

Suicide Prevention Annual Report 2025

Content warning: this report contains information about suicide, which some readers may find distressing. Please reach out for formal or informal help if you are impacted by the contents of this report. Information on support for suicide and mental health locally is available at: hackney.gov.uk/mental-health

1. Summary

- 1.1 Approximately 20 Hackney residents die by suicide per year. There were 16 deaths by suicide registered in 2024, 17 in 2023 and 23 in 2022, an average of 18.7 in the last three years. The rate of suicides in Hackney over the last three years is 9.1 per 100,000, below the national rate but above the London and inner London rates. (1)
- 1.2 Similar to the national picture, approximately 75% of suspected deaths by suicide in Hackney are by men and the majority take place in people's own homes. Suicide risk in Hackney increases with age, with the highest rate in the 65+ age group, differing from the national trend which peaks in the 50-54 age group. Mental illness, previous suicide attempts, substance use, prescription drugs, relationship issues, debt, housing concerns, bereavement, loneliness, physical illness have all been identified as possible risk factors for those who died. (2)
- 1.4 Services including ELFT, James' Place, Safe Connections (Mind CHWF) and Body and Soul provide specialist support locally for residents who are at risk of suicide or have been bereaved by suicide.
- 1.5 Suicide prevention in Hackney is coordinated by a suicide prevention stakeholder group, which was established in 2018. Proposed priorities for the coming year include, improving awareness of suicide prevention, suicide prevention in educational facilities and for young people, response to suicides that are outside of the home, support for people who have previously attempted suicide and a focus on suicide risk for autistic people, people with substance misuse issues and older adults.

2. Introduction

- 2.1 Suicide is the act of intentionally taking one's own life. Causes of suicide are usually many and complex, though mental or physical health problems, loneliness, housing or financial worries, trauma, discrimination and substance use, as well as significant life events can all contribute to suicidal feelings. Individuals with learning disabilities and neurodivergent individuals, including autism, also experience increased risk of suicide. Suicide is preventable, not inevitable and many people who have attempted suicide go on to lead happy, healthy, fulfilling lives.

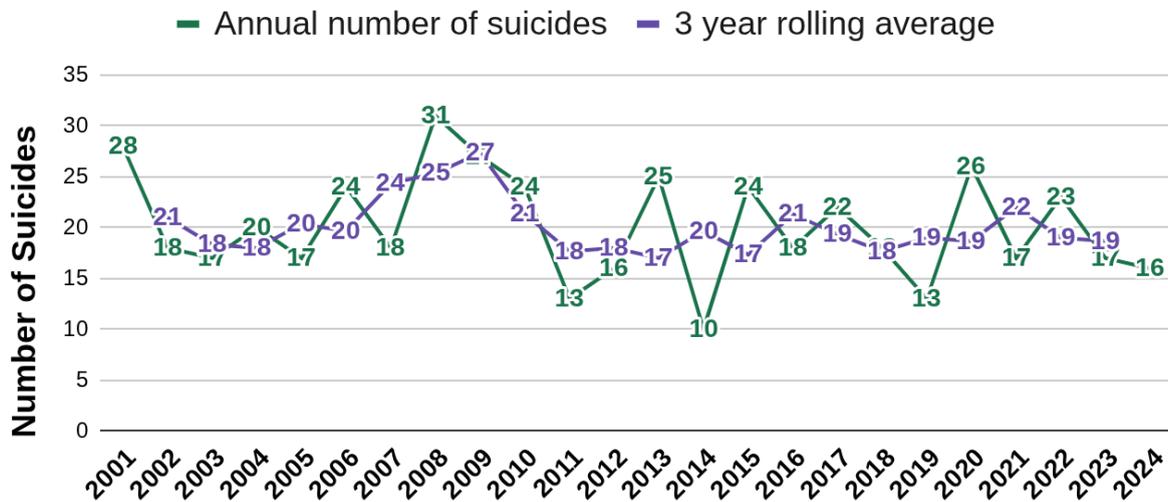
2.2 Many people are usually impacted by any one suicide, with one study estimating this is 135 on average. (3) The emotional, social and economic loss of each suicide was conservatively estimated to cost £1.7 million in 2011, based on 2009 prices, which would now in 2025 be £2.74m updated for inflation. (4) While 30% of this figure represented the direct costs, such as emergency services, health and local authorities, 70% was due to the impact on those bereaved. This is because people bereaved by suicide experience an increased risk of issues such as mental health problems, substance use, unemployment and also suicide themselves. In some suicides there can also be witnesses who are deeply affected by the event.

2.3 People living in the most disadvantaged communities face the highest risk of dying by suicide, with low income and unmanageable debt, unemployment, poor housing conditions, and other socioeconomic factors all contribute to high suicide rates. (5) Given the current economic climate and some of the significant challenges being experienced by many of Hackney’s residents, this is of particular concern.

3 Hackney Official Death Registrations Data 2024

3.1 Over the last two decades years, on average 20 people per year were registered as having died by suicide in Hackney (based on coroners reports), with the most occurring in 2001, 2008, 2009 and 2020 at 28, 31, 27 and 26 respectively. Given the small numbers involved, some annual variation is expected and a three year average provides a smoother illustration of the trend in the number of deaths. This shows that number of suicides has remained broadly similar over the last decade (Figure 1). (1)

Figure 1: Number of registered suicides per year in Hackney, 2001-2024

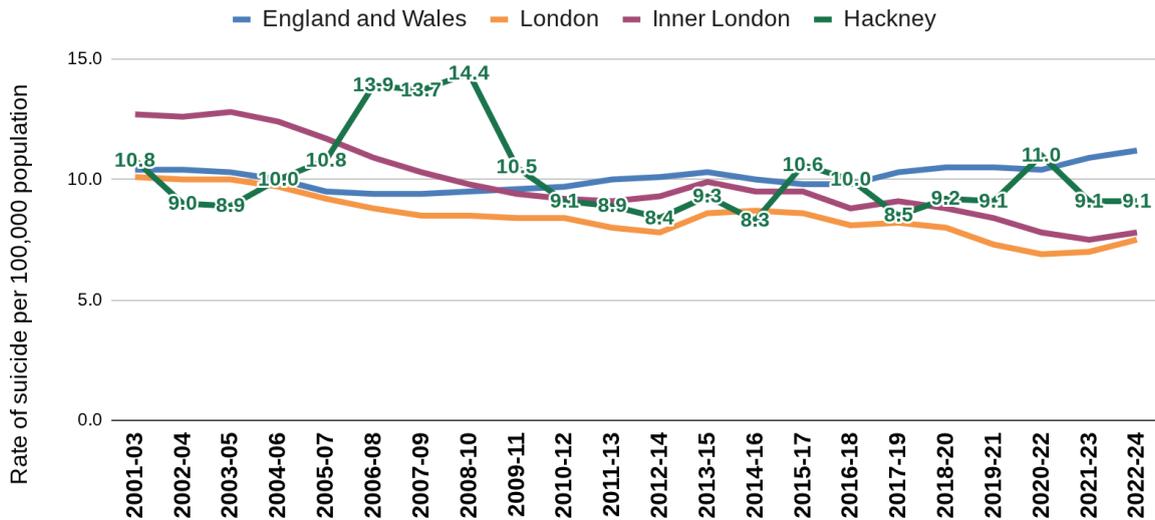


Source: Office for National Statistics, Suicides in England and Wales by local authority 2025

3.2 In 2022-24 the rolling three year aggregate rate of suicides in Hackney was 9.1, compared to 11.1 in England and Wales, 7.5 in London and 7.8 in inner London. At an average rate of around 10 deaths by suicide per 100,000 population, the overall trend in Hackney for the last 20 years is similar to the national rate, though the variation is greater due to the small numbers involved. More recently, in the last decade the Hackney rate has been on average slightly lower than the national trend.

3.3 Across inner London boroughs, the average rolling three year aggregate rate of registered deaths per 100,000 population has seen a steady decline from 12.7 to 7.8 deaths by suicide between 2001-2003 and 2020-2024. However in Hackney, there is not a clear comparable trend, with rates remaining much more stable and now higher than inner London, where it was previously lower (Figure 2). London was the region with the lowest rate in 2022-24 at 7.5 deaths per 100,000 people, lower than any other region in England or Wales. (1)

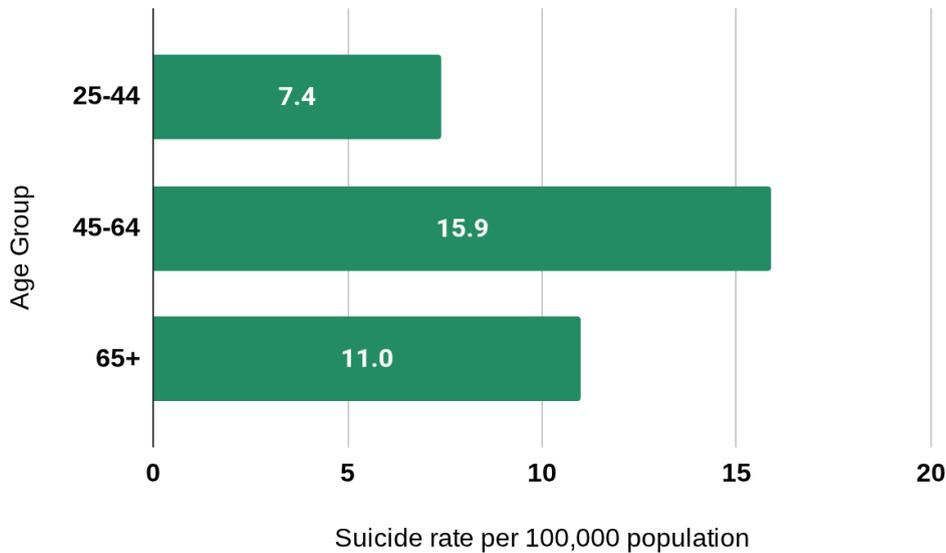
Figure 2: Number of registered suicides (age-standardised) per 100,000 population, rolling three year aggregates, 2001-03 to 2022-24



Source: Office for National Statistics, *Suicides in England and Wales by local authority 2025*

3.4 Deaths by suicide were most common in the 45-64 age group, with a rate of 15.9 per 100,000 between 2020 and 2024. This compares to a rate of 11.0 in the over 65 age group and 7.5 in the 25-44 age group. Data for the under 25 age group was not available to small numbers. This age distribution is similar to the national picture. (6)

Figure 3: Rate of registered deaths by suicide by age group, rates per 100,000 population, Hackney, 2020-24

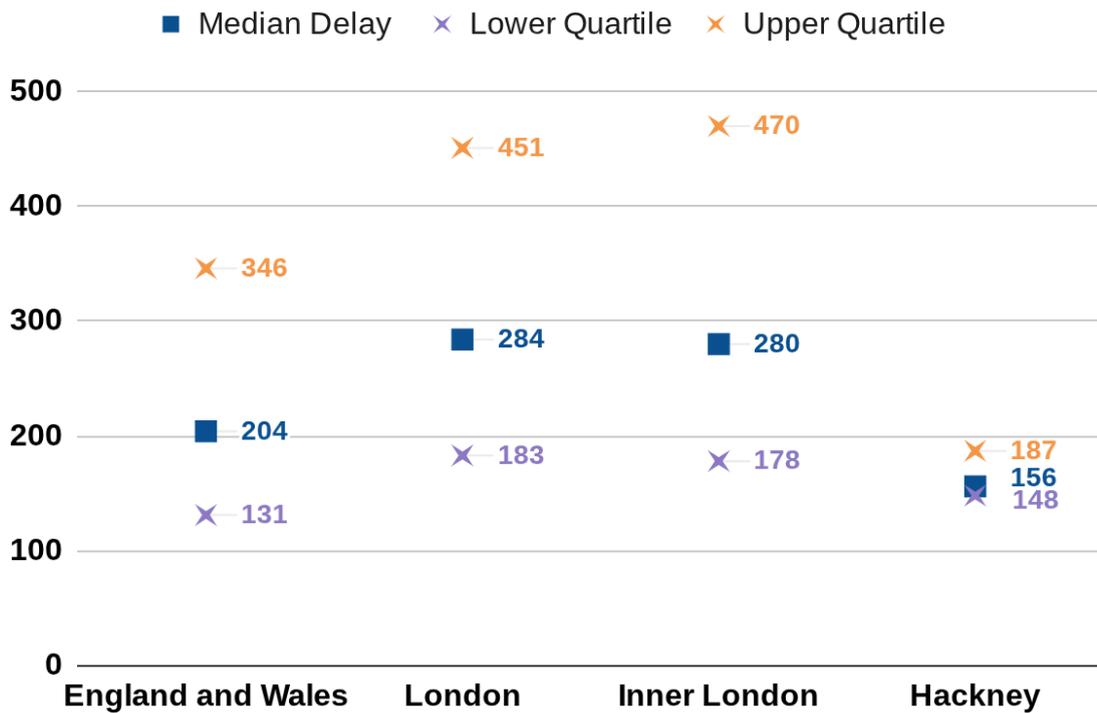


Source: Fingertips, public profiles

Note: Under 25 gr group data not available due to small numbers

3.5 The investigations by the Coroner to determine whether a death was by suicide varies from a few months to over a year for a so there is often a delay in data reporting. Some deaths registered in 2024 will have taken place in 2023. However, delays in Hackney are comparatively low, with 75% of deaths by suicide in 2024 registered within 187 days, compared to 346 days across England and Wales and 470 for inner London boroughs (Figure 3). (1)

Figure 4: Registration delay for suicides registered 2024



Source: Office for National Statistics, *Suicides in England and Wales by local authority 2025*

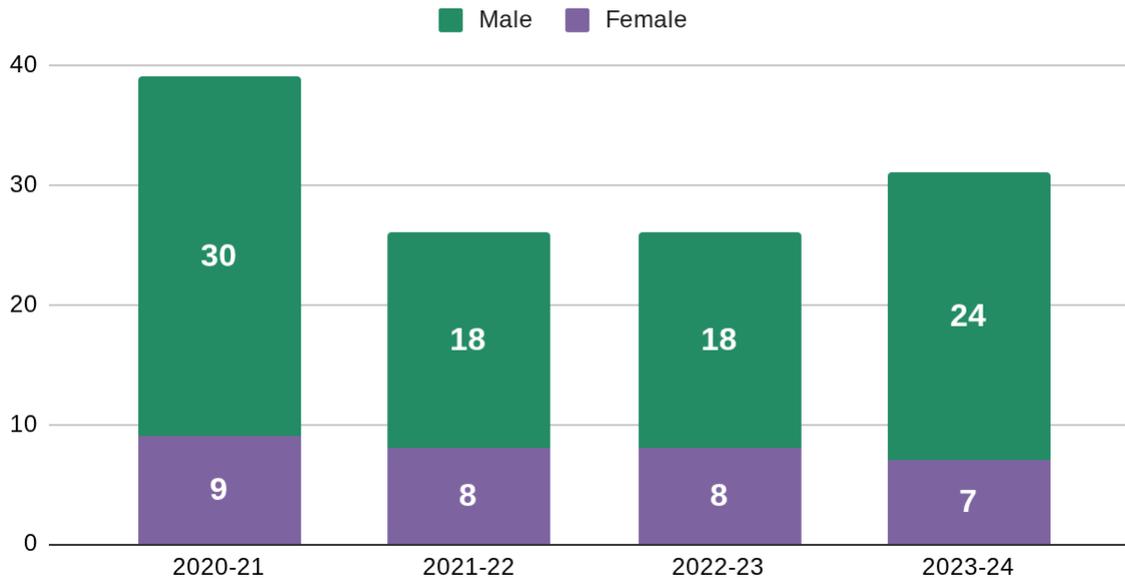
4 Suspected Suicides by Hackney Residents, 2020-2024

4.1 The Thrive London Suicide Prevention Real-time Surveillance database (RTSS) was launched in 2020 and data is uploaded by the police for any death they believe to be a suicide within a few days. Unlike the registered deaths data, they are 'suspected' suicides, as the causes of death have not yet been confirmed by a coroner. It is possible that a few deaths may be missed in the Thrive data, or included erroneously, but data do appear to be similar to the ONS coroner confirmed deaths.

4.2 In 2024, 16 suspected deaths by suicide were recorded on the RTSS for Hackney residents. Of the total deaths between 2020 and 2024, 75% were male, similar to the national average¹. Using a two year rolling average, this trend appears to be consistent over time (figure 4). (2,7)

Figure 5: Suspected deaths by suicide in Hackney by gender, 2020-24

¹ Non binary data suppressed due to small numbers



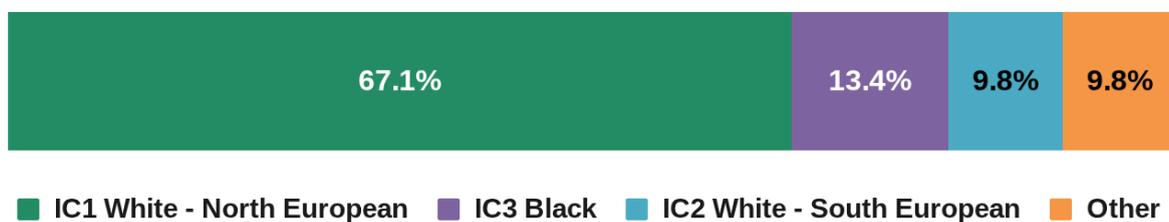
Source: Thrive London Suicide Prevention Real-time Surveillance database (RTSS)

Note: Non-binary data has been suppressed due to small numbers

4.3 Ethnicity in the RTSS is recorded using the police’s Identity Code (IC) system, which describes the *apparent* ethnicity of a person. Therefore, the data is unlikely to be as accurate as, or directly comparable to, census population data, so caution is needed when interpreting it, especially given the small numbers involved.

4.4 Of the Hackney residents who died by suspected suicide between 2020 and 2024, 67.1% were identified as IC1 White - North European, 13.4% as IC3 Black and 9.8% IC2 White - South European². In total, residents recorded as being from white population groups made up 77% of the suicides, a higher proportion than the 53% of white residents in the Hackney population. Nationally the highest suicide rates are also among white ethnicity groups, as well as mixed ethnicity, groups. Black ethnicity groups make up approximately 21% of Hackney’s population. (2,8)

Figure 6: Suspected deaths by suicide by ethnicity, Hackney, 2020-24



Source: Thrive London Suicide Prevention Real-time Surveillance database (RTSS)

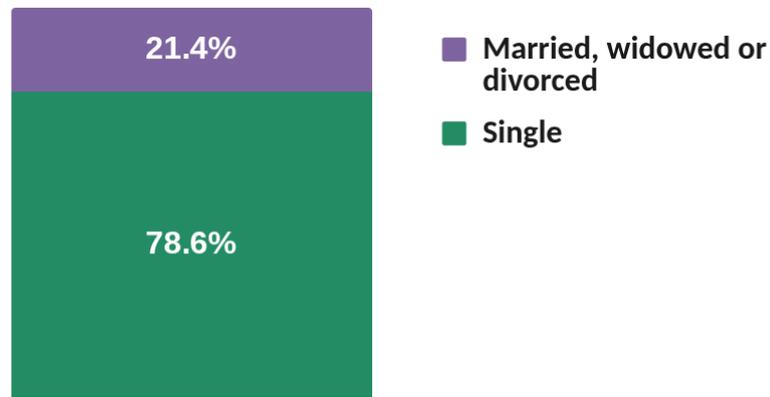
4.5 The majority of suspected suicides by Hackney residents take place within Hackney (88%), with no specific areas identified as being high risk. Most took place in people’s own homes (70% where recorded). (2)

4.6 Of the 42 Hackney residents who died by suspected suicide where a marital status

² IC codes IC5 Chinese, Japanese, or other Southeast Asian, IC4 South Asian, IC6 North African or Arab and Unknown were combined into the ‘other’ category due to small numbers

was recorded, 78.6% were single. However, this field was not completed for about half the cases and it also does not distinguish between people who are in relationships but unmarried from those who are single and not in a relationship at all. Nevertheless, it does appear that being single may be a risk factor for suicide in Hackney and loneliness or relationship breakdown are both known risk factors for suicide (figure 7). (2)

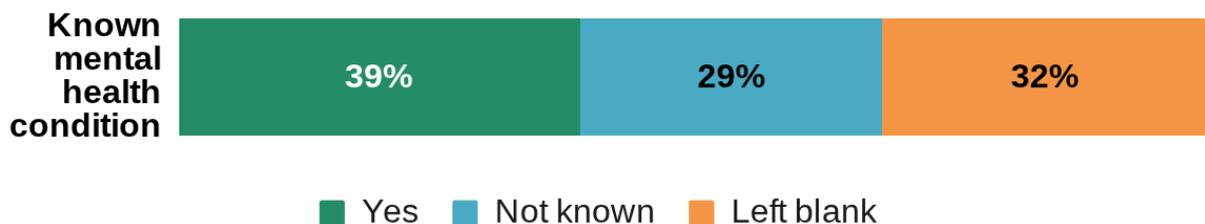
Figure 7: Suspected deaths by suicide by marital status, Hackney, 2020-24



Source: Thrive London Suicide Prevention Real-time Surveillance database (RTSS)

4.7 At least 39% of the Hackney residents listed in the RTSS were recorded as having a mental health condition, 29% were recorded as ‘not known’ and for 32% this field was left blank. It is possible that some people listed as the latter two also had a mental health condition but this was either not known or recorded. Nevertheless, this data reflects what is already known; that mental health is a risk factor for suicide (figure 8). (2)

Figure 8: Suspected deaths by suicide by known mental health condition, Hackney, 2020-24



Source: Thrive London Suicide Prevention Real-time Surveillance database (RTSS)

4.8 At least 41% residents recorded as having a mental health condition were noted as having been in contact with mental health services. It is possible more also had been but there are limitations with the data, including that recording of this is only possible via a qualitative written summary and therefore at the discretion of the entering officer.

4.9 Additional risk factor data were analysed, based on a review of the written summaries for each case. These data should be interpreted with caution as the level and type of detail varies greatly across the different cases. There will also

always be some variation in what the reviewer chose to include and what information was available to them. Unsurprisingly, mental health was the most common factor cited, followed by substance use, previous attempts, family or relationship issues and prescription drugs.

5 Learning from Lives and deaths of People with a Learning Disability and Autistic Adults (LeDeR) - Findings

- 5.1 The recent NEL Learning from Lives and deaths of People with a Learning Disability and Autistic Adults (LeDeR) report included a focus on deaths of autistic people. It found that suicide was the main cause of death, with over thirty deaths by suicide of autistic people in the North East London area since 2021. The report highlights the need to focus prevention on this group. Current long waiting times for autism and ADHD diagnoses may also mean under reporting of autism in those who have died by suicide. According to the National Autistic Society, autistic people are nine times more likely to take their own life than those who are not neurodivergent, with approximately 30% of autistic adults having attempted suicide. Autistic children and young people are 28 times more likely to consider or attempt suicide than their non-autistic peers. (9)
- 5.2 The report also highlights how most of the NEL existing suicide awareness and prevention programmes are designed for the general population and may not be suitable for autistic people. (9)

6 Local Suicide Prevention Support

- 6.1 In Hackney, NHS East London Foundation Trust (ELFT) provides crisis support services, including a local crisis line (which can be reached via NHS 111) and a walk in crisis cafe. NHS North East London fund Safe Connections, suicide prevention and support, delivered by Mind CHWF. Additionally, Hackney is very fortunate to have a number of community organisations in or close to the borough that can support residents with suicidal crisis, suicide ideation and bereavement by suicide including James' Place, Mind CHWF, Body and Soul and The Listening Place. There are also a number of phone, text and email services, such as Samaritans, Shout and Papyrus.
- 6.2 Further information on suicide prevention and wider mental health services are available [here](#)

NHS East London Foundation Trust

- 6.3 Between April 2024 and March 2025, across ELFT, there were 26 deaths suicide was identified as the leading cause of death (subject to coroner's inquest and verdicts).
- 6.4 Key areas of work in relation to suicide prevention in ELFT are outlined below. These are informed by investigations into deaths by suicide and the The National Confidential Inquiry into Suicide and Safety in Mental Health.

1. **Improved Risk assessment:** ELFT is currently developing a risk formulation training plan, with the aim of moving from risk prediction to risk formulation. They are also updating their risk assessment forms. This will be piloted in February 2026, with rollout in the spring.
2. **72-hour Follow-up:** ELFT has introduced targeted initiatives to improve patient follow-up contact rates and strengthen discharge planning, including closer coordination between inpatient and community teams, as well as real-time feedback mechanisms for wards, education and training.
3. **Improving inpatient safety:** a large scale programme was introduced in 2022 to improve therapeutic engagement on inpatient wards. This resulted in a range of positive outcomes including: general observation completion increased to 99.57%, incidents of monthly physical violence reduced by 23%, verbal aggression reduced by 38% and incidents of seclusion use reduced by 38%.
4. **Families and carer involvement:** there is ongoing work across ELFT to improve family and carers engagement in patient safety incident investigations and signposting to bereavement services. The patient safety review team always includes information on support pathways in their initial contact letters to families and carers.
5. **Training:** ELFT has developed a suite of online training for staff, covering suicide prevention, ligatures, observations, and patient searches, in order to support staff in learning lessons from previous incidents. The necessity for autism awareness training was also recognised as a key priority and this will be included in suicide prevention training once finalised.
6. **Improving staff experience:** through delivery of the trust's pursuing equity quality improvement programme, which aims to to improve equity for staff and residents. ELFT also recently took part in a 12 month pilot as part of the NHS England People Promise Exemplar Programme, which uses a data led approach to improve outcomes and optimum staff satisfaction and retention.
7. **Upgrading systems:** ELFT has recently transitioned from the Serious Incident Framework (SIF) to the Patient Safety Incident Response Framework (PSIRF). The SIR and the Root Cause Analysis (RCA) model has been replaced by the System Engineering Initiative for Patient Safety (SEIPS), which is a systems wide based framework for conducting safety reviews The new systems prompt services to look for interactions rather than simple linear cause and effect relationships, so safety actions can focus on wider system issues, not individuals. Aims/advantages of the new approach include: compassionate engagement and involvement; application of a range of system-based approaches to learning; considered and proportionate responses; and supportive oversight focused on strengthening response system functioning and improvement.

James' Place

- 6.5 James' Place are a charity offering free, life-saving treatment to suicidal men, utilising unique, proven therapeutic treatments. Access to support is offered quickly and delivered in a safe, friendly, non-clinical environment by trained, professional therapists.

6.6 2025 up until the 22nd October, James' Place received 109 referrals from Hackney residents for suicide prevention support. This is already an increase from the 97 referrals received in 2024. Of the 109 referrals received, 32 were self-referrals, with the other referrals from professional or concerned third parties. City and Hackney Talking Therapies and Tower Hamlets Talking Therapies remain high in terms of professional referrers.

6.7 Overall, James' Place has helped over 4,300 men out of suicidal crisis since opening in 2018. The service is continually evaluated in terms of impact. (10)James' Place will open a fourth centre in Birmingham next year, adding to London, Liverpool and Newcastle.

Grief in Pieces Support for Suicide Loss

6.8 Grief in Pieces Support for Suicide Loss, is delivered as part of the Safe Connections Collaborative. Mind in City, Hackney, and Waltham Forest, functioning as Mind in North East London, has run the Grief in Pieces Support for Suicide Loss service since April 2021. Grief in Pieces offers a dedicated support service for anyone in North East London who has been impacted by suicide loss, including as a loved one, a friend, a colleague or witness.

6.9 The service offers individual support and therapy, workshops on coping and understanding suicide loss, crisis intervention, family support and a longer-term healing support group, with the opportunity to connect with and even support others who have lost someone to suicide. A strength of the service is the involvement of people with lived experience of suicide loss in designing and delivering interventions.

6.10 Outcomes:

- At the end of March 2025, the service had managed over 402 referrals for postvention support.
- The service responded to 185 referrals for immediate postvention support, following a suspected instance of suicide loss, providing crisis Intervention, emotional and practical support.
- The service has also delivered over 650 hours of (BACP-accredited) individual and group-based therapeutic interventions to persons bereaved by suicide loss across NEL.

6.11 This service is contracted until March 31, 2026, but it is hoped that it will be recommissioned by the Mental Health and Learning Disabilities Board within NEL ICB. New innovations for the current financial year include:

- Development of a children, young people and families pathway
- Expansion of the traumatic bereavement counselling offer
- Expansion of the lived experience pathway
- Delivery of children, young people and families focused workshops on navigating traumatic grief and loss
- Delivery of specialised, ad-hoc crisis interventions for workplaces and communities in response to incidents of suspected suicides.

7 Steering Group Meetings and Action Planning

7.1 In 2018 a Hackney Suicide Prevention group was established which is coordinated by Public Health. The group includes representatives from NHS Integrated Care Board, East London Foundation Trust, Adults and Children's representatives, the police, housing, and relevant voluntary and community sector organisations.

7.2 Based on group feedback, the full quarterly meetings are now primarily used for information sharing and networking, as well as setting the priority areas for actions. These action areas are taken forward by subgroups, from which updates are provided at the wider meetings.

7.3 Previous actions:

1. Continue to improve awareness around suicide prevention, especially among resident facing staff, including knowledge of what to look out for, how to respond and what relevant resources and services are available.

Update: training has been promoted to frontline staff and a list of [training resources](#) for mental health and suicide prevention developed. This work is ongoing, although offering bespoke local training is not currently available due to lack of budget but we will continue to explore opportunities for this.

2. Improve suicide prevention awareness and processes in schools, including supporting schools to implement suicide prevention policies and provide appropriate training for all staff.

Update: engagement work took place with schools and guidance was drafted. In person PAPYRUS suicide prevention for schools training took place in September. All-staff training resources to support school staff are being developed. This will remain a priority area.

3. Develop and implement a process for reviewing and responding to suicides when they occur, to enable immediate preventative actions to be implemented where appropriate and to facilitate longer terms learning to inform suicide prevention.

Update: Unfortunately this was not possible due to funding reductions and restructures in the NEL team that would carry these out. An alternative priority focusing on responding to suicides out of the home, has been proposed for this year.

4. Develop a clear pathway for individuals identified as being at high-risk of suicide for use by frontline professionals and determine whether there are any gaps in the pathway or available provision.

Update: A pathway document was created, with input from stakeholders, including those that would use it. It has been circulated among relevant stakeholders and services.

7.4 The Hackney suicide prevention group has proposed the following areas of focus for the coming year. Input on these from people with lived experience of suicide is being sought and the priority areas will be further worked up finalised following this engagement work.

- Continue to improve awareness around suicide prevention, especially among resident facing staff, including knowledge of what to look out for, how to respond and what relevant resources and services are available.
- Continuing work with schools on suicide prevention, possibly considering expanding it to other educational institutions.
- Formalising how we respond as a system to suicides that occur outside of the home, are high profile and/or of young people.
- Collate information from LeDeR and other reviews that may be relevant to suicide prevention and use this to inform prevention work
- Consider how we could prioritise wrap around, whole person support for people who have attempted suicide, considering this is the greatest risk factor for future attempts.
- Further investigation into the relatively higher risk of suicide locally among autistic people, people with substance misuse issues and older people, including what additional data sources may be available and possible preventative actions.

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