

Information paper

Quality and Methodology Information

General details

Title of output:	Mortality Statistics
Designation:	National Statistics
Geographic Coverage:	England and Wales
Date of last SQR or QMI*:	July 2015
Contact details:	vsob@ons.gsi.gov.uk

Executive summary

Mortality statistics represent all deaths which take place in England and Wales. Statistics are published based on the week, month or calendar year in which the death was registered. Figures are compiled using information collected when a death is certified and then registered as part of civil registration, a legal requirement. More detailed information is available in the [User guide to mortality statistics](#).

To meet user needs, very timely, but provisional, counts of death registrations are published by week and by month. Provisional figures have not been subject to the full quality assurance process.

Annual mortality statistics for England and Wales (based on deaths registered in a calendar year) are then published in 3 separate packages to enable the timely release of statistics. Information on these packages is covered under the Relevance section.

The [Vital statistics: population and health reference tables](#) provide a range of mortality statistics for the UK and its constituent countries, with some measures available back to 1838.

This document contains the following sections:

- Output quality
- About the output
- How the output is created
- Validation and quality assurance
- Concepts and definitions
- Other information, relating to quality trade-offs and user needs
- Sources for further information or advice

Output quality

This document provides a range of information that describes the quality of the data and details any points that should be noted when using the output. The Office for National Statistics (ONS) has developed [Guidelines for Measuring Statistical Quality](#); these are based upon the 5 European Statistical System (ESS) Quality Dimensions. This document addresses these quality dimensions and other important quality characteristics, which are:

- Relevance
- Timeliness and punctuality
- Coherence and comparability
- Accuracy
- Output quality trade-offs

* Quality and Methodology Information (QMI) replaced 'Summary Quality Reports (SQR) from 04/11

- Assessment of user needs and perceptions
- Accessibility and clarity

More information is provided about these quality dimensions in the following sections.

About the output

Relevance

(The degree to which statistical outputs meet users' needs.)

The registration of deaths occurring in England and Wales is carried out by the Local Registration Service in partnership with the General Register Office (GRO). Information collected at death registration in England and Wales is recorded on the Registration Online (RON) system by registrars. Most of the information is normally supplied by the informant (usually a close relative of the deceased), while the cause of death is usually obtained from the Medical Certificate of Cause of Death (MCCD), completed by a medical practitioner when the death is certified.

ONS quality assures mortality data for England and Wales and also coordinates and publishes statistics for the whole of the UK alongside statistics for each constituent country. Once published, they are freely available on our website.

All deaths that occur in England and Wales must be registered in England and Wales. Deaths of those whose usual residence is outside England and Wales are included in total figures for England and Wales but are excluded from any sub-division of England and Wales. ONS mortality statistics exclude deaths of all residents of England and Wales that occur and are registered outside England and Wales.

To meet user needs, very timely but provisional counts of death registrations are published:

- [Provisional counts of weekly death registrations for England and Wales](#) by age group, sex and regions (within England) and Wales are published 11 days after the week ends. Weeks run from Saturday to Friday, and figures are normally published the following Tuesday. The respiratory disease counts are updated with each weekly publication as the coding of the underlying cause is not always complete at the time of production. Other figures are not updated. Figures for the latest week are published
- [Provisional counts of monthly death registrations for England and Wales](#) by regions (within England), unitary authorities, counties, districts and London boroughs are published on the fourth Tuesday of the following month

Our first release of final annual data take place in July, when our [Death registration summary tables](#) are published, with supporting commentary in a statistical bulletin. More detailed figures are then released in a series of themed packages:

The [Death registration summary tables](#) provide the main death statistics for the reference year including:

- numbers and rates by age group and sex (with 1 and 10 year comparisons available)
- numbers by selected underlying cause and age group and sex
- numbers and mortality rates by area of usual residence (regions (within England), unitary authorities, counties, districts, London Boroughs and Local Health Boards (within Wales))
- numbers and rates for infant deaths (under 1 year), neonatal deaths (under 28 days) and perinatal deaths (under 7 days plus stillbirths)
- numbers of deaths by single year of age and sex for England and Wales (1963 onwards) and the UK (1974 onwards)

[Deaths registered in England and Wales \(Series DR\)](#) provides detailed figures by cause of death for the reference year including:

- numbers by age group, sex and detailed underlying cause classified using the [Tenth Revision of the International Classification of Diseases and Related Health Problems \(ICD-10\)](#)
- numbers by age group and sex, marital status and place of occurrence (for example, at home or in hospital)
- numbers for regions (within England) and local health boards (within Wales)
- numbers of injury and poisoning deaths by external cause (the most recent 4 years of data are provided to enable comparisons)

- age-standardised rates by selected underlying cause
- years of life lost due to mortality from certain underlying causes

[Mortality statistics: area of usual residence](#) provides detailed figures down to local authority level for the reference year including:

- numbers by age group and sex
- numbers and rates for all deaths (male and female), infant deaths, neonatal deaths and perinatal deaths, and age-standardised mortality rates (ASMRs). This table provides figures for all areas within the United Kingdom and its constituent countries (numbers and rates) by regions (England), unitary authorities, counties, districts, London boroughs, health areas, council areas (Scotland) and local government districts (Northern Ireland)

ONS also publish more detailed mortality statistics as follows:

- [20th Century mortality files](#) provides death registration statistics for England and Wales by sex, age group and underlying cause
- [21st Century mortality files](#) provides death registration statistics for England and Wales by sex, age group and underlying cause
- [Deaths involving Clostridium difficile](#) (Wales only from 2013 data year onwards) provides deaths (numbers and rates) broken down by sex, age group and place of occurrence for Wales
- [Deaths involving MRSA](#) (Wales only from 2013 data year onwards) provides deaths (numbers and rates) broken down by sex, age group and place of occurrence for Wales
- [Deaths related to drug poisoning](#) provides number of deaths by cause of death, sex, age, substance(s) involved in the death by country for England and Wales. It also includes rates for deaths related to drug misuse by regions (within England), unitary authorities, counties, districts, London Boroughs and average registration delay by Local authorities (England) and unitary authorities (Wales)
- [Alcohol-related deaths in the UK](#) provides numbers and rates of alcohol-related deaths by sex, age group and individual cause of death by UK and its constituent countries and regions (within England)
- [Suicides in the UK](#) provides suicide rates by sex for the UK and its constituent countries. There are numbers and rates of narrative conclusions by sex by regions (within England) and Wales. It also includes numbers (registrations) and rates of suicides and median registration delay for Local authorities (England) and unitary authorities (Wales). There are numbers of occurrences and rates by age and sex by country for England and Wales
- [Avoidable mortality](#) provides numbers and rates by sex and age by country for England and Wales
- [Excess winter mortality](#) provides selected provisional and final numbers and rates by age, sex and cause for England and Wales, regions and local authorities (within England) and unitary authorities (Wales)

We also publish more detailed annual mortality statistics as an [explorable dataset](#) for England and Wales.

These releases are covered by separate [Quality and Methodology Information \(QMI\)](#) reports.

ONS uses mortality statistics to:

- produce population estimates and population projections both, national and subnational
- produce life expectancy estimates
- quality assure census estimates
- report on social and demographic trends
- conduct health analysis
- further analyse mortality, for example, life expectancies and causes of death (including deaths from certain infections and drug-related deaths)

- further analyse infant mortality where infant deaths are linked to their corresponding birth record to enable more detailed analyses on characteristics, such as age of parents, birthweight and whether the child was born as part of a multiple birth

The Department of Health (DH) and the Welsh Government (WG) are key users of mortality statistics. DH use data, for example, to inform policy decisions and monitor child mortality. The [Public Health Outcomes Framework](#) sets out the desired outcomes for public health and how these will be measured. This includes indicators related to births and deaths. Similar indicators are also included within the [NHS Outcomes Framework](#). WG use data to determine delivery priorities, such as those relating to cancer and circulatory diseases, as outlines in the Wales NHS [health delivery plans](#) and in the [Public Health Outcomes Framework](#).

Infant mortality, including stillbirths and neonatal deaths, is considered to be a priority measure among health outcomes. There is a long established link between social and health inequalities, and infant mortality. Infant mortality continues to take a central role in DH and WG's work on health inequalities.

Other key users of the data are local authorities and other government departments for planning and resource allocation. The Department for Work and Pensions uses detailed mortality statistics to feed into statistical models for calculating pensions and benefits. Health organisations also use the data.

Other public sector organisations such as the Police and the Home Office are interested in data on external causes of death. Private sector organisations such as banks, insurance and investment companies are particularly interested in deaths by single year of age and region, which feeds into risk estimation models.

Academics, demographers and health researchers conduct research into trends and characteristics. Lobby groups use mortality statistics to support their cause, for example, alcohol misuse or suicide. Organisations such as Eurostat and the UN use mortality statistics for making international comparisons. The media also report on trends and statistics.

Public Health England (PHE) use weekly death figures for influenza surveillance and for monitoring the impact of cold weather and heat waves. Monthly death figures assist local authorities in public health monitoring and civil contingency planning. Funeral directors also use these figures to monitor their market share.

The [Disclosure control policy for births and death statistics](#) provides guidance for the release and publication of tables based on ONS death registration data for England and Wales.

Timeliness and punctuality

(Timeliness refers to the lapse of time between publication and the period to which the data refer. Punctuality refers to the gap between planned and actual publication dates.)

To meet user needs, very timely but provisional counts of death registrations are published by week and by month. Annual figures are then published in 3 themed packages. Summary figures are published in July, 7 months after the end of the reference year, following the full quality assurance of the data. Mid-year population estimates for the reference year are also required to calculate mortality rates and these are not usually published until June. The Summary figures are laid before Parliament pursuant to Section 19 of the Registration Services Act 1953 as amended by the Statistics and registration Service Act 2007. More detailed statistics on death registrations are published in packages between August and January.

For more details on related releases, the [GOV.UK release calendar](#) is available online and provides 12 months' advance notice of release dates. In the unlikely event of a change to the pre-announced release schedule, public attention will be drawn to the change and the reasons for the change will be explained fully at the same time, as set out in the [Code of Practice for Official Statistics](#).

How the output is created

Mortality statistics are based on information collected when deaths are certified and registered in England and Wales. Deaths in England and Wales should be registered within 5 days of the date of death. There are, however, a number of situations when the registration of a death will be delayed; for example, if the death is referred to a coroner. Some analysis of the [impact of registration delays on mortality statistics](#) by cause and the time taken to register a death is available.

More detailed information on the main processes used in the compilation of mortality statistics including cause of death coding, accuracy and quality of the data, and the calculation of rates are available in our [User guide to Mortality statistics](#).

Rates for “all causes” include deaths at all ages, while rates by cause of death for 1986 to 2013 exclude neonatal deaths (infants aged under 28 days). Following recommendations by the World Health Organisation (WHO), the cause of death for neonates has been recorded differently by ONS from 1986 onwards. Assigning an underlying cause for deaths under 28 days has not been possible since the change. More information is available in our [User guide to mortality statistics](#) and our [User guide to child mortality statistics](#).

In January 2014, software from the IRIS Institute was implemented by ONS to automatically code the underlying cause of death. Further information on [IRIS](#) and a [dual coding study](#) looking at the impact on mortality statistics are available.

Validation and quality assurance

Accuracy

(The degree of closeness between an estimate and the true value.)

Data collection

Before submitting a death registration through the RON system, the registrar will verify that all the information provided has been entered accurately. There are some automatic validation checks within RON to help the registrar with this process. Information supplied by the informant is generally believed to be correct since knowingly supplying false information may render the informant liable to prosecution for perjury. More information on the information supplied when a death is registered or cause of death is certified is available in our [User guide for mortality statistics](#).

The cause of death reported, represents the final underlying cause of death. This takes account of additional information received from medical practitioners or coroners after the death has been registered; around 40% of deaths are referred to the coroner. The process of referral to a coroner and how referred deaths are dealt with varies between areas. A consultation on a charter for the [coroner service](#) took place in 2011 and aimed to “ensure a greater level of consistency across the country”.

Annually, there are around 30,000 coroner’s inquests in England and Wales. The majority are “Short-form” conclusions such as accident or misadventure, natural causes, suicide or homicide. “Narrative” conclusions can be used by a coroner or jury instead of a short-form conclusion to express their conclusions as to the cause of death following an inquest.

In deaths from injury and poisoning, some narrative conclusions clearly state the intent and mechanism. However, in a proportion the narrative conclusions give no indication of whether the fatal injury or toxic substance was self-administered or if there was deliberate intent to self-harm. These deaths are defined by ONS as “hard to code”. Around 2% of deaths coded as accidents in recent years were “hard to code”. Consequently, narrative conclusions could inflate the number of deaths classified as accidents and decrease the number classified as intentional self-harm.

Since 2013 when a death is referred to a Coroner for investigation, they may issue a Certificate of the Fact of Death (also known as an interim death certificate) to allow relatives to obtain probate and proceed with other practical arrangements without waiting for the outcome. In those cases where the Coroner subsequently decides not to hold an inquest, the legal responsibility to register the death remains with the next of kin (or other person involved). It is understood that in a small number of cases the person responsible does not understand this situation, possibly because the interim death certificate resembles the formal certificate of death registration in appearance and serves most of the same purposes, and so this has led to a small number of deaths being unintentionally left unregistered. It is estimated that approximately 50 to 100 deaths a year remain unregistered for this reason. These unregistered deaths are not included in our mortality statistics.

Coding cause of death

Coding for cause of death is carried out according to the WHO [ICD-10](#) and internationally agreed rules. More information can be found in section 2.12 of the [User guide to mortality statistics](#).

The majority of deaths (around 80%) have the underlying cause of death coded automatically using coding software. The remainder are coded manually by experienced coders. Manual coding is necessary for deaths involving a coroner's inquest. Using an automated coding tool improves the international and temporal comparability of mortality statistics. Periodical reports on persistent coding problems are referred to a Medical Epidemiologist and to international forums.

The cause of death reported in national and regional level mortality statistics represents the final underlying cause of death. This takes account of additional information received from medical practitioners or coroners after the death has been registered; around 0.2% of deaths have their underlying cause amended. Sometimes the later information becomes available only after the annual extract has been taken. Users with access to individual records of deaths may consequently find some differences with published statistics. Further information is available in section 2.15 of our [User guide to mortality statistics](#).

The Coroners and Justice Act 2009 will reform the death certification process by introducing a single unified system. The introduction of medical examiners and the scrutiny they provide is expected to improve the quality (precision and completeness) of the cause of death recorded on the MCCD, helping to improve mortality statistics.

The consistency of manual cause of death coding for narrative conclusions (previously known as narrative verdicts) has previously been assessed; [narrative verdicts and their impact on mortality statistics](#) provides more information. The study showed that in 2001, 0.01% of all deaths registered in England and Wales had a narrative conclusion, this increased to 0.61% in 2009. Of these deaths with a narrative conclusion, around 25% had an external cause of death in 2001, the remaining 75% were disease related. By 2009, around 40% of deaths with narrative conclusions were from external causes. The exercise to establish the consistency of coding the cause of death by ONS cause coders showed that the current coding rules were being applied uniformly so the impact of manual coding on statistics is negligible. In 2015, 0.45% of all deaths registered in England and Wales had a narrative conclusion and 43% of these had an external cause of death.

Quality assurance

Daily extracts of death registrations from RON are received by ONS then pass through a series of automatic validation processes which highlight any inconsistencies. The [User guide to mortality statistics](#) provides detailed information on the processing and quality of mortality data for England and Wales.

Internal consistency checks are then conducted to eliminate any errors made during the recording of deaths, and to ensure the annual dataset is complete. Any concerns relating to cause of death are referred to a Medical Advisor/Medical Epidemiologist. The [User guide to mortality statistics](#) provides more detail on all these checks.

Coherence and comparability

(Coherence is the degree to which data that are derived from different sources or methods, but refer to the same topic, are similar. Comparability is the degree to which data can be compared over time and domain, for example, geographic level.)

Mortality statistics form an important component of public health measurement; they adhere to key international standards (for example, cause of death classification and coding) which facilitates international comparisons.

The European Standard Population (ESP) is an artificial population structure used to weight Age Standardised Mortality Rates (ASMRs) enabling comparisons. Originally published in 1976 it was updated by Eurostat in 2013. The distribution of the 1976 and 2013 ESPs can be found in the [User guide to mortality statistics](#). Further information about the [change in ESP methods](#) is available. Rates based on the 2 different ESPs are not comparable.

Revisions to mortality statistics occur infrequently and generally only take place following revisions to the mid-year population estimates, resulting in revised mortality rates. Footnotes are added to tables where revisions have taken place and documented in supplementary information accompanying the release. Errors are rare but any identified are corrected and clearly marked on the release. Please see the [Revisions policy for population, migration and life events statistics](#) for more information.

Changes to the format and content of publications

Over the years, the format and content of mortality publications have changed. Prior to 1993, annual mortality statistics were based on the number of deaths registered in a year. From 1993 to 2005 the figures related to the number of deaths that occurred in a year. From 2006 onwards, annual mortality statistics reverted back to the number of deaths registered in a year. More details on these changes can be found in [Series DR](#) for 2006. Registrations are not entirely comparable to occurrences, however the differences are relatively minor and figures are broadly comparable for most causes.

Findings from the [ONS consultation on statistical products](#) in 2013 resulted in several mortality publications being discontinued from May 2014 onwards:

- Provisional quarterly mortality statistics for the UK, and its constituent countries in the [Vital statistics: population and health reference tables](#) (last published February 2014)
- annual data on [Injury and poisoning mortality, England and Wales](#) (last published February 2013)
- [Deaths involving Clostridium difficile](#) and [Deaths involving MRSA](#) continue to be published for Wales only from the 2013 data year

Changes to definitions and classifications used in published statistics

Due to improvements in the classification and coding of communal establishments, the place of death definition used by ONS was revised in 2011. These changes were implemented for 2010 mortality statistics. In particular, the classification was changed to reflect user needs and now identifies: local authority and non-local authority care homes; NHS and non-NHS hospitals (acute or community not psychiatric) and other communal establishments (including schools; nurses' homes, hotels; aged persons' accommodation; university and college halls of residence; young offender institutions; prisons and remand homes).

The Stillbirth (Definition) Act 1992 changed the definition of a stillbirth from a child being born after 28 weeks to a child being born after 24 weeks (which did not breathe or show any other signs of life). This means that data for 1992 onwards are not directly comparable with data for stillbirths before the introduction of the Act.

Since 1993, a shortlist of selected underlying causes has been used in Death registrations (Series DR) table. This list was developed in consultation with the Department for Health and consists of around 100 conditions. The list is based on the following:

- all conditions given in the WHO basic tabulation list; with the exception of a few conditions that are so rare as certified causes of death in England and Wales that they could safely be excluded from the list
- totals for each ICD Chapter
- conditions used in monitoring public health targets
- other conditions often referred to by ONS

This shortlist provides a standard listing of conditions frequently referred to by all users of the data. For more information on the shortlist see section 2.13 of our [User guide to mortality statistics](#).

Changes in the collection and coding of mortality data

Changes in the collection and coding of mortality data may affect the interpretation of trends. The most recent changes which have affected mortality statistics are detailed below:

- **2001** - from 1 January 2001, ICD-10 was used to code cause of death, replacing ICD-9 which had been used since 1979. Overall the vast majority of deaths remained in comparable chapters but some diseases and conditions did move between chapters. Causes of death most affected included leukaemia, diseases of the liver and land transport accidents. There were also some changes to the rules governing the selection of underlying cause of death, especially Rule 3, which had a large effect: [Understanding the changes to mortality statistics following the move to coding cause of death to ICD-10](#). Comparability ratios were produced to ensure trends over time could be analysed. Further assessments of the change were also published in [Health Statistics Quarterly 13](#) and [Health Statistics Quarterly 19](#)

- **2007** - from 1 January 2007, a new ICD-10 code (U50.9) was introduced by ONS for deaths involving adjourned inquests previously coded to Y33.9. This has simplified the tabulation of deaths from undetermined intent, and estimates of intentional self-harm
- **2009** - following guidance from WHO, the ICD-10 code J09 “Influenza due to identified avian influenza virus” was extended to include H1N1 swine influenza from 2009. The numbers of deaths shown under ICD code J09 (Influenza due to identified avian or swine influenza virus) differ from the figures reported by Public Health England (PHE). PHE reports deaths as related to pandemic A/H1N1 using information from either the death certificate or from laboratory testing or both. The Registration Online System was fully implemented in 2009
- **2011** – we moved to using ICD-10 v2010 in 2011 from ICD-10 v2001.2. Initial assessments of [the impact on cause of death of moving to ICD10 v2010](#) and [the impact of moving to ICD v2010 for stillbirths and neonatal deaths](#) have been published. The impact of the change on specific causes is published alongside the relevant statistics for 2011
- **2014** - on 1 January 2014 we implemented IRIS software version 2013 to code cause of death. This incorporated official updates to ICD-10 approved by WHO. Further information on IRIS can be found in Section 2.12 of our [User guide to mortality statistics](#) and in the [dual coding study](#) looking at the impact on mortality statistics. A further study looks at the [impact of the coding changes on stillbirths and neonatal deaths](#)
- **2014** - on 1 October 2014, the **Presumption of Death Act 2013** came into force in England and Wales. This enabled applications to the High Court for a declaration that a missing person is presumed to be dead, where the person who is missing is thought to have died or has not been known to be alive for a period of at least 7 years

Earlier changes can be found in section 3.4 of the [User guide to mortality statistics](#).

Comparisons across reference periods and subnational areas

The number of registration days in a reference period can impact upon mortality statistics. For example, bank holidays can affect the number of registrations within a week/month.

Weekly deaths counts cannot be summed to match the counts for monthly deaths as some weeks may span more than 1 month.

Annual mortality statistics by area of usual residence are produced using the boundaries that were in place during the year the death was registered. This approach means that changes in boundaries can affect the comparability of statistics over time. Since 1993, the informant has been able to decide what address to give if more than one might be applicable. Prior to 1993, there were “rules” determining the validity of 1 address over another (previous annual reference volumes contain details of these rules).

UK and international comparability

There is a large degree of comparability in mortality statistics between countries within the UK; all figures are based on the details collected when deaths are registered. We quality assure data for England and Wales enabling detailed mortality statistics to be published. Similarly, National Records of Scotland (NRS) and Northern Ireland Statistics and Research Agency (NISRA) quality assure data for their own countries and subsequently publish detailed mortality statistics based on deaths registered in the reference period. The definitions, classifications and methods used to produce published death statistics are broadly comparable across the 4 countries. More information can be found in the [Quality Information for Northern Ireland](#) and in the [Quality information for Scotland](#).

ONS publishes several internationally-recognised indicators which facilitate comparisons, these include:

- crude death rates (total deaths per 1,000 population)
- infant mortality rates (deaths under 1 year per 1,000 live births)
- neonatal mortality rates (deaths under 28 days per 1,000 live births)
- perinatal mortality rates (stillbirths and deaths under 7 days per 1,000 live and stillbirths)
- age-specific death rates (deaths per 1,000 population in age-sex group; rates for age under 1 use the number of live births)

- Age-standardised mortality rates (ASMRs) (deaths per 100,000 population standardised to the European Standard Population), which enable comparisons between populations with different age structures, including between males and females and over time. (From the 2015 data year ASMRs are calculated using population estimates for all age groups. Prior to this, the number of live births were used for the population aged under 1. This change has had no significant impact on the rates.)

To enable international comparisons, the [Vital statistics: population and health reference tables](#) provide the crude death rate for different countries. ONS produces the UK death rate in the table. All other figures are obtained from the United Nations Monthly Bulletin of Statistics.

Internationally, ONS provides data to [Eurostat](#), WHO and the UN each year to allow them to compile mortality figures to enable comparison across countries.

Concepts and definitions

(Concepts and definitions describe the legislation governing the output and a description of the classifications used in the output.)

For information on UK legislation relating to mortality statistics and for definitions of terms please see our [User Guide to Mortality Statistics](#).

Other information

Output quality trade-offs

(Trade-offs are the extent to which different dimensions of quality are balanced against each other.)

Up to 1992, publications gave numbers of deaths registered in the period concerned. From 1993 to 2005, figures relate to the number of deaths that occurred in the reference period. Since 2006, figures have been based on deaths registered in the reference period. This change was made to enable the timely release of mortality statistics; figures based on the period of occurrence are much less timely and complete due to late registrations resulting from referral to a coroner. More details on these changes can be found in [Mortality Statistics: Deaths registered in 2006](#).

We continue to take an annual extract of death occurrences in the autumn following the data year, this is used for seasonal analysis of mortality data and several infant mortality outputs.

Assessment of user needs and perceptions

(The processes for finding out about uses and users, and their views on the statistical products.)

The findings of the [ONS consultation on statistical products](#) from September and October 2013 have resulted in certain mortality publications being discontinued. For more information see section on changes to the format and content of publications.

A user consultation to review infant mortality statistics produced by ONS took place between 5 July 2011 and 16 August 2011. The [ONS response to the review](#) is available on the ONS website.

User feedback is also requested at the bottom of all e-mails sent by customer service teams within the Vital Statistics Outputs Branch. ONS also receive feedback through regular attendance at user group meetings and conferences.

Sources for further information or advice

Accessibility and clarity

(Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the release details, illustrations and accompanying advice.)

Our recommended format for accessible content is a combination of HTML webpages for narrative, charts and graphs, with data being provided in usable formats such as CSV and Excel. Our website also offers users the option to download the narrative in PDF format. In some instances other software may be used, or may be available on request. Available formats for content published on our website but not produced by us, or referenced on our website but stored elsewhere, may vary. For further information please refer to the contact details at the beginning of this document.

For information regarding conditions of access to data, please refer to the links below:

- [Terms and conditions \(for data on the website\)](#)

- [Copyright and reuse of published data](#)
- [Pre-release access \(including conditions of access\)](#)
- [Accessibility](#)

Special extracts and tabulations of mortality data for England and Wales are available to order (subject to legal frameworks, disclosure control, resources and the [ONS charging policy](#), where appropriate). Such enquiries should be made to Vital Statistics Outputs Branch (vsob@ons.gsi.gov.uk or telephone: +44 (0)1329 444 110). All user requested data will be published onto [our website](#).

Access to microdata and disclosive data, that is, data which have the potential to identify an individual record, requires the approval of the ONS Microdata Release Procedure (MRP) before the data can be provided.

Useful links

For information on data quality, legislation and procedures relating to mortality statistics, please see the [User guide to mortality data](#).

Links to our death statistics publications are included in the section titled 'About the Output'.

For deaths data for other UK countries please see [the latest death statistics for Northern Ireland](#) and [the latest death statistics for Scotland](#).