

NSW Suicide Monitoring System

Report 2. November 2020.

This report provides estimates of suspected suicides in NSW in 2019 and 2020, from the newly established NSW Suicide Monitoring and Data Management System.

Warning

The following report contains information about the collection and reporting of suicide data in NSW. NSW Health acknowledges that behind these numbers are people, their families and their friends who are deeply affected by suicide. Some people may find the content of this report confronting or distressing. If affected in this way, please contact:

Beyond Blue, 1300 22 4636, www.beyondblue.org.au or Lifeline, 13 11 14, www.lifeline.org.au

What is the NSW Suicide Monitoring and Data Management System?

The NSW Suicide Monitoring and Data Management System is a collaboration between the NSW Ministry of Health, Department of Communities and Justice, the State Coroner and NSW Police. It estimates the number of recent suspected and confirmed suicides in NSW, using data collected by NSW Police and the State Coroner.

Where does this suicide data come from?

All suicides or suspected suicides in NSW are reported to the Coroner. Data on these Police notifications of suspected suicides are obtained from the "JusticeLink" information system managed by NSW Department of Communities and Justice. As well as the initial Police advice, records are searched for potential indicators of suicide in other fields. These include the manner or place of death, and whether the person communicated their intention to family and friends. Each potential suicide death record is then screened manually by the Department of Communities and Justice to confirm the classification of suspected or confirmed suicide.

How accurate is this data?

The data about suspected suicides are an estimate. A final determination of the manner of death can only be made by the Coroner after detailed enquiry. This will mean that there may be small differences in the number of suicides between reports for the same reporting period. The numbers reported for the most recent month may be underestimated due to time taken to record a report of a death. Evidence from Suicide Registers in other states shows that initial Police advice is usually accurate. However once all facts are known, some suspected suicide deaths are found to be due to other causes, and some deaths initially thought to be accidental are found to be due to suicide.

This report will differ from suicide statistics reported by the Australian Bureau of Statistics (ABS), which count suicide deaths which have been confirmed or are being finalised through the coronial process. ABS have reported 937 suicide deaths in NSW in 2019. National and state reports may also differ slightly in how they count years and locations of death. Some deaths occur in one year and are registered in another, and some deaths occur in a location in a different state from the person's address.

Initial findings

There have been 742 suspected or confirmed suicide deaths reported in NSW from 1 January to 31 October 2020. This is broadly similar to the number of deaths reported within the same time period in 2019.

| | 2019 | | 2020 |
|---------------------------------|------------|-------------------------|-------------------------|
| Suspected suicide deaths in NSW | 950 | 762 | 742 |
| | Full year | 1 January to 31 October | 1 January to 31 October |
| | | | |

Table 1 Monthly frequency

| | 2019 | 2020 |
|------------------|-------------|-------------|
| January | 75 | 81 |
| February | 75 | 63 |
| March | 91 | 88 |
| April | 57 | 59 |
| May | 68 | 66 |
| June | 68 | 71 |
| July | 73 | 88 |
| August | 77 | 87 |
| September | 88 | 75 |
| October | 90 | 64 |
| November | 91 | |
| December | 97 | |
| Total | 950 | 742 |

Table 2 Gender

| | Full year | 1 January to 31 October | |
|---------------|------------------|--------------------------------|-------------|
| | 2019 | 2019 | 2020 |
| Female | 214 | 177 | 192 |
| Male | 736 | 585 | 550 |
| Total | 950 | 762 | 742 |

Table 3 Age group

| | Full year | 1 January to 31 October | |
|--------------------|------------------|--------------------------------|-------------|
| | 2019 | 2019 | 2020 |
| Under 18 | 31 | 23 | 25 |
| 18-24 | 109 | 87 | 87 |
| 25-34 | 173 | 137 | 140 |
| 35-44 | 165 | 136 | 113 |
| 45-54 | 184 | 146 | 132 |
| 55-64 | 126 | 103 | 108 |
| 65 and over | 155 | 125 | 136 |
| Not known | 7 | 5 | 1 |
| Total | 950 | 762 | 742 |

Information about methods

Coding of “Suspected Suicide” deaths.

In this report, deaths have been coded as suspected suicides using a two stage process of (i) computerised screening followed by (ii) manual review and checking by experienced staff from the NSW Department of Communities and Justice.

At the computerised screening stage, all NSW deaths in the NSW JusticeLink database in 2019 and 2020 were examined. A wide range of fields were searched. Deaths were flagged as “Suspected Suicides” if the apparent cause of death was described as suicide or suspected suicide, or any of the key fields included words suggesting specific suicide methods. They were also flagged if any field indicated that the person had left a note or indicated to their family or others that they intended to end their life. All deaths flagged as “Suspected Suicide” were then manually checked against other information, including the determination of the Coroner where this was available.

Deaths were also flagged for screening if they met any of three other criteria. First, if the death occurred in circumstances that are sometimes due to suicide, such as drug overdoses or single vehicle accidents. Second, if Police had recorded that the person had previously attempted to end their life. Third, if the person had experienced recent stressors such as relationship breakups or job loss. All of these records were manually checked, and some were re-classified as “Suspected Suicide” deaths.

The methods used in this report have been based on consultation with experts in NSW and with other state and national suicide data systems. They will be tested and refined with each report. The data will be updated as methods develop, and as data collection systems continue to improve.

Inclusion and exclusion criteria for reporting

| Issue | What is included | What has been corrected | What is excluded |
|-------------------------|--|--|--|
| Month and Year of death | Deaths occurring in 2019 and 2020 | Date of death is unknown or missing for some records – the date of recording of death has been used for those records. | Deaths occurring prior to 2019, even if registered in 2019 or 2020. |
| Place of death | Deaths occurring in NSW, or involving a NSW resident and investigated by the State Coroner | Records where the place of death is unknown or missing are assumed to have occurred in NSW | Two records were excluded, one in each of 2019 and 2020. See note (1) below. |
| Address of the person | All records | Where the person’s residence is unknown, assumed to be in NSW | No records were excluded |
| Age group | All age groups, including people where age is unknown or not recorded | No correction | No records were excluded |
| Gender | All records | No correction. See note (2) below | No records were excluded |

Notes:

- (1) Suspected suicide deaths occurring in NSW and reported to the State Coroner are counted in this report, including deaths of overseas visitors and residents of other states. A small number of incidents occurred in NSW and involved NSW Police and the Coroner, but death occurred after transfer to an interstate hospital: these are also included. Two deaths of interstate residents were excluded where the incident occurred in that state but death occurred in a NSW hospital, because both were investigated by that state’s Coroner and would be included in reporting in that state.
- (2) No JusticeLink records included gender other than male or female.

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