NSW Suicide Monitoring System

Report 38. Data to October 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 963 in 2019, 910 in 2020, 894 in 2021 and 911 in 2022. 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 798 suspected or confirmed suicide deaths reported in NSW from 1 January to 31 October 2023.

	2019		2020		2021		2022		2023
Suspected suicide deaths in NSW	946 Full year	759 1 January to 31 October	897 Full year	733 1 January to 31 October	908 Full year	741 1 January to 31 October	962 Full year	809 1 January to 31 October	798 1 January to 31 October

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Table 1 Monthly frequency

	2019	2020	2021	2022	2023
January	76	79	101	80	91
February	72	63	55	73	65
March	91	88	86	97	90
April	57	58	74	93	70
May	67	64	78	75	86
June	67	68	65	64	75
July	74	85	75	98	91
August	78	88	63	74	73
September	85	75	66	81	78
October	92	65	78	74	79
November	92	77	70	78	-
December	95	87	97	75	-
Total	946	897	908	962	798

Table 2 Location of usual residence

	Full year				1 January to 31 October				
	2019	**2020**	**2021**	**2022**	**2019**	**2020**	**2021**	**2022**	**2023**
Greater Sydney	473	472	441	538	387	381	353	461	421
Rest of NSW	455	414	461	411	358	343	384	336	356
Overseas/ Interstate	15	11	6	10	12	9	4	9	20
Total	946	897	908	962	759	733	741	809	798

Table 3 Gender and age group

	Full year				1 January to 31 October				
	2019	**2020**	**2021**	**2022**	**2019**	**2020**	**2021**	**2022**	**2023**
Total	946	897	908	962	759	733	741	809	798
Under 18	30	30	31	24	22	26	29	22	21
18-24	108	95	78	79	85	84	66	68	72
25-34	171	165	167	166	135	135	135	125	127
35-44	164	136	163	180	137	112	132	148	138
45-54	186	171	154	168	148	134	126	150	148
55-64	133	133	126	165	107	108	99	145	135
65-74	82	78	87	88	69	60	66	73	81
75-84	43	50	62	62	33	40	54	53	55
85 plus	29	39	40	30	23	34	34	25	21
Female	213	224	238	214	175	187	203	184	173
Under 18	7	9	16	10	5	7	16	10	8
18-24	27	17	20	22	19	13	18	19	14
25-34	36	41	36	41	30	35	28	32	28
35-44	43	34	47	37	38	29	41	31	39
45-54	40	46	43	33	30	37	35	30	30
55-64	31	33	29	34	26	27	25	31	25
65-74	14	20	23	16	12	18	18	15	15
75-84	9	14	13	13	9	13	12	11	8
85 plus	6	10	11	8	6	8	10	5	6
Male	733	673	670	747	584	546	538	624	625
Under 18	23	21	15	14	17	19	13	12	13
18-24	81	78	58	57	66	71	48	49	58
25-34	135	124	131	124	105	100	107	92	99
35-44	121	102	116	143	99	83	91	117	99
45-54	146	125	111	135	118	97	91	120	118
55-64	102	100	97	131	81	81	74	114	110
65-74	68	58	64	72	57	42	48	58	66
75-84	34	36	49	49	24	27	42	42	47
85 plus	23	29	29	22	17	26	24	20	15

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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