NSW Health

NSW Suicide Monitoring System

Data to May 2025

28 July 2025

NSW GOVERNMENT

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Introduction

This report provides estimates of suspected and confirmed suicides in NSW since 2021 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 913 in 2020, 932 in 2021, 940 in 2022 and 878 in 2023. 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 403 suspected or confirmed suicide deaths reported in NSW from 1 January to 31 May 2025.

Suspected suicide deaths in NSW

Table 1 Monthly frequency

	2021	2022	2023	2024	2025
January	100	77	87	81	91
February	56	72	68	75	67
March	85	97	87	69	89
April	74	92	70	74	85
May	77	75	85	82	71
June	66	64	75	80	-
July	72	90	90	74	-
August	64	72	71	79	-
September	64	80	77	78	-
October	78	73	82	78	-
November	71	74	69	108	-
December	93	73	66	76	-
Total	900	939	927	954	403

Table 2 Gender and age group

	Full year				1 January to 31 May				
	2021	2022	2023	2024	2021	2022	2023	2024	2025
Total	900	939	927	954	392	413	397	381	403
Under 18	30	24	23	18	15	12	10	5	12
18-24	78	76	85	59	28	31	33	22	40
25-34	166	159	148	161	77	72	70	60	70
35-44	162	179	161	173	73	75	70	74	71
45-54	150	165	181	183	67	74	74	76	73
55-64	126	164	156	163	53	77	72	70	62
65-74	86	84	91	104	36	36	38	39	41
75-84	62	58	58	57	28	24	21	21	23
85 plus	40	30	24	36	15	12	9	14	11
Female	231	211	202	225	100	92	81	86	106
Under 18	15	10	9	7	8	6	6	-	7
18-24	20	21	20	14	7	11	9	4	11
25-34	36	39	34	46	18	18	14	15	18
35-44	46	37	44	29	20	14	21	12	18
45-54	39	33	34	41	18	15	12	19	16
55-64	29	36	27	42	12	13	10	17	17
65-74	22	16	18	29	9	8	4	12	9
75-84	13	11	9	9	8	5	3	3	6
85 plus	11	8	7	8	-	2	2	4	4
Male	669	727	725	729	292	320	316	295	295
Under 18	15	14	14	11	7	6	4	5	5
18-24	58	55	65	45	21	20	24	18	28
25-34	130	119	114	115	59	53	56	45	52
35-44	116	142	117	144	53	61	49	62	52
45-54	111	132	147	142	49	59	62	57	57
55-64	97	128	129	121	41	64	62	53	45
65-74	64	68	73	75	27	28	34	27	32
75-84	49	47	49	48	20	19	18	18	17
85 plus	29	22	17	28	15	10	7	10	7

Table 3 Location of usual residence

	Full year				1 January to 31 May				
	2021	2022	2023	2024	2021	2022	2023	2024	2025
Greater Sydney	438	523	474	482	182	230	202	199	214
Rest of NSW	456	404	429	450	207	177	182	174	178
Overseas/ Interstate	6	10	21	20	3	5	10	8	11
Total	900	939	927	954	392	413	397	381	403

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 2021, 2022, 2023, 2024 and 2025 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 2021, 2022, 2023 ,2024 and 2025	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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