaritans.org to find your nearest branch. The [Community Advice and Listening Line \(CALL\)](#) is also available on 0300 132 737 (also available day or night) and offers a confidential listening and support service. For urgent mental health support [call 111 and press option 2](#). Additional sources of support are listed at [NHS help for suicidal thoughts webpage](#).

Considerate Journalism

If you are a journalist covering news relating to suicide, please follow the [Samaritans' media guidelines](#) and the [Independent Press Standards Organisation reporting suicide guidance](#) which advise on how to reduce the risk of media coverage negatively impacting on people who may be vulnerable.

Background

Real Time Suspected Suicide Surveillance (RTSSS) was established in Wales on 1 April 2022. It collects information on deaths by suspected suicide that occur in Wales, as well as deaths of Welsh residents that occur outside of Wales.

The aim of the RTSSS is to act as a central national repository for deaths by suspected suicide in Wales and of Welsh residents and to generate the intelligence to inform suicide prevention activity across Wales.

Suspected suicides are reported to the RTSSS before a Coroner's inquest. It is anticipated that these may be higher than the number of suicides as determined by a Coroner, as some may be found to have a different cause following a Coroner's investigation and inquest.

Data collected on suspected suicides are different from suicide data as reported by the Office for National Statistics (ONS). Suicides reported by the ONS include deaths which are registered following an inquest where a Coroner has determined:

- a suicide conclusion
- a narrative conclusion (where the death may be recorded as intentional self-harm or injury or poisoning of undetermined intent, based on the information provided by the Coroner)
- an open conclusion (where the death may be coded as injury or poisoning of undetermined intent based on the information provided by the Coroner).

([Suicide rates in the UK QMI](#). 2019, ONS)

Suicide statistics published by the ONS are the official statistics on suicide and should be used for strategic planning and comparison purposes. [ONS suicide statistics on deaths registered in 2023](#) were published on 29 August 2024.

Using RTSSS data

Coroner's inquests can be a lengthy process lasting months or years in some cases. Once a conclusion is reached, the death is then registered and coded by the Office for National Statistics. As official suicide statistics are for deaths registered during a calendar year, they may not reflect any actual changes in the rate suspected suicides occurring that year. RTSSS data on deaths occurring that year is intended to be available earlier so that suicide prevention leads across multiple agencies can respond quickly to emerging patterns. RTSSS data is also used routinely to monitor suspected suicides on a monthly basis. The timeliness offered by RTSSS is a trade-off for accuracy of data and is

an important consideration when considering the need for action. In future reports time-series trends will be available and this should allow us to understand patterns.

The data in this report includes deaths that occurred between 1 April 2023 and 31 March 2024. Data from the [first RTSSS annual surveillance report](#) on deaths that occurred between 1 April 2022 and 31 March 2023 has been revised due to additional information received after data were extracted for analysis and are shown in data tables alongside 2023/24 data.

Further information on RTSSS can be found at [Public Health Wales – Real Time Suspected Suicide Surveillance](#).

Official Statistics in Development

These statistics are published as [Official Statistics in Development](#). These are statistics that have not yet been fully developed and are still being tested, but we are confident they are still of value. This is the second year of publication and the RTSSS is still in development. Additional data sources have been included since the first year and further sources are being explored. There have been a number of amendments since the 2022/23 report in response to feedback from users. Further developments will require a period of testing with users. In time it is anticipated that these statistics can be published to the standard of the [Code of Practice for Statistics](#) and can be published as [Official Statistics](#).

The **Technical Information** section in Appendix 2 contains information on:

- Current data sources
- Data quality
- Data analysis
- Strengths and limitations
- Amendments since the 2022/23 annual surveillance report



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User engagement

We welcome feedback on this report. We clarified user needs with a number of stakeholders prior to the publication of the first annual report, and widely circulated a feedback survey following its publication and have taken into consideration the feedback and comments in the planning of this report. Please complete our [feedback survey](#) on this report or direct any feedback, comments, or queries to PHW.RTSSS@wales.nhs.uk.

We plan to further involve users by:

- RTSSS team attendance at national and regional suicide and self-harm prevention fora to present the data, gather feedback, and share RTSSS development updates
- disseminating the feedback survey to a wide range of users and acting on feedback
- holding a follow up session with key stakeholders to determine the value of the data.

We will also keep users informed about the development of this work by providing updates on our website.

Pre-release list

Public Health Wales

- Iain Bell, Executive National Director for Research, Data and Digital, Public Health Wales
- Dr. Louisa Nolan, Head of Data Science & Analytics, Public Health Wales

RTSSS Implementation Group

- Jon Lane, Suicide and self-harm prevention team, Welsh Government
- Claire Cotter, National lead for suicide and self-harm prevention, NHS Executive
- Prof. Ann John, Professor of Public Health and Psychiatry, Swansea University and Chair of the National Advisory Group on prevention of suicide and self-harm
- Philip Daniels, Director of Public Health, Cwm Taf Morgannwg University Health Board
- Chief Inspector Paul Biggs, Police Liaison Unit, Welsh Government
- Dave Semmens, Assistant Director, Mental Health & Learning Disabilities, NHS Executive

Welsh Government (in addition to above)

- Kim Swain, Mental Health Senior Statistical Officer, Welsh Government
- Annie Campbell, Principal Statistician - Head of Public Health Statistics, Welsh Government
- Holly Howe-Davies, Senior Research Officer, Welsh Government



Findings

Deaths by suspected suicide in Wales

From 1 April 2023 to 31 March 2024, there were 350 suspected suicides of Welsh residents that occurred in Wales or outside Wales, giving a rate of 12.4 per 100,000. There were 16 suspected suicides of non-Welsh residents that occurred in Wales.

From 1 April 2022 to 31 March 2023, revised figures (due to additional information received after data were extracted for initial analysis) show that there were 359 suspected suicides of Welsh residents that occurred in Wales or outside Wales, giving a rate of 12.7 per 100,000, and 19 suspected suicides of non-Welsh residents that occurred in Wales (see revised 2022/23 data).

The analyses presented in this report include suspected suicides of Welsh residents only for 2023/23, with revised figures for 2022/23 in the data tables.

Deaths by suspected suicide, Welsh residents, by month

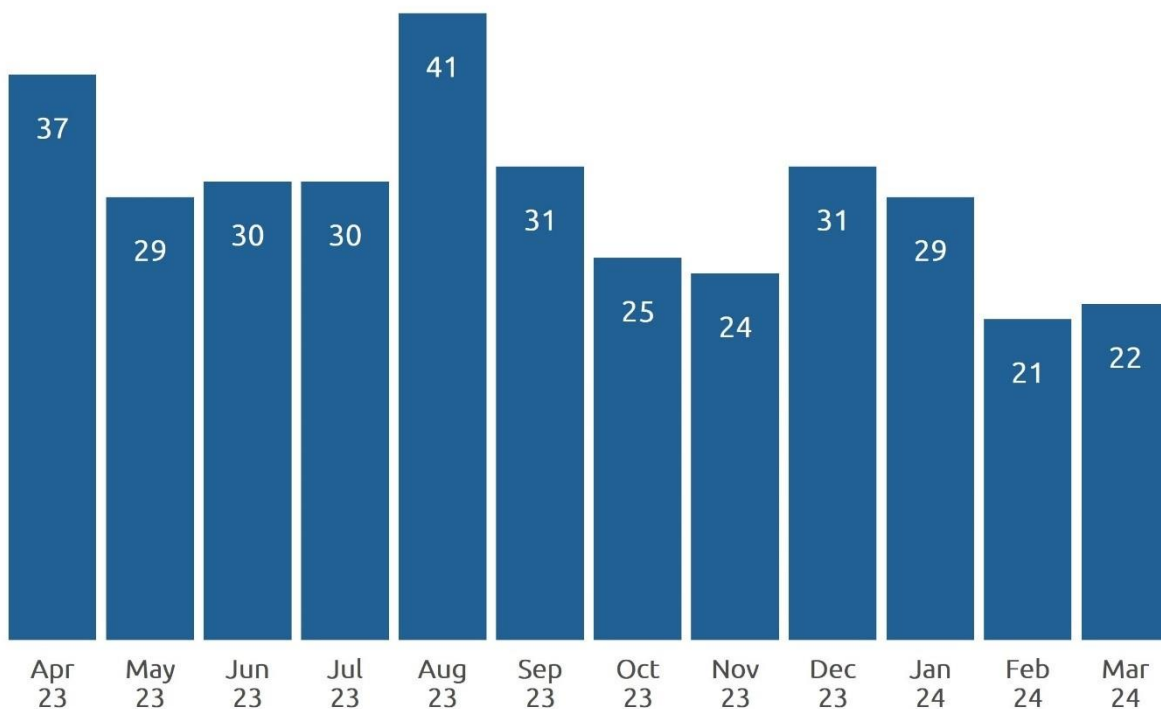
The number of suspected suicides ranged from 21 deaths in February 2024 to 41 deaths in August 2023. The mean (average) number of deaths was 29 per month and the standard deviation was 6. It is expected that around two thirds of the time that counts would be inside one standard deviation of the mean, and this was the case for 10 out of 12 months, so the variation seen is what would be expected.

In 2022/23, a similar range was seen in the previous year: 20 in November 2022 and 37 in September 2022 (see revised 2022/23 data).

From these data you cannot conclude that there was any significant variation in the number of suspected suicides month on month during 2023/24.

Figure 1. Deaths by suspected suicide, by month, all persons, all ages, counts, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data



Deaths by suspected suicide, by region of residence

Comparisons between regional estimates and the all-Wales rate

The rate of suspected suicides was highest in North Wales (14.1 per 100,000, 95% CI 11.4-17.4 per 100,000) but this difference was not statistically significant to the all-Wales rate, as the confidence intervals included the all-Wales rate (12.4 per 100,000). The rates in Mid and West Wales (11.9 per 100,000, 95% CI 9.7-14.5 per 100,000) and South-East Wales (11.8 per 100,000, 95% CI 10.1-13.8 per 100,000) were lower than the all-Wales rate but again these differences were not statistically significant, as the confidence intervals included the all-Wales rate.

In comparison, the highest rate in 2022/23 was in Mid and West Wales (15.9 per 100,000) and the lowest was in North Wales (11.0 per 100,000) (see revised 2022/23 data). Annual rates are prone to fluctuation, so caution is advised when interpreting these figures.

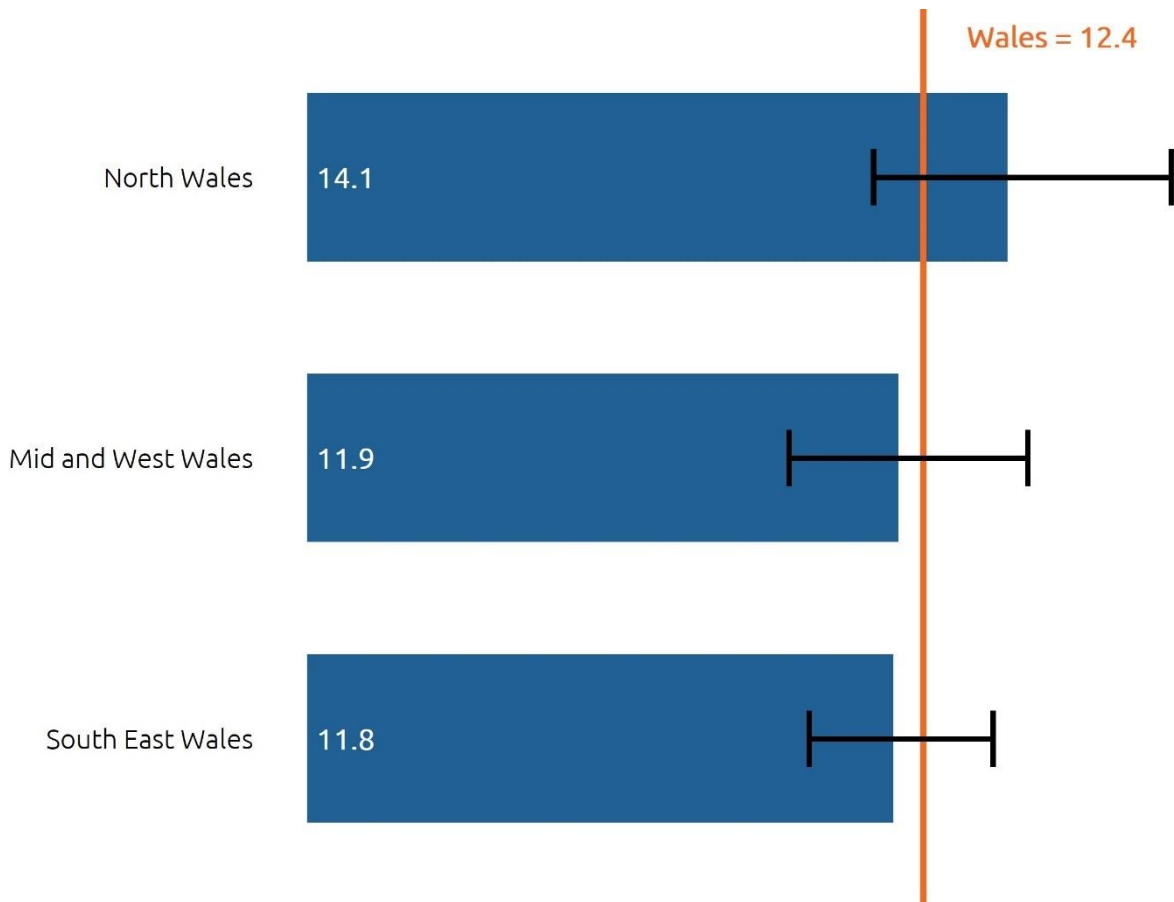
Comparisons between regional estimates

The 95% confidence intervals of the regional rate estimates overlapped but since two estimates with overlapping confidence intervals can still be statistically significantly different, further testing using the pairwise comparison of regions was done. It showed that there was no statistically significant difference between regional rate estimates (see results in Appendix 1).

From these data you can conclude that the rate of suspected suicides in North Wales, Mid & West Wales and South-East Wales in 2023/24 was not statistically significantly different to the all-Wales rate.

Figure 2. Deaths by suspected suicide, by region of residence crude rate per 100,000, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data and MYE (ONS)





Deaths by suspected suicide, by health board area of residence

Comparisons between health board estimates and the all-Wales rate

The rates in residents of Hywel Dda University Health Board (15.7 per 100,000, 95% CI 11.8-20.4 per 100,000), Betsi Cadwaladr University Health Board (14.1 per 100,000, 95% CI 11.4-17.4 per 100,000), and Cwm Taf Morgannwg University Health Board (12.8 per 100,000, 95% CI 9.5-16.8 per 100,000) were higher than the all-Wales rate but the confidence intervals overlapped the all-Wales rate so they were not statistically significantly higher. The rate in Aneurin Bevan University Health Board was the same as the all-Wales rate. The remaining health board areas had lower (but not statistically significantly lower) rates than the all-Wales rate.

Rates in residents of Hywel Dda University Health Board, Betsi Cadwaladr University Health Board and Cwm Taf Morgannwg University Health Board increased since 2022/23 (see revised 2022/23 data) but none of these increases were statistically significant, as confidence intervals between 2022/23 and 2023/24 rates overlapped.

Comparisons between health board estimates

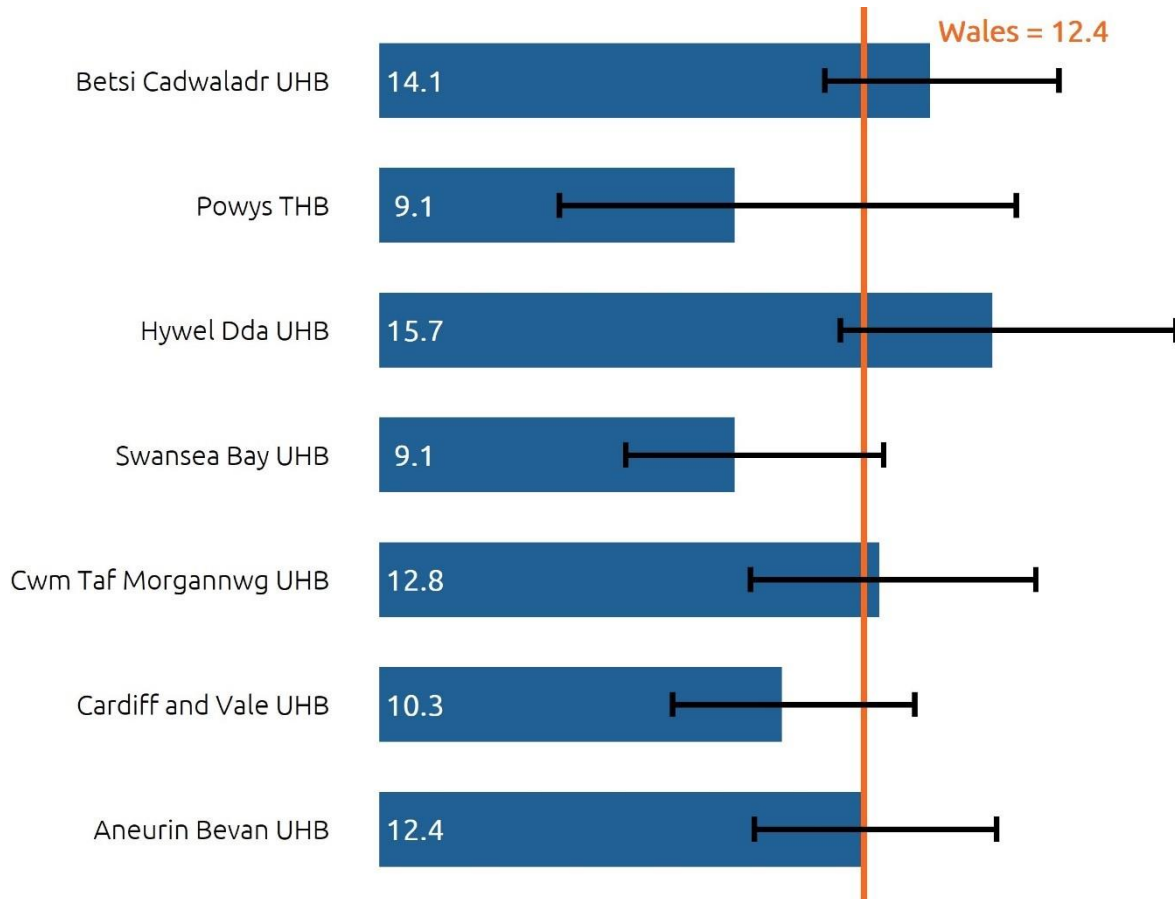
The 95% confidence intervals of the health board rate estimates overlapped but since two estimates with overlapping confidence intervals can still be statistically significantly different, further testing using the pairwise comparison of health boards was done.

It showed that the rates in residents of Betsi Cadwaladr University Health Board and Hywel Dda University Health Board were statistically significantly higher than the rate in Swansea Bay University Health Boards. The rate in Hywel Dda University Health Board was also statistically significantly higher than the rate in Cardiff & Vale University Health Board. There were no other statistically significant differences between the remaining health boards.

From these data you can conclude that none of the health board rates were statistically significantly different from the all-Wales rate, although there were some statistically significant differences between health board estimates.

Figure 3. Deaths by suspected suicide, by health board area of residence crude rate per 100,000, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data and MYE (ONS)



Deaths by suspected suicide, by area deprivation

Comparisons between area deprivation estimates and the all-Wales rate

The rate of suspected suicides was statistically significantly higher in residents who lived in the most deprived areas at 15.8 per 100,000 (95% CI 12.6-19.5 per 100,000) and statistically significantly lower in residents who lived in the least deprived areas at 8.6 per 100,000 (95% CI 6.4-11.4 per 100,000) compared with the all-Wales rate (12.4 per 100,000). The rates were lower than the all-Wales rate in residents who lived in the next most deprived and middle deprived areas, but the confidence intervals around the rates overlapped with the all-Wales rate so these were not statistically significant. For the next least deprived area the rate was the same as the all-Wales rate.

In 2022/23, the rate in the least deprived areas was statistically significantly lower than the all-Wales rate. None of the other area deprivation estimates were statistically significantly different to the all-Wales rate (see revised 2022/23 data).

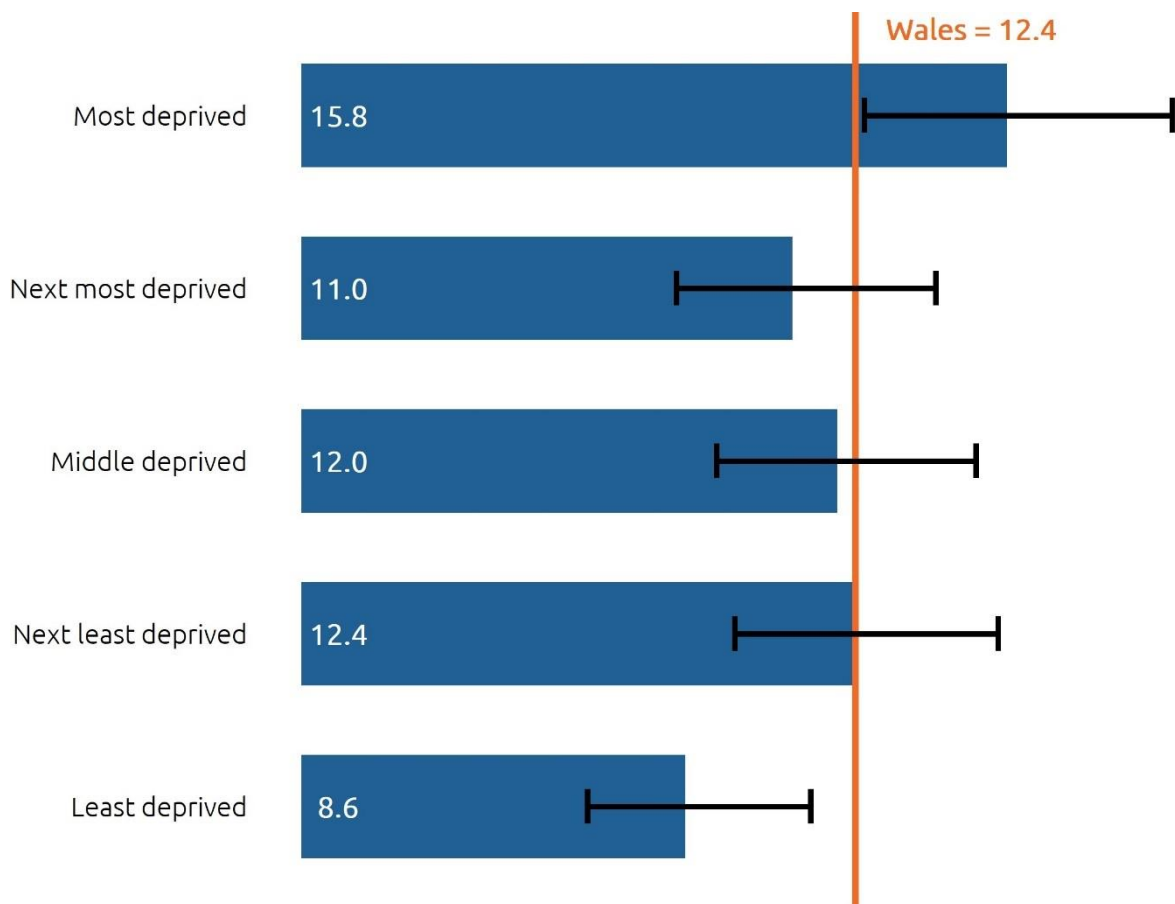
Comparisons between area deprivation estimates

The 95% confidence intervals of the deprivation rate estimates between the most deprived and the least deprived areas did not overlap with each other, so there was a statistically significant difference between these two groups. Further testing between the other area deprivation estimates using the pairwise comparison was done. It showed that there was also a statistically significant difference between the rate in the most deprived compared with the next most deprived. There was no statistically significant difference between other groups (see results in Appendix 1).

From these data you can conclude that the rate of suspected suicides in 2023/24 was statistically significantly higher in residents in the most deprived areas compared with the all-Wales rate and with the rate in the next most deprived and least deprived areas.

Figure 4. Deaths by suspected suicide, by deprivation fifth*, crude rate per 100,000, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data and WIMD 2019 (WG)

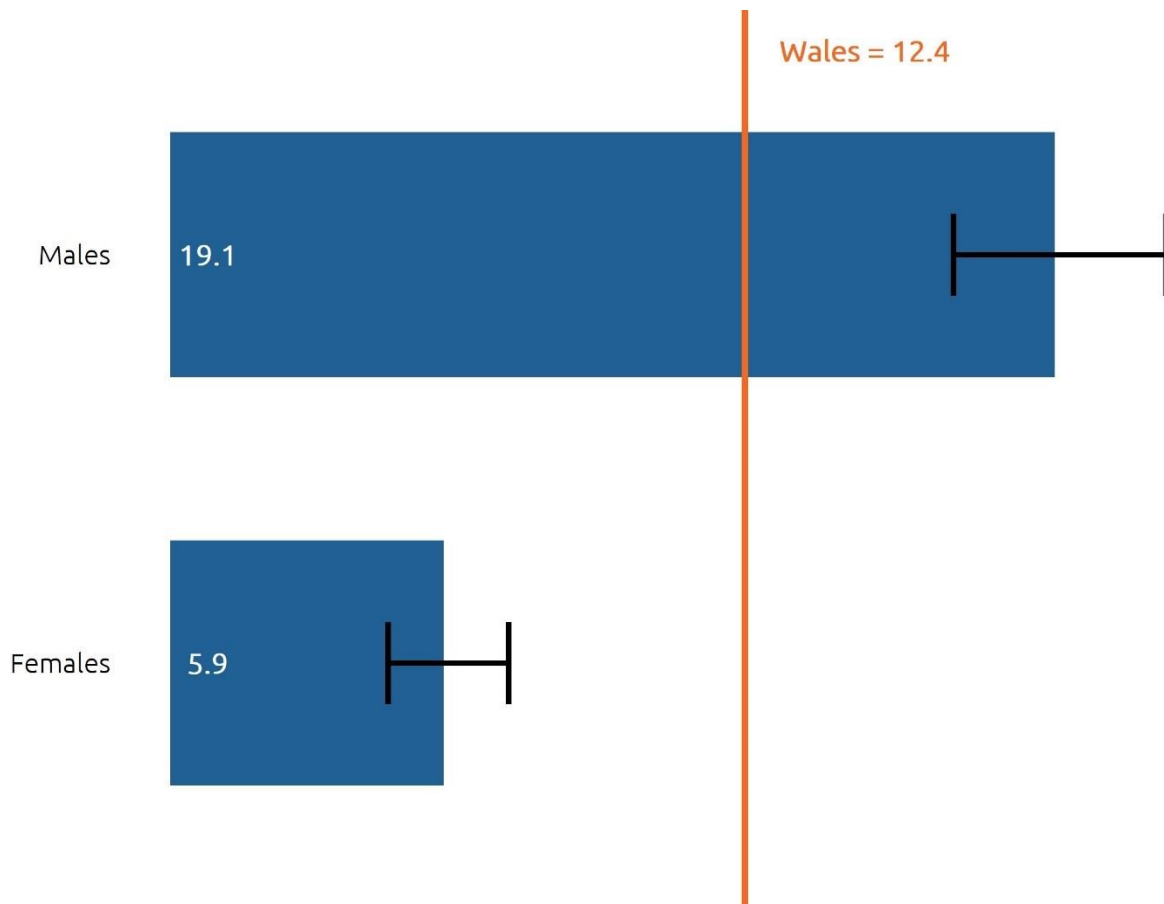


*13 cases had incomplete postcode data and therefore are not included

Deaths by suspected suicide, by sex and age

Males accounted for 76% (265 out of 350) of suspected suicides. The rate in males (19.1 per 100,000, 95% CI 16.9-21.5 per 100,000) was statistically significantly higher compared with the all-Wales rate (12.4 per 100,000) and with the rate in females (5.9 per 100,000, 95% CI 4.7-7.3 per 100,000). The rate of death in females was statistically significantly lower than all-Wales rate. The rates in males and females were similar to the rates in 2022/23 with rates of 20.0 per 100,000 (95% CI 17.7-22.5 per 100,000) for males and 5.6 per 100,000 (95% CI 4.5-7.0 per 100,000) for females (see revised 2022/23 data).

Figure 5. Deaths by suspected suicide, by sex, crude rate per 100,000, Welsh residents, 2023/24
 Produced by Public Health Wales, using RTSSS data and MYE (ONS)



The highest rate of suspected suicides occurred in males aged 35-44 years (35.6 per 100,000, 95% CI 27.3-45.5 per 100,000), followed by males aged 45-54 years (24.6 per 100,000, 95% CI 18.2-32.5 per 100,000). In 2022/23, the highest rate also occurred in males aged 35-44 years (29.9 per 100,000, 95% CI 22.4-39.2 per 100,000) (see revised 2022/23 data) and although it has increased in 2023/24,



this increase is not statistically significant as the confidence intervals around the rates overlapped.

The non-overlapping confidence intervals showed that the rate in males aged 35-44 years was statistically significantly higher than in all female age groups, males aged under 25 years, males aged 55-64 years, males aged 65-74 years and males aged 75 years and over. The rate in males ages 45-54 years was statistically significantly higher than in all female age groups (apart from females aged 35-44 years), males aged under 25 years and males aged 65-74 years.

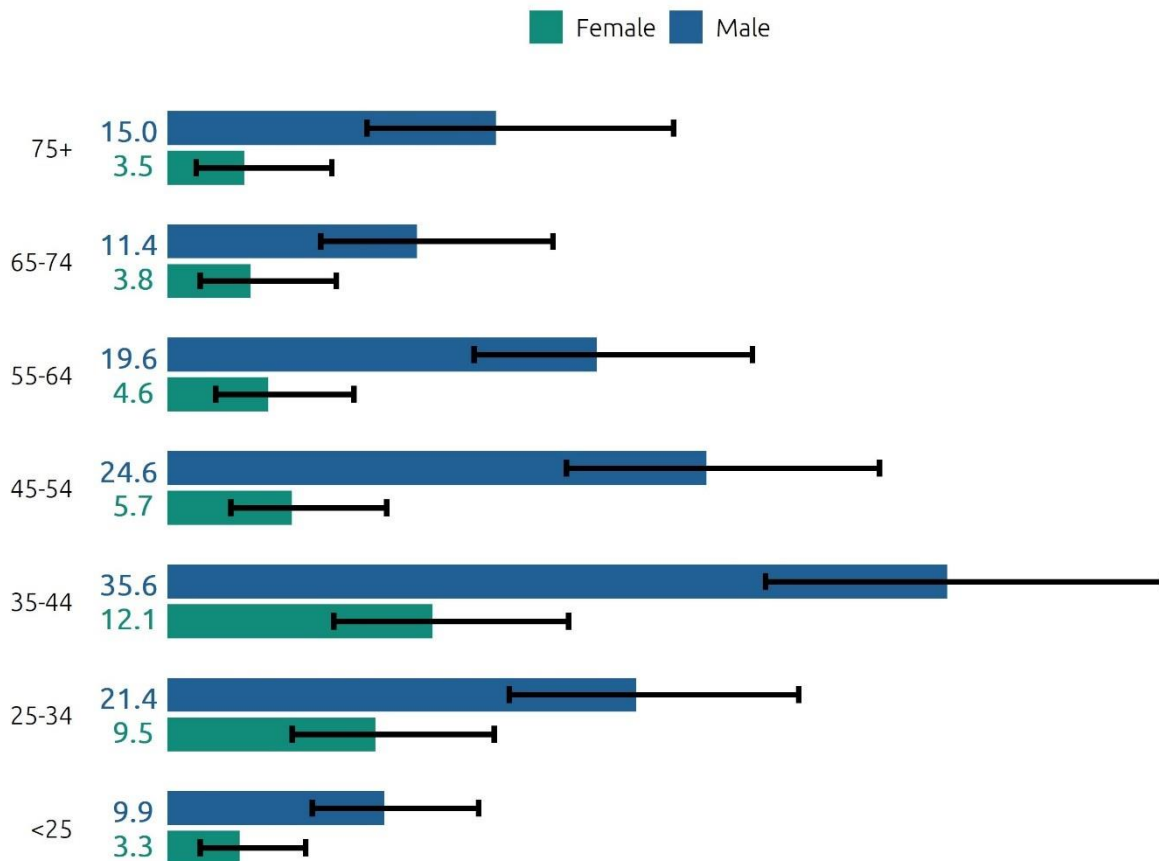
The pairwise comparison was not done for age-sex groups as in order for the pairwise estimates to be robust a minimum count of 10 is required and some groups had counts of less than 10.

The rates were higher in males compared to females in each age group. The difference in the rate for males and females was statistically significantly different in all age groups (as shown by non-overlapping confidence intervals) apart from the 65-74 years age group, although further testing using the pairwise comparison was not done to assess whether this difference may have been statistically significant.

The highest rate in females was in the 35-44 years age group (12.1 per 100,000, 95% CI 7.6-18.3 per 100,000), followed by the 25-34 years age group (9.5 per 100,000, 5.7-14.9 per 100,000). The rate in females aged 35-44 years was higher than the rate in 2022/23 (8.8 per 100,000, 95% CI 5.0-14.3 per 100,000) (see revised 2022/23 data) but the overlapping confidence intervals showed that it was not statistically significantly higher.

Figure 6. Deaths by suspected suicide, by age group* and sex all persons, crude rate per 100,000, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data and MYE (ONS)



*Age group <25 has been used instead of 10-24 years to ensure all deaths by suspected suicide are reported

Deaths by suspected suicide by employment status

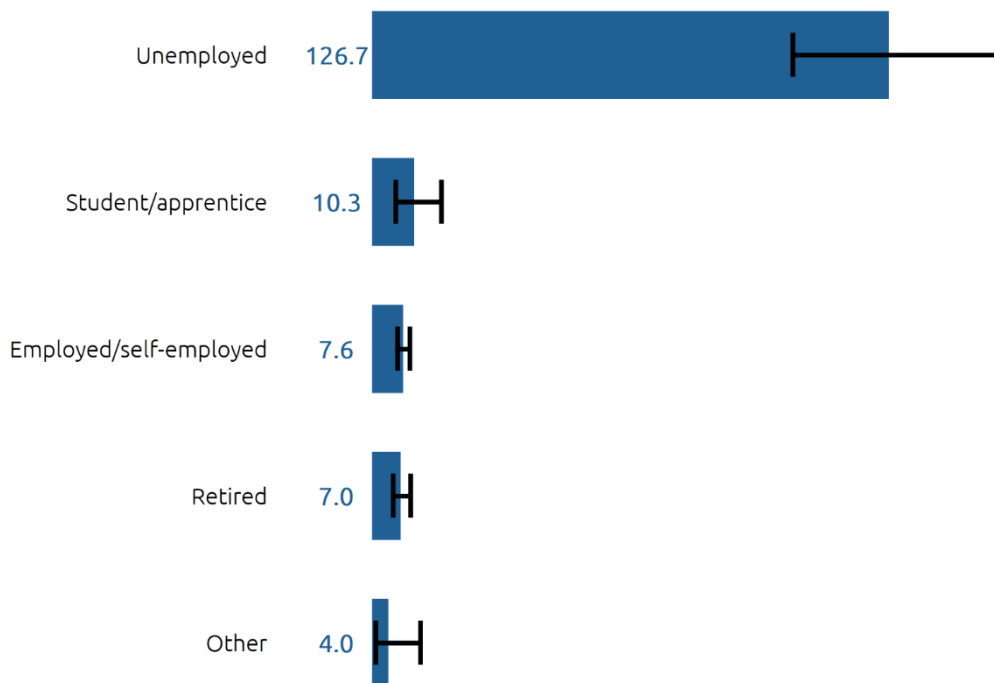
The highest rate of suspected suicides was in people where employment status was recorded as unemployed (126.7 per 100,000, 95% CI 103.1-154.2 per 100,000). This was statistically significantly higher than any other employment status group and over 12 times higher than the next highest group which was people who were students/apprentices (10.3 per 100,000, 95% CI 5.8-17.0 per 100,000). The rate in people who were unemployed increased since 2022/23, when it was 114.1 per 100,000 (95% CI 91.7-140.2 per 100,000) (see revised 2022/23 data) but the overlapping confidence intervals show that the increase is not statistically significant. It should be noted that in 84 people (24%) the employment status was unknown. This could affect the findings (by increasing or decreasing the rate) if those who had unknown employment status were more likely or less likely to

be unemployed.

From these data you can conclude that the rate of suspected suicides was statistically significantly higher in people who were reported to be unemployed compared with any other employment status group.

Figure 7. Deaths by suspected suicide, by employment status*, crude rate per 100,000, aged 16+, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data and Economic activity status data (ONS)



*84 cases had an unknown employment status therefore are not included

Deaths by suspected suicide and associated factors

The most common associated factor was mental health condition, which was reported in 219 out of 350 people (63%) who died by suspected suicide. This is an increase since 2022/23 in which 170 out of 359 people (47%) (see revised 2022/23 data) were reported to have had a mental health condition. There could be several reasons for this increase. There could be a real increase in people who were reported to have had a mental health condition, there could be better reporting, or it could be due to improved cross checking of data with other sources.

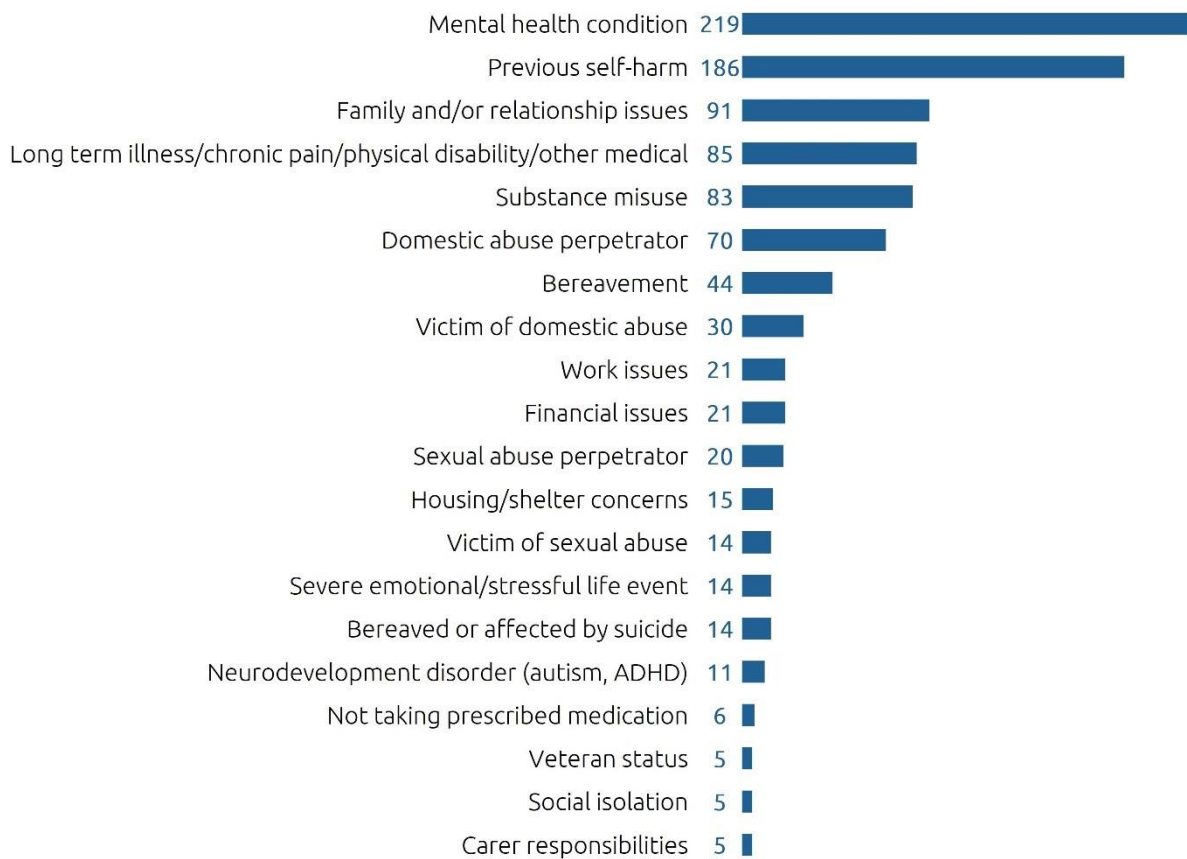
A history of previous self-harm was reported in 186 out of 350 people (53%), in 2022/23 it was reported in 175 out of 359 people (49%) (see revised 2022/23 data).

Family and/or relationship issues were reported in 91 out of 350 people (26%), in 2022/23 they were reported in 70 out of 359 people (19%) (see revised 2022/23 data).

From these data you cannot conclude what the risk of suicide was in someone who had a mental health condition or history of previous self-harm, or any other associated factor, as denominator data were not available (i.e. the number of people in the whole population who have each associated factor).

Figure 8. Deaths by suspected suicide, by associated factors*, all persons, all ages, count, Welsh residents, 2023/24**

Produced by Public Health Wales, using RTSSS data



* Multiple associated factors listed, therefore, some may be counted in more than one category

** Counts under 5 have been removed



Deaths by suspected suicide, by whether people were known to mental health services

Of the 350 people who died by suspected suicide, 103 (29%) were known to mental health services in the 6 months prior to death. 156 (45%) were not known to mental health services. For 91 people (26%) it was unknown whether they were known to mental health services (figure 9), so it is possible that the percentage of people who were known to mental health services was underestimated or overestimated. A similar figure was reported in 2022/23, when 104 out of 359 people (29%) were known to mental health services (see revised 2022/23 data).

Not all people who were known to mental health services had a known mental health condition. Of the 219 people who were reported to have had a mental health condition, 88 (40%) were known to mental health services in the 6 months prior to death, 81 (37%) were not known to mental health services and for 50 (23%) it was unknown (not shown on chart). In 2022/23, of the 170 people who were reported to have had a mental health condition, 77 (45%) were known to mental health services, 47 (28%) were not known to mental health services and for 46 (27%) it was unknown (see revised 2022/23 data).

From these data you cannot conclude what is meant by 'known to mental health services'. There is not yet enough information to determine how people were known to services.

Figure 9. Deaths by suspected suicide, by whether known to mental health services, all persons, all ages, count, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data



Deaths by suspected suicide, by whether people were previously known to police

Out of 350 suspected suicides, 227 people (65%) were previously known to police at any point in their lives prior to their death. There is no indication of the time between being known to police and death by suspected suicide. The most common reason for being known to the police was from being suspected/convicted of a crime (129 out of 350, 37%).

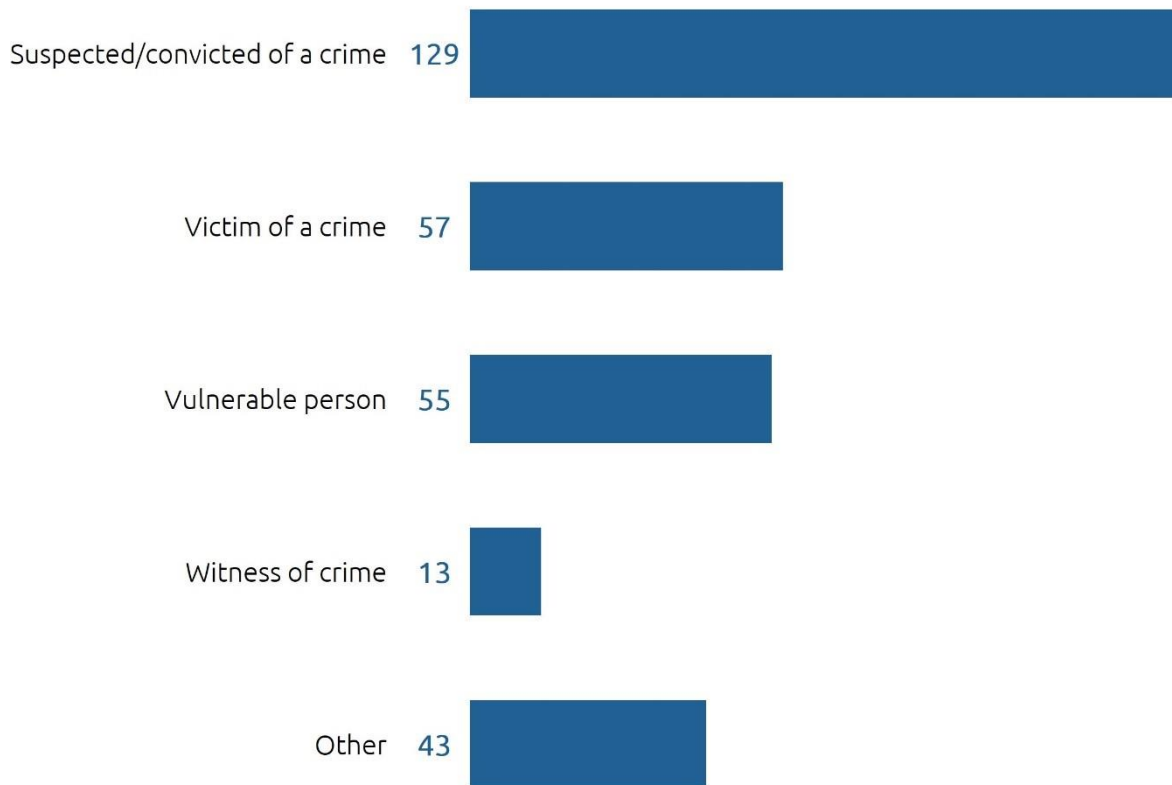
A higher figure was reported in 2022/23, when 264 out of 359 people (74%) were known to police (see revised 2022/23 data). These figures are likely to fluctuate over time.

From these data you cannot conclude what the risk of suicide was in someone who was suspected/convicted of a crime, was a victim or witness of a crime, or was a vulnerable person, as denominator data were not available.



Figure 10. Deaths by suspected suicide, by reasons previously known to police*, all persons, all ages, count, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSS data



*Some may be counted in more than one category

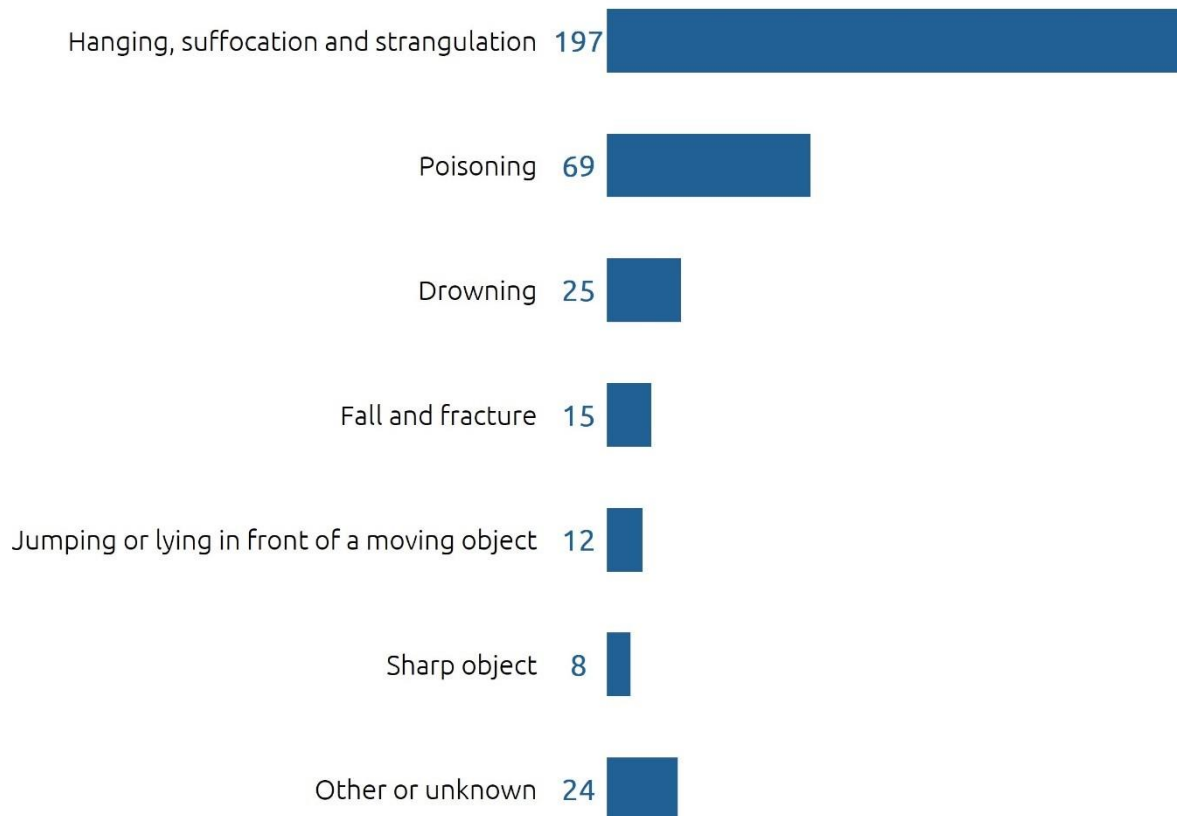
Deaths by suspected suicide, by mode of death

Hanging / strangulation / suffocation was the most common mode of death, accounting for 197 out of 350 (56%) suspected suicides. The second most common mode of death was poisoning which accounted for 69 out of 350 (20%) suspected suicides.

In comparison to revised 2022/23 figures, there were more deaths by drowning in 2023/24 (25 deaths, compared with 13 in 2022/23). There were also more deaths by jumping or lying in front of a moving object in 2023/24 (12 deaths, compared with 7 in 2022/23) (see revised 2022/23 data). It is expected that when there are small numbers, these will fluctuate year on year, so caution is advised in interpreting these differences.

Figure 11. Deaths by suspected suicide, by mode of death*, all persons, all ages, count, Welsh residents, 2023/24**

Produced by Public Health Wales, using RTSSS data



*Categories have been revised from last year to align with England nRTSSS

**Counts under 5 are included in the 'Other' category

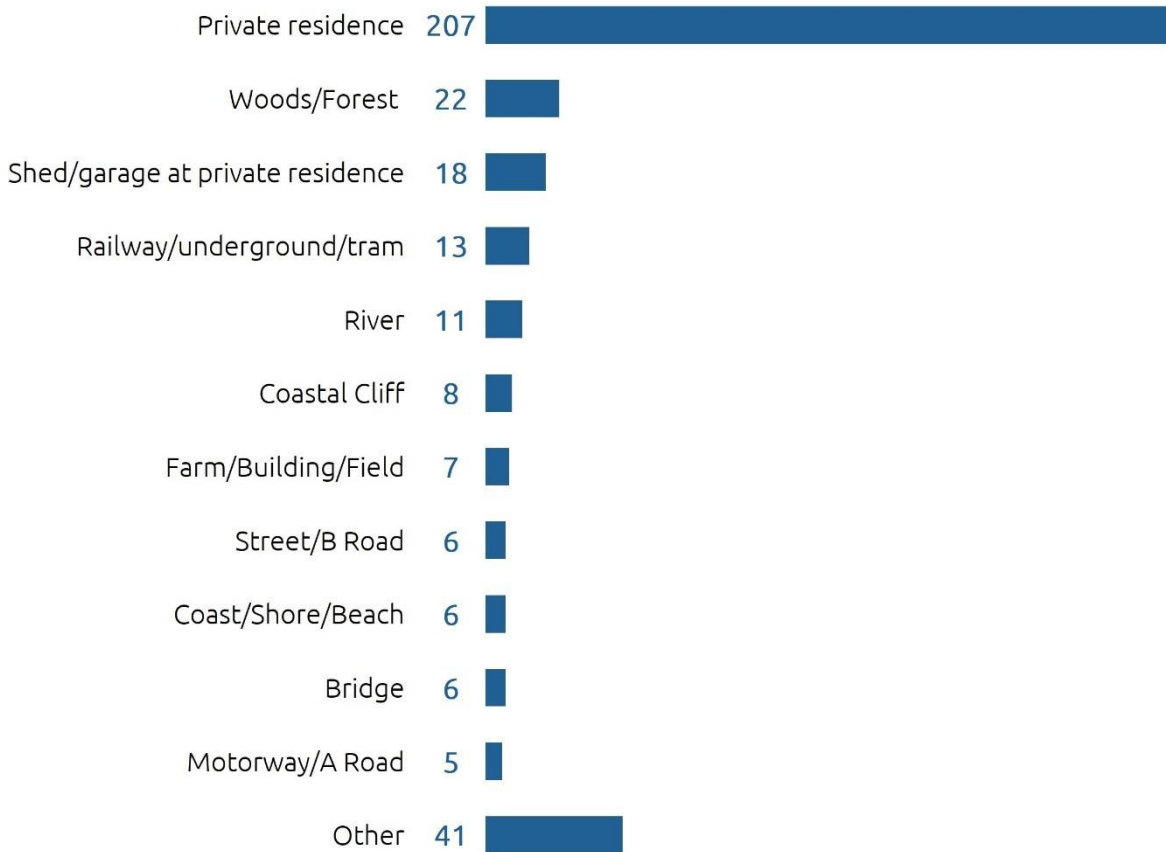
Deaths by suspected suicide, by location type

Incidents that led to death by suspected suicide most commonly occurred in private residences, accounting for the majority (207) of the 350 incidents (59%). Woods or forests were the next most common, accounting for 22 (6%) out of 350 incidents.

There were similar findings for 2022/23 data. It showed that 213 out of 359 incidents (59%) occurred in private residences and 30 out of 359 incidents (8%) occurred in woods or forests (see revised 2022/23 data).

Figure 12. Deaths by suspected suicide, by location type, all persons, all ages, count*, Welsh residents, 2023/24

Produced by Public Health Wales, using RTSSS data



*Counts under 5 included in the 'Other' category

Conclusion

There were 350 suspected suicides of Welsh residents who died in or outside of Wales, between 1 April 2023 and 31 March 2024, giving a rate of 12.4 per 100,000 people. Males accounted for 76% of suspected suicides. The age-specific rate was highest in males aged 35-44 years (35.6 per 100,000). North Wales had the highest rate of suspected suicides (14.1 per 100,000), but it was not statistically significantly different to the all-Wales rate.

The rates of suspected suicides in residents in the most deprived areas (15.8 per 100,000) were statistically significantly higher than the all-Wales rate, and the rate of suspected suicides in residents

in the least deprived area (8.6 per 100,000) was statistically significantly lower than the all-Wales rate. The rate of suspected suicides in people who were reported to be unemployed was 126.7 per 100,000, which was at least 12 times higher than in any other employment status group. 63% of people were reported to have had a mental health condition and 29% were known to mental health services in the 6 months prior to death. A history of previous self-harm was reported in 53% of people. 65% of the suspected suicides were in people previously known to the police.

This information can be used to inform suicide prevention work in Wales in order to reduce the number of suicides in the Welsh population.

Glossary

Confidence interval

Confidence intervals are indications of the natural variation that would be expected around a rate, and they should be considered when assessing or interpreting a rate. The size of the confidence interval is dependent on the number of events occurring and the size of the population from which the events came. In general, rates based on small numbers of events and small populations are likely to have wider confidence intervals. Conversely, rates based on large populations are likely to have narrower confidence intervals. A 95% confidence interval means that we are 95% confident that the true value of the estimate lies within the range.

Count

The count is the number of suspected suicides that occurred over a particular period of time.

Crude rate

A crude rate is the number of suspected suicides occurring in a population over a specific time period, expressed as the number of deaths per 100,000 of the population. These rates were used as they are most suitable to inform action, which is one of the aims of the RTSSS.

Known to Police categories (as reported by the Police)

- **Vulnerable person** – this includes situations where a person is unable to take care of or protect themselves or others from harm or exploitation.
- **Other** – this includes situations not captured by existing categories, for example the person having reported an incident or concern, the person was involved in a road traffic incident, or the person was a firearms license holder.

Mean

The average number of deaths.

Mental health condition

This is a broad term covering conditions that affect emotions, thinking and behaviour, and which substantially interfere with our life. Mental health conditions can significantly impact daily living, including our ability to work, care for ourselves and our family, and our ability to relate and interact with others. This is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time, for each person. Mental health conditions can range from mild through to severe and enduring illness. People with mental health conditions are more likely to experience lower levels of physical and mental wellbeing, but this is not always or necessarily the case. Some mental health conditions like eating disorders and schizophrenia are associated with a higher risk of mortality ([Consultation on Draft Suicide and Self-harm Prevention Strategy \(Welsh Government\)](#)).

Rate

The rates in this report are crude rates (see above).

Regions

The three regions of North Wales, Mid and West Wales and South-East Wales are defined below and are consistent with the regional suicide prevention fora in Wales.

- North Wales – Health boards: Betsi Cadwaladr University Health Board. Local authorities: Isle of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, Wrexham.
- Mid and West Wales – Health boards: Hywel Dda University Health Board, Swansea Bay University Health Board, Powys Teaching Health Board. Local authorities: Carmarthenshire, Ceredigion, Pembrokeshire, Swansea, Neath Port Talbot, Powys.
- South-East Wales – Health Boards: Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff & Vale University Health Board. Local authorities: Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen, Bridgend, Merthyr Tydfil, Rhondda Cynon Taf, Cardiff, Vale of Glamorgan.

Self-harm

Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress. Self-harm includes suicide attempts as well as acts where little or no suicidal intent is involved (for example, where people harm themselves to reduce internal tension, communicate distress, or obtain relief from an otherwise overwhelming situation). ([Consultation on Draft Suicide and Self-harm Prevention Strategy \(Welsh Government\)](#)).



Standard deviation

A measure of the amount of variation of a set of values in relation to the mean.

Statistical significance

Statistical significance when comparing local area estimates to the all-Wales value was determined using 95% confidence intervals. The local area estimate is statistically significantly different if its confidence interval lies outside the Wales value. If the confidence interval overlaps with the Wales value, then the difference is not statistically significant.

When comparing local area estimates with another local area estimate, age groups by sex, and deprivation fifths, non-overlapping confidence intervals between values indicate that the difference is unlikely to have arisen from random fluctuation (i.e. statistically significant). However, when the confidence intervals overlap, we cannot determine if there is a statistically significant difference or not by comparing confidence intervals alone, so a more exact test is required. The pairwise comparison looked at the difference between the rates and the 95% confidence intervals of the difference. When the confidence interval of the rate difference is above zero, the two rates are considered significantly different with 95% confidence.

Substance misuse

Substance misuse is formally defined as the continued use of any psychoactive substance that substantially affects a person's physical and mental health, social situation and responsibilities. The most severe forms of substance misuse are normally treated by specialist drug and alcohol rehabilitation services. Substance misuse covers misuse of a range of psychoactive substances including alcohol, illicit drugs and licit drugs including prescribed medications taken in a way not recommended by a GP or the manufacturer. ([Consultation on Draft Suicide and Self-harm Prevention Strategy \(Welsh Government\)](#)).

Suspected suicide

When a person is suspected to have taken their own life intentionally ([Consultation on Draft Suicide and Self-harm Prevention Strategy \(Welsh Government\)](#)).

A death by suspected suicide as reported in most cases here has been determined by the Police. The College of Policing have outlined the classification of suspected suicide and state that:

"..There is often a requirement for an initial judgment to be made on whether a case is potentially suicide. ... Officers should use their professional judgment – based on all the known facts – and supported by the national decision model (NDM), to record whether a fatality is a suspected suicide. Witness accounts, CCTV material, the presence of a suicide note and other available evidence will help in this determination. The 'Ovenstone criteria' (Ovenstone, 1973) may be used as a tool to



support decision making on whether a death was more likely to have been suicide than not. Any judgement made in the first instance must be reviewed as further information becomes available.”

Appendix 1 – Pairwise comparison results

Deaths by suspected suicide, Real Time Suspected Suicide Surveillance data, overall significance, all persons, Wales, April 2023 to March 2024

Table 1: Suspected Suicides, Overall significance by Region, April 2023 to March 2024

Produced by Public Health Wales, using RTSSS data.

Breakdown 1	Breakdown 2	Rate Difference	LCL difference	UCL difference	Overall Significance (5%)
Mid and West Wales	North Wales	2.22	-1.55	5.99	Not significantly different
Mid and West Wales	South East Wales	0.08	-2.90	3.06	Not significantly different
North Wales	Mid and West Wales	2.22	-1.55	5.99	Not significantly different
North Wales	South East Wales	2.30	-1.16	5.76	Not significantly different
South East Wales	Mid and West Wales	0.08	-2.90	3.06	Not significantly different
South East Wales	North Wales	2.30	-1.16	5.76	Not significantly different

Table 2: Suspected Suicides, Overall significance by Health Board, April 2023 to March 2024

Produced by Public Health Wales, using RTSSS data.

Breakdown 1	Breakdown 2	Rate Difference	LCL difference	UCL difference	Overall Significance (5%)
Aneurin Bevan UHB	Betsi Cadwaladr UHB	1.71	-2.50	5.91	Not significantly different
Aneurin Bevan UHB	Cardiff and Vale UHB	2.14	-2.09	6.37	Not significantly different
Aneurin Bevan UHB	Cwm Taf Morgannwg UHB	0.35	-4.27	4.97	Not significantly different
Aneurin Bevan UHB	Hywel Dda UHB	3.24	-1.88	8.36	Not significantly different
Aneurin Bevan UHB	Powys THB	3.31	-2.86	9.49	Not significantly different
Aneurin Bevan UHB	Swansea Bay UHB	3.30	-1.06	7.67	Not significantly different

Betsi Cadwaladr UHB	Aneurin Bevan UHB	1.71	-2.50	5.91	Not significantly different
Betsi Cadwaladr UHB	Cardiff and Vale UHB	3.85	-0.34	8.03	Not significantly different
Betsi Cadwaladr UHB	Cwm Taf Morgannwg UHB	1.35	-3.22	5.93	Not significantly different
Betsi Cadwaladr UHB	Hywel Dda UHB	1.53	-3.55	6.62	Not significantly different
Betsi Cadwaladr UHB	Powys THB	5.02	-1.12	11.16	Not significantly different
Betsi Cadwaladr UHB	Swansea Bay UHB	5.01	0.69	9.33	Significantly different
Cardiff and Vale UHB	Aneurin Bevan UHB	2.14	-2.09	6.37	Not significantly different
Cardiff and Vale UHB	Betsi Cadwaladr UHB	3.85	-0.34	8.03	Not significantly different
Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	2.49	-2.11	7.10	Not significantly different
Cardiff and Vale UHB	Hywel Dda UHB	5.38	0.28	10.48	Significantly different
Cardiff and Vale UHB	Powys THB	1.17	-4.99	7.33	Not significantly different
Cardiff and Vale UHB	Swansea Bay UHB	1.16	-3.18	5.51	Not significantly different
Cwm Taf Morgannwg UHB	Aneurin Bevan UHB	0.35	-4.27	4.97	Not significantly different
Cwm Taf Morgannwg UHB	Betsi Cadwaladr UHB	1.35	-3.22	5.93	Not significantly different
Cwm Taf Morgannwg UHB	Cardiff and Vale UHB	2.49	-2.11	7.10	Not significantly different
Cwm Taf Morgannwg UHB	Hywel Dda UHB	2.89	-2.54	8.32	Not significantly different
Cwm Taf Morgannwg UHB	Powys THB	3.66	-2.77	10.10	Not significantly different

Cwm Taf Morgannwg UHB	Swansea Bay UHB	3.65	-1.07	8.38	Not significantly different
Hywel Dda UHB	Aneurin Bevan UHB	3.24	-1.88	8.36	Not significantly different
Hywel Dda UHB	Betsi Cadwaladr UHB	1.53	-3.55	6.62	Not significantly different
Hywel Dda UHB	Cardiff and Vale UHB	5.38	0.28	10.48	Significantly different
Hywel Dda UHB	Cwm Taf Morgannwg UHB	2.89	-2.54	8.32	Not significantly different
Hywel Dda UHB	Powys THB	6.55	-0.25	13.36	Not significantly different
Hywel Dda UHB	Swansea Bay UHB	6.54	1.33	11.76	Significantly different
Powys THB	Aneurin Bevan UHB	3.31	-2.86	9.49	Not significantly different
Powys THB	Betsi Cadwaladr UHB	5.02	-1.12	11.16	Not significantly different
Powys THB	Cardiff and Vale UHB	1.17	-4.99	7.33	Not significantly different
Powys THB	Cwm Taf Morgannwg UHB	3.66	-2.77	10.10	Not significantly different
Powys THB	Hywel Dda UHB	6.55	-0.25	13.36	Not significantly different
Powys THB	Swansea Bay UHB	0.01	-6.24	6.27	Not significantly different
Swansea Bay UHB	Aneurin Bevan UHB	3.30	-1.06	7.67	Not significantly different
Swansea Bay UHB	Betsi Cadwaladr UHB	5.01	0.69	9.33	Significantly different
Swansea Bay UHB	Cardiff and Vale UHB	1.16	-3.18	5.51	Not significantly different
Swansea Bay UHB	Cwm Taf Morgannwg UHB	3.65	-1.07	8.38	Not significantly different
Swansea Bay UHB	Hywel Dda UHB	6.54	1.33	11.76	Significantly different
Swansea Bay UHB	Powys THB	0.01	-6.24	6.27	Not significantly different

Table 3: Suspected Suicides, Overall significance by Deprivation Fifth Quintile, April 2023 to March 2024

Produced by Public Health Wales, using RTSSS data.

Breakdown 1	Breakdown 2	Rate Difference	LCL difference	UCL difference	Overall Significance (5%)
Least deprived	Next least deprived	3.73	-0.01	7.48	Not significantly different
Least deprived	Middle deprived	3.32	-0.38	7.02	Not significantly different
Least deprived	Next most deprived	2.39	-1.28	6.07	Not significantly different
Least deprived	Most deprived	7.15	3.01	11.28	Significantly different
Next least deprived	Least deprived	3.73	-0.01	7.48	Not significantly different
Next least deprived	Middle deprived	0.41	-3.59	4.41	Not significantly different
Next least deprived	Next most deprived	1.34	-2.64	5.32	Not significantly different
Next least deprived	Most deprived	3.41	-0.99	7.82	Not significantly different
Middle deprived	Least deprived	3.32	-0.38	7.02	Not significantly different
Middle deprived	Next least deprived	0.41	-3.59	4.41	Not significantly different
Middle deprived	Next most deprived	0.93	-3.01	4.87	Not significantly different
Middle deprived	Most deprived	3.83	-0.54	8.20	Not significantly different
Next most deprived	Least deprived	2.39	-1.28	6.07	Not significantly different
Next most deprived	Next least deprived	1.34	-2.64	5.32	Not significantly different
Next most deprived	Middle deprived	0.93	-3.01	4.87	Not significantly different
Next most deprived	Most deprived	4.75	0.40	9.10	Significantly different
Most deprived	Least deprived	7.15	3.01	11.28	Significantly different
Most deprived	Next least deprived	3.41	-0.99	7.82	Not significantly different
Most deprived	Middle deprived	3.83	-0.54	8.20	Not significantly different

Most deprived	Next most deprived	4.75	0.40	9.10	Significantly different
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Table 4: Suspected Suicides, Overall significance by Sex, April 2023 to March 2024
 Produced by Public Health Wales, using RTSSSS data.

Breakdown 1	Breakdown 2	Rate Difference	LCL Difference	UCL Difference	Overall Significance (5%)
Males	Females	13.19	10.57	15.81	Significantly different
Females	Males	13.19	10.57	15.81	Significantly different

Appendix 2 – Technical information

Legal basis

The legal basis for the processing of data is Paragraph 3(b) of the Public Health Wales NHS Trust (Establishment) Order 2009 “to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public in Wales; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters” and Paragraph 3(c) of the Public Health Wales NHS Trust (Establishment) Order 2009 which states as one of its functions: ‘to undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies.’

RTSSS has Data Disclosure Agreements in place with the four Welsh Police forces and British Transport Police to receive information via the British Transport Police (BTP)/National Police Chief’s Council (NPCC) data collection template with addition of fields for name and date of birth. Although the Data Protection Act 2018 and General Data Protection Regulations do not apply to the data collected for RTSSS, the exchange of personal data is conducted within the legal framework of the Data Protection Act 2018 and in compliance with the common law duty of confidence. We have conditional support from the Confidentiality Advisory Group to process confidential patient information without consent (Ref: 22/CAG/0163).

Data sources

Notification of deaths by suspected suicide: Data in this report were obtained from the RTSSS database. Information is provided to RTSSS mainly by the four Welsh police forces, using a template developed by the British Transport Police (BTP) for the National Police Chief’s Council (NPCC) Suicide Prevention Portfolio. Suspected suicides have been determined to be suspected suicides by the Police (see ‘suspected suicide’ in glossary).

In addition to data in the BTP/NPCC template, we obtain name and date of birth from the four Welsh Police forces so that we are able to link each record with other data sources to cross check information and add additional information. BTP also separately notify suspected suicides which are transport related. Other sources for initial notifications include ad-hoc reports from services outside of Wales and the NHS Wales Joint Commissioning Committee.

Cross checking and additional information: A number of sources of data are used to cross check the information received in the initial notification, and to obtain further information where there may be gaps. These include: Welsh Clinical Portal, Welsh Demographic Service, Child Death Review Programme, Network Rail and Nationally Reported Incidents held by the NHS Executive.

Welsh Index of Multiple Deprivation 2019 (WIMD) was used as the estimate of deprivation. It is Welsh Government's official measure of relative deprivation for small areas in Wales. It is made up of eight separate domains/types of deprivation: Income, Employment, Health, Education, Access to Services, Housing, Community Safety and Physical Environment.

The ONS mid-year estimates (MYE) were used as the denominator when calculating rates. The ONS is the official source of population sizes, produced annually, covering populations of local authorities, counties, regions and countries of the UK by age and sex. Denominator for rates were based on lower super output areas, MYE 2020.

ONS Census 2021 data was used for estimating employment rates.

Location data were derived from postcodes, What Three Words and grid reference data provided by the data suppliers, on the British National Grid. If these were not available, name of health board or region of residence was supplied, if known.

Data quality

Data quality has been considered using the Data Management Association UK dimensions, i.e. completeness, accuracy, timeliness, uniqueness, consistency and validity.

It should be noted that ethnic group and gender identity are important indicators, but the data quality of these data items is not clear, so we are not able to report on them. See section on Limitations for a further explanation.

Completeness:

The table outlines the indicators presented in this report and the corresponding data items in the BTP/NPCC return and other sources.

Indicator in RTSSS report	Data item in deaths reported by Police (BTP/NPCC data collection template)	Data item in deaths reported by others	Completeness (2023/24 data)
Month of death	Date of death	Date of death or month of death was available	100% complete, <5 cases with minor date discrepancy (i.e. day of death) between different sources.
Region & health board of residence	Postcode of residence	Region & health board of residence was	100% complete in deaths reported on



		available	BTP/NPCC template. For deaths notified by other sources postcode was not available but region and health board of residence was available for all deaths.
Area deprivation (based on Welsh Index of Multiple Deprivation)	No data field – obtained from postcode of residence	Not available unless postcode provided	96% complete.
Age range	Age	Age or age range was available	100% complete.
Sex (assigned at birth)	Gender (includes information on sex and gender)	Data on sex was available	100% complete. Only male and female data items used from the NPCC/BTP gender category and referred to as sex. For data items other than male/female, sex assigned at birth obtained from Welsh Demographic Service.
Employment status (Unemployed, Employed/Self-employed, Retired, Student/apprentice, Other)	Employment status/occupation (includes the following options: former police officer, serving police officer, former police staff, serving police staff, serving HM forces, NHS staff, social care worker, other public sector, other private sector, self-employed, unemployed, student, retired, other, unknown).	Employment status was not available	76% complete. If occupation rather than employment type was listed in BTP/NPCC return, employment status was determined from this. Free text field was also interrogated.
Associated factors	Historical risk factor(s)*	Information on associated factors was available for some deaths	Only positive findings were collected and reported. Unknown level of completeness

			therefore may be underestimated. Free text field was also interrogated to populate data fields in RTSSS database.
Known to mental health services	Known to mental health services 6 months prior to death	Use of mental health services was available for some deaths	74% complete overall. Free text field was also interrogated. Mainly police reported although some information from health systems (see Limitations section).
Known to Police	Known to Police	Known to Police not available	96% complete. Free text field was also interrogated.
Mode of death	Suicide method	Mode of death usually available	97% complete.
Location type	Suicide means location type	Location type usually available	>99% complete

*The sources of information for these data items may have differed slightly in each Police force. For 'mental health condition' and 'previous self-harm' all Police force reporters based the information reported to RTSSS on evidence that the person had a diagnosed mental health condition or had a history of self-harm, respectively. This information may have been obtained from health records, police records or from a family statement.

Accuracy

Data were cross checked with other sources where possible. Queries relating to the data on the BTP/NPCC return were checked directly with the Police Forces. A small number of cases were reported by sources other than the Police and there was less information available on these. Also, we did not obtain personally identifiable information on these cases so cross-checking or adding further information was not possible.

Timeliness

Data on the BTP/NPCC return were received by RTSSS within 10 working days of the following month from the month of death. One Police force submitted a weekly return. The addition of further information could take up to several weeks. A small number of deaths were not reported in the initial BTP/NPCC return, but were added retrospectively, with revised figures from the previous year being published. Deaths reported via other sources could take one to two months to be received by RTSSS.

Consistency

Each record was inputted by a member of the RTSSS core team and quality checked by another team member. If data values conflicted with other values the data source was checked and queried if necessary. A monthly data review meeting was held by the core RTSSS team to review any records where there were queries about the data identified from either the data entry or data quality checking stages.

Uniqueness

Duplicated entries would be identified during the data entry or quality checking stages.

Validity

Data were cross checked with other sources where possible. RTSSS has a minimum dataset with definitions and rules relating to the data items collected.

Data analysis

The rates referred to in this report are crude rates as they are most suitable to inform action, which is one of the aims of the RTSSS. A crude rate is the number of suspected suicides occurring in a population over a specific time period, expressed as the number of deaths per 100,000 of the population. Both the numerator (number of events) and denominator (mid-year population estimate) are based on the same geographical area and should be based on the same time period; however, 2020 mid-year estimates were used as these were the latest available for lower super output areas.

Region, health board, sex, age/sex, and deprivation rates are estimated rates. 95% confidence intervals around these rates were calculated to give an indication of the precision of the estimate of the rate.

For comparisons between:

- regional estimates
- health board estimates
- deprivation estimates
- sex estimates

and the all-Wales rate, the all-Wales rate is treated as an exact reference (no confidence interval). This is a widely adopted method for national level estimates, with the random error deemed negligible for large populations. If the confidence interval of the estimate lies outside of the all-Wales rate, then the difference is statistically significant. If the confidence interval of the estimate overlaps

the all-Wales rate, the difference is not statistically significant.

For comparisons between two estimates such as:

- regional estimates with another regional estimate
- health board estimates with another health board estimate
- deprivation estimates with another deprivation estimate

non-overlapping confidence intervals between values indicate that the difference is unlikely to have arisen from random fluctuation (i.e., statistically significant). However, when the confidence intervals overlap, we cannot determine if there is a statistically significant difference or not by comparing confidence intervals alone, so a more exact test is required. The pairwise comparison looked at the difference between the rates and the 95% confidence intervals of the difference. When the confidence interval of the rate difference is above zero, the two rates are considered significantly different with 95% confidence. In order for the pairwise estimates to be robust a minimum count of 10 was required, so this was not undertaken for comparisons between age groups.

Therefore, where estimated rates are compared with each other, a difference is statistically significant if either:

- the confidence intervals of the values do not overlap
- the confidence intervals overlap, but the confidence interval for the difference between the rates does not include zero.

Where appropriate, the mean (average) number of cases and standard deviation were estimated. It is expected that counts are within one standard deviation above or below the mean two thirds of the time. This gives a measure of whether there are counts or trends of concern.

Strengths

Figures are for deaths that occurred during the stated time period and provide a timely indication of suspected suicides. This compares with official statistics which are published by year of registration, so the actual occurrence of those deaths may have been months or years prior.

Data fields for month of death, age, sex, postcode (for deprivation quintile), known to police, mode of death and location type were almost 100% complete.

Collection of personally identifiable information means that we were able to link the data with additional data sources, either to add further information or to cross check existing data therefore improving the quality of the dataset.

Limitations

The data collected are surveillance data so although we are able to provide more timely data than official statistics, the data are not of as high quality.

There is limited trend data available, as only data from 2022/23 is available as a comparison.

This report contains small numbers which are prone to fluctuation.

There are large confidence intervals around the rate estimates.

Deaths of all Welsh residents by suspected suicide may not be fully captured, because:

- We do not yet have fully established links with other RTSSS teams outside of Wales, so we may not have captured all deaths of Welsh residents that occurred outside Wales.
- We do not yet have an established process for capturing suspected suicides where the death occurred in hospital after the event.

Data on occupation was incomplete so were not included in this report.

Data on mental health conditions and whether the person was known to mental health services in the 6 months prior to death was mainly based on information available to the Police. Much of this information included data from health information systems but this may not have always been available. We were able to include additional information and cross check some, but not all, data on mental health conditions and use of mental health services with other sources (e.g. Welsh Clinical Portal, reports from NHS Wales Joint Commissioning Committee).

The extent of data capture may vary between Police forces as different systems are accessed to obtain data.

A list of data fields has been developed for the RTSSS, but we are not yet able to collect all of the data, e.g., religion, disability status, or to establish the level of data quality, e.g. ethnic group, gender identity. For ethnic group we will explore the options for improving data quality, but it remains difficult in the absence of access to GP data. Data on gender identity is not currently readily available from other sources, but when this becomes available from a reliable source, we will explore the feasibility of collecting this information.

Amendments since 2022/23 annual surveillance report

In the 'Associated factors' indicator (figure 8):

- Family issues and relationship issues have been combined into one category (family and/or relationship issues)
- Domestic abuse bystander has been incorporated into domestic abuse victim
- Previous self-harm has been included (and has been included in revised 2022/23 data)
- 'Mental illness' has been renamed mental health condition to more accurately reflect the data that is collected (see glossary for definition of mental health condition).

In the 'Location type' indicator (figure 12) the 'At sea' category in the 2022/23 data has been reviewed and a small number of cases have been re-categorised into the following water related categories: coast/shore/beach and harbour/dock/marina. These categories were used for 2023/24 data. If there were fewer than five in a category, they were included in 'other'.

Age group <25 years has been used instead of 10-24 years to ensure that all suspected suicides are reported.

Mode of death categories have been amended from 2022/23 to reflect categories used in Near to real-time suspected suicide surveillance (nRTSSS) for England, which are based on ONS categories. They are now presented in the following higher-level categories:

- Hanging, strangulation and suffocation
- Drowning
- Fall and fracture
- Poisoning
- Jumping or lying in front of a moving object
- Sharp object
- Other or unknown

The changes to the mode of death categories from the 2022/23 to 2023/24 reports are shown in the table below:

Mode of death category in 2022/23 report	Comment	Mode of death category in 2023/24 report
Hanging/strangulation/suffocation	Remains same	Hanging/strangulation/suffocation
Drowning	Remains same	Drowning
Jumping from height	Change of name only	Fall and fracture
Overdose/poisoning	Separate category in 22/23, now included in higher level category	Poisoning
Asphyxiation by CO/or other gases	Separate category in 22/23, now included in higher level category	Poisoning
Self-poisoning by and exposure to alcohol	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Poisoning
Self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Poisoning
Self-poisoning by and exposure to pesticides	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Poisoning
Self-poisoning by and exposure to other and unspecified chemicals and noxious substances	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Poisoning
Struck by moving object	Change of name only	Jumping or lying in front of a moving object
Sharp object/cutting	Change of name only	Sharp object
Shotgun/firearm	Separate category in 22/23, now included in higher level category	Other or unknown
Self-harm by explosive material	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Other or unknown
self-harm by smoke, fire and flames	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Other or unknown
self-harm by steam, hot vapours and hot objects	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Other or unknown
self-harm by blunt object	Separate category in 22/23, (and was in 'Other' in as count	Other or unknown



	<5), now included in higher level category	
self-harm by crashing of motor vehicle	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Other or unknown
self-harm by electrocution	Separate category in 22/23, (and was in 'Other' in as count <5), now included in higher level category	Other or unknown
Other	Separate category in 22/23, now included in higher level category	Other or unknown
Unknown	Separate category in 22/23, now included in higher level category	Other or unknown



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ISBN: 978-1-83766-540-2