9-Aug-2019

Dear Dr. Humphreys,

Manuscript ID BMJ-2019-050778.R1 entitled "Media coverage of the "violence epidemic" in England and Wales: are we adding fuel to the fire?"

Thank you for sending us your revised manuscript, which we discussed at our editorial meeting earlier today. We are pleased to make a provisional offer of publication if you are able to revise it to address the points made by the referees. The referees' comments are available at the end of this letter.

We hope that you will be able to revise the paper and send it back to us within one month. When you resubmit, could you kindly ensure that you provide:

(a) A covering letter outlining how you have responded, or not responded and why, to both the referees comments and those of the editors.
(b) A word count (excluding the references and words in boxes and tables). You should aim to keep this count below or very close to 2000 words.
(c) Please check that all the information required in the manuscript (see note below) is included in the revised manuscript.

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I hope you will find the comments useful.

Best wishes,
Emma

Emma Rourke
Associate editor for analysis, the BMJ
ERourke@bmj.com

*** Present at Analysis meeting:[INSERT]

INFORMATION TO INCLUDE IN REVISION
Please would you also check that you have provided the following information

* Competing interest statement (in the style explained at http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests)

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* Signed patient consent form(s), if the article gives enough personal information about any patient(s):
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Reviewer(s)' Comments to Author:

Reviewer: 1

Recommendation:

Comments:
This analysis paper discusses the data sources available to examine trends in violence and specifically knife crime in England and Wales - specifically, that recorded crime data are too poor to assess trends and whether media reporting may even contribute to increased violence. As a 'data nerd' I found the discussion of quality of crime data fascinating and I think this could be expanded as this was the strongest part of the paper. I have a few specific comments which I hope will improve the paper:
1) My main concern is regarding your conclusions drawn from the available hospital data on knife crime, which for all of England do show an increase in admissions, albeit from a historically low level in 2014. You show data for all of England when you discuss trends but in the conclusion you mention that homicides (rates?) have increased in London. On which data you base this conclusion? I think you should either present regional trends in hospital and mortality data (which would be very interesting indeed) in which case you can make inferences about London, or state that these data are not available (if this is the case). In which case I would have thought publication by NHS D and ONS of these data should be prioritised – otherwise interventions to reduce violence cannot be targeted or assessed for their effectiveness.

2) Ideally the mortality and admission rates should also be age and sex adjusted, a point which you don't mention (but I think you should). Can you present both crude and adjusted rates?
3) In relation to point 1) above, mortality may be a poor indicator of incidence of violence, since death rates may be decreasing due to improved treatment for severe injuries. A further challenge in England & Wales with recording of violent deaths is that there are substantial delay between occurrence and registration when deaths are referred to coroners (See https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/impactofregistrationdelaysonmortalitystatistics2016). Since ONS publish mortality data by date of registration, the number of *registered* homicides in a particular year may reflect deaths occurring several years previously. In addition, changing hospital thresholds over time may explain changes in admission rates, although very severe injuries that require intensive care and/or an operation would still require an admission. I think all these points would be worth mentioning when you discuss the quality of these data sources.
4) I found the section on recorded crime extremely useful and I think it could be expanded. For example, I would have liked to see plotted not just the ratio of police recorded violence to CSEW reported incidents but the actual rates or recorded and reported crime. Perhaps this can be added to Figure 2? I think it would also be very important to report how much of the increase in recorded violent crime since 2012 can be attributed to different types of crime, eg is most of the increase due to better reporting of domestic violence and stalking/harassment, or has there also been increases in recorded knife crime? Could you present the ratio of recorded:reported violent crime broken down by type?
5) In box 1, you mention that HES includes admissions, outpatient appointments and A&E attendances – but I would flag that it is only the admissions that are well coded using ICD-10. HES A&E data is currently being replaced by the new Emergency Care Dataset (ECDS) which should contain better data on A&E attendances, including reason for attendance, going forward: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds you may want to mention this.
6) I definitely agree that the reporting of the data quality for violent crime should improve, however based on the available data (and bearing in mind that you don't present subnational data, or data on whether reported knife crime has increased based on CSEW – see point 4) I think you play down the increase in knife crime related injury admissions too much. For a rare but serious event such as this, a continuous increase since 2014 is concerning, and something that should continue to be monitored and may need to be acted on by policy makers.
7) An alternative view to the one you present is that it is positive that the media does give attention to a very serious type of crime that tends to cluster strongly among vulnerable teenagers from non-white ethnic groups living in poor urban areas. An alternative might be that they ignored it until it affected a white, middle class community. Although your comment about data quality and historical context still stands.
8) Can you make clearer whether you are actually calling for a reporting guideline for violent crime similar to the WHO for suicide reporting?

Additional Questions:
Please enter your name: Pia Hardelid

Job Title: Associate professor

Institution: UCL Great Ormond Street Institute of Child Health

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

Funds for a member of staff?: No

Fees for consulting?: No

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Reviewer: 2

Recommendation:

Comments:
This is an important study that highlights the need to look at multiple sources of data when interpreting trends that could be affected by changes in data quality or systems over time. This triangulation of data sources has also been effective in other settings, e.g. child maltreatment (see, e.g. Roehrkasse et al. Administrative data and long-term trends in child maltreatment: the prospects and pitfalls. The Lancet Public Health, Volume 4, Issue 3, e121 - e122).

I have a few suggestions, the main one being that there should be a little more recognition of the potential pitfalls in using administrative hospital / mortality data to look at trends (where differences in recording over time can also occur, e.g. in response to changing guidelines e.g. QOF). In addition to the critique of the police data, the limitations of the hospital and mortality data used in this study should also be discussed.

Box 1 states that there is typically a delay between death and registration of 5 days. In fact, only around 40% of deaths are registered within 5 days, and around 4% of deaths are registered the year after the death occurred. Only 7.1% of deaths to external causes of morbidity and mortality were registered within five days of the death in 2016 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/impactofregistrationdelaysonmortalitystatistics2016). This should be discussed, in light of the reliability of the mortality data and the difference late registration might make to results.

Was the HES data restricted to Admitted Patient Care? From Figure 1a, this seems to be the case, but this is not clear in Box 1 which mentioned appointments and attendances. I would question whether it is appropriate to include elective admissions in these estimates. It might be helpful to say that diagnoses aren't historically recorded with accuracy in HES A&E data.

Please be specific about what you mean by 'rate', e.g. in Figure 1a. Could there have been double counting of events if someone was re-admitted more than once following the same event?

Further to the above comment, the text states that "HES suggest 0.086 per 1000 population are admitted to hospital each year". Again this implies that you are counting people rather than admissions, was this the case? Please be explicit about the unit of analysis within HES.

Is it possible to tell whether the increase in homicides by knife since 2014 was offset by reductions in homicides by other means?

The text mentions that "stalking and harassment" is now included in the definition of violent crime. Crimes like this are less likely to result in death, hospital admission, or A&E. This is a limitation of the data presented and there should be some discussion of this – that a limitation of this analysis is that we cannot infer anything about trends in other forms of violent crime.

Figure 2 – be more precise in what the ratio represents (is this a ratio of rates or of numbers?) What exactly is the comparable subset that is being compared? It would be helpful to give some figures here, e.g. how many crimes in each source for at least some of the years.

Figure 3 axis states 'hospital attendances' but the figure caption describes this more specifically as A&E attendances. Please be consistent and state the data source.

Additional Questions:
Please enter your name: Katie Harron

Job Title: Associate Professor

Institution: UCL

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

Funds for a member of staff?: No

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Reviewer: 3

Recommendation:

Comments:
David Cromwell, London School of Hygiene & Tropical Medicine

This paper examines issues generated by the recent focus on rates of violence in the UK media. It addresses an important topic and challenges the perceptions given in the media by comparing the figures on violent crimes based on police data with figures from other sources. They highlight that the trends in the police figures are not evident in the time-series produced from routine hospital data or from population surveys, both of which the authors argue might be more reliable, with just reason. Furthermore, the authors highlight that the unbalanced view of rates of violent offences in the media can lead to undesirable consequences both in terms of policy responses and in relation to the population's reaction. That the latter could lead to an increase in rates of violence makes this a relevant topic for the BMJ.

The article would be improved if various weaknesses could be addressed. The major issues of concern for me are:
1. The article contains a number of phrases that are like the journalist language being condemned. The article would benefit if these were rewritten to be more specific and neutral. For example, the first line of the Abstract reads "Media coverage of spiralling rates of violence in England and Wales has been ubiquitous…", followed by "motivating a search for drastic measures". Alternative statements might be: "National newspapers and television news programmes have reported a rise in rates of violence in England and Wales…" and "stimulating debate among politicians and policy commentators about measures that might reduce the risk of violence." There is also a tendency to use phrases that are broad generalisations (eg, last sentence of Abstract - "safety concerns", "intensify the problem") when more precise concepts would be more helpful.
2. The article refers to the media without distinguishing between the different types of media (newspaper, television, web-based), the extent of their coverage (national, local) and their quality (tabloid, broad-sheet). It would be helpful to separate / contrast the responses to the changes in the police figures in the different sectors of the media. For instance, it would be interesting to see the media time-series in Figure 4 for different groups, if feasible.
3. There needs to be more consistent referencing of sources for statements about media coverage throughout the article. For example, the last sentence of the introduction refers to recent increases in rates of stabbings but gives no reference.
4. The article needs to be clearer in presenting the numerical figures from the different sources. Firstly, sufficient information should be given to enable the results to be reproduced (eg, how were the hospital data obtained, what codes were used to identify events, and how where the data analysed?). The statement about recent HES data not being available (pg 4) is not true - data are released / published on a monthly basis by NHS Digital. Secondly, the graphs need to be redrawn so that the vertical axis is clearly anchored at 0. A well-known way of emphasising change is to remove 0 from the vertical axis. The general statement about the accuracy of HES at the bottom of page 4 needs to be more nuanced.
5. The article does not examine how the strengths / weaknesses of the different data sources on the rates of violent offences might influence the results. For example, deaths from violence are likely to make the news but people who die before arriving at hospital will not be admitted and so will not be part of these statistics. The article should state how (un)likely is it that these differences explain the observed patterns.
6. The section describing the evidence is inconsistent when describing the setting in which studies were conducted. I think it is difficult to extrapolate from the US or other countries with different cultures / laws to the UK. The source of the evidence needs to be clearly stated with appropriate caveats.
7. The conclusion needs to be revised to give a balanced account of the paper results and its implication. For example, its first line refers to fatalities which is odd – the data presented concerns all injuries. Also, why does the conclusion refer to "swift justice"? – the nature of justice is a new idea and is outside the scope of this article.

Minor points
1. page 3: I would say "we examine the consistency of police-recorded trends in serious violence .. with other national sources of data on injuries rather than "using injury data from…"

2. The section titled “Data reliability” is more accurately described as “Reliability of police-reported data on violent offences"
3. The end paragraph of the section on data reliability seems inconsistent with the rest of the content in this section, and the article more generally. I feel it needs to be reviewed / moved.
4. Page 6: I would re-write the phrase “may have in skewing the public debate” to something more neutral “may have on the public debate”. Also, in the following sentences, “adverse effects” and “respond disproportionately” are also vague statements that require revision.
5. Page 8: I don’t think it is accurate / clear to write “During the recent crisis,” – crisis in what sense?
6. The summary points need to be revised after the changes to the abstract / main article have been made.

Additional Questions:
Please enter your name: David Cromwell

Job Title: Professor of Health Services Research

Institution: London School of Hygiene & Tropical Medicine

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

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