NSW Suicide Monitoring System

Report 34. Data to June 2023.

This report provides estimates of suspected and confirmed suicides in NSW since 2019 from the 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 reported the number of suicide deaths in NSW was 960 in 2019, 876 in 2020, and 880 in 2021. 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.

Current findings

There have been 477 suspected or confirmed suicide deaths reported in NSW from 1 January to 30 June 2023.

Suspected suicide deaths in NSW

2019		2020		2021		2022		2023
946 Full year	430 1 January to 30 June	898 Full year	421 1 January to 30 June	908 Full year	459 1 January to 30 June	966 Full year	483 1 January to 30 June	477 1 January to 30 June

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Table 1 Monthly frequency

	2019	2020	2021	2022	2023
January	76	79	101	80	91
February	72	63	55	73	66
March	91	88	86	97	90
April	57	58	74	94	70
May	67	65	78	76	86
June	67	68	65	63	74
July	74	85	75	98	-
August	78	88	63	75	-
September	85	75	66	80	-
October	92	65	78	74	-
November	92	77	69	80	-
December	95	87	98	76	-
Total	946	898	908	966	477

Table 2 Location of usual residence

	Full year				1 January to 30 June				
	2019	**2020**	**2021**	**2022**	**2019**	**2020**	**2021**	**2022**	**2023**
Greater Sydney	473	472	441	541	212	204	218	272	249
Rest of NSW	455	415	461	412	212	211	238	204	214
Overseas/ Interstate	15	11	6	10	6	6	3	6	13
Total	946	898	908	966	430	421	459	483	477

Table 3 Gender and age group

	Full year				1 January to 30 June				
	2019	**2020**	**2021**	**2022**	**2019**	**2020**	**2021**	**2022**	**2023**
Total	946	898	908	966	430	421	459	483	477
Under 18	30	30	31	24	13	16	19	15	11
18-24	108	95	78	79	47	41	39	34	41
25-34	171	165	166	167	75	79	86	83	81
35-44	164	136	163	179	80	66	79	85	85
45-54	186	172	155	167	87	84	80	86	89
55-64	133	133	126	168	62	61	61	88	82
65-74	82	78	87	89	37	33	43	45	48
75-84	43	50	62	63	16	20	34	32	29
85 plus	29	39	40	30	13	21	18	15	11
Female	214	225	237	217	103	97	116	106	100
Under 18	7	9	16	10	3	4	10	8	6
18-24	27	17	20	22	13	4	8	11	9
25-34	37	41	35	40	13	19	19	21	17
35-44	43	34	47	37	22	13	22	16	23
45-54	40	47	43	33	21	23	21	17	18
55-64	31	33	29	36	16	12	15	16	13
65-74	14	20	23	17	7	11	10	8	7
75-84	9	14	13	14	5	6	8	7	5
85 plus	6	10	11	8	3	5	3	2	2
Male	732	673	671	748	327	324	343	376	377
Under 18	23	21	15	14	10	12	9	7	5
18-24	81	78	58	57	34	37	31	23	32
25-34	134	124	131	126	62	60	67	61	64
35-44	121	102	116	142	58	53	57	69	62
45-54	146	125	112	134	66	61	59	69	71
55-64	102	100	97	132	46	49	46	72	69
65-74	68	58	64	72	30	22	33	37	41
75-84	34	36	49	49	11	14	26	25	24
85 plus	23	29	29	22	10	16	15	13	9

Information about methods

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.

All deaths in the NSW JusticeLink database in 2019, 2020, 2021, 2022 and 2023 were screened. Deaths were flagged as "Suspected Suicides" if the apparent cause of death was described as suicide or suspected suicide, or if key fields included words suggesting specific suicide methods, 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 Coroner's determination 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.

People with a recorded residential address in NSW were allocated to Capital City Geographical Area (Greater Sydney, Rest of NSW) using Australian Bureau of Statistics definitions. *Rest of NSW* includes the Level 4 Statistical Areas (SA4s) of Richmond - Tweed, Coffs Harbour, Grafton, Mid North Coast, Newcastle and Lake Macquarie, Hunter Valley, New England and North West, Central West, Far West and Orana, Murray, Riverina, Capital Region, Illawarra, Southern Highlands and Shoalhaven. Central Coast and Blue Mountains regions are included in Greater Sydney. People with an interstate or overseas address, or no address but a residency status *of Overseas Visitor* were classified as interstate or overseas visitors.

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, 2020, 2021 ,2022 and 2023	Date of death is unknown 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	Three records were excluded, one in 2019 and two in 2020. See note (1) below
Address of the person	All records; Totals include records where the address of the person is not known	No correction	No exclusion
Age group	All records; Totals include records where age is not known	No correction	No exclusion
Gender	All records; Totals include records where gender is not known or other	No correction	No exclusion

Notes:

(1) Three deaths of interstate residents were excluded where the incident occurred in the state of residence, but death occurred in a NSW hospital. These incidents were investigated by that state's Coroner and would be included in reporting in that state. 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 included in the figures in this report.

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