NSW Health

NSW Suicide Monitoring System

Data to August 2024

29 October 2024

NSW GOVERNMENT

www.health.nsw.gov.au

Introduction

This report provides estimates of suspected and confirmed suicides in NSW since 2020 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, 923 in 2021, 928 in 2022 and 847 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 621 suspected or confirmed suicide deaths reported in NSW from 1 January to 31 August 2024.

Suspected suicide deaths in NSW

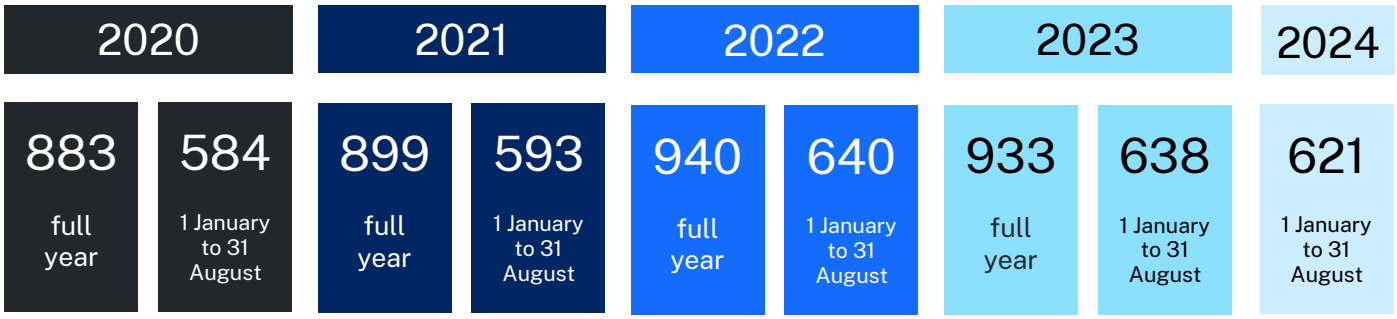

Table 1 Monthly frequency

	2020	2021	2022	2023	2024
January	78	100	77	88	83
February	65	56	72	67	73
March	86	85	97	86	70
April	57	74	92	70	73
May	63	77	75	87	83
June	67	66	65	75	86
July	83	72	90	92	75
August	85	63	72	73	78
September	73	64	80	77	-
October	63	78	73	83	-
November	75	71	75	68	-
December	88	93	72	67	-
Total	883	899	940	933	621

Table 2 Gender and age group

	Full year				1 January to 31 August				
	2020	2021	2022	2023	2020	2021	2022	2023	2024
Total	883	899	940	933	584	593	640	638	621
Under 18	29	30	24	23	21	25	20	16	10
18-24	95	78	76	84	71	58	49	58	34
25-34	164	165	160	147	109	112	106	111	97
35-44	131	162	179	164	91	99	112	112	117
45-54	167	150	166	181	106	95	119	123	123
55-64	132	126	163	160	83	78	119	109	108
65-74	78	86	84	91	48	56	55	56	70
75-84	49	62	58	59	27	43	38	40	37
85 plus	38	40	30	24	28	27	22	13	25
Female	222	231	210	203	136	163	146	139	143
Under 18	9	15	10	9	6	14	9	8	4
18-24	18	20	21	20	11	18	16	16	4
25-34	41	36	39	33	26	25	25	23	28
35-44	32	46	37	45	19	29	26	31	19
45-54	46	39	33	34	28	27	23	25	26
55-64	33	29	35	29	17	19	25	18	26
65-74	20	22	16	17	13	12	10	10	24
75-84	13	13	11	9	9	12	8	5	7
85 plus	10	11	8	7	7	7	4	3	5
Male	661	668	729	730	448	430	493	499	478
Under 18	20	15	14	14	15	11	11	8	6
18-24	77	58	55	64	60	40	33	42	30
25-34	123	129	120	114	83	87	80	88	69
35-44	99	116	142	119	72	70	86	81	98
45-54	121	111	133	147	78	68	96	98	97
55-64	99	97	128	131	66	59	94	91	82
65-74	58	64	68	74	35	44	45	46	46
75-84	36	49	47	50	18	31	30	35	30
85 plus	28	29	22	17	21	20	18	10	20

Table 3 Location of usual residence

	Full year				1 January to 31 August				
	2020	2021	2022	2023	2020	2021	2022	2023	2024
Greater Sydney	464	438	524	478	292	287	358	332	324
Rest of NSW	409	455	404	431	284	303	274	285	287
Overseas/ Interstate	9	6	10	21	7	3	6	18	9
Total	883	899	940	933	584	593	640	638	621

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 2020, 2021, 2022, 2023 and 2024 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 2020, 2021, 2022 ,2023 and 2024	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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