

PLYMOUTH SUICIDE AUDIT – SUMMARY

Deaths registered 2021 to 2023



Author: Office of the Director of Public Health, Plymouth City Council

Date: January 2025 (v1.0)

This document is produced as part of Plymouth's Joint Strategic Needs Assessment.

Document information

Document status	Draft
Author	Office of the Director of Public Health
Document version	V1.0
Original document date	January 2025

Amendment record

Version	Date	Reason(s) for change	Pages affected

Office of the Director of Public Health
Plymouth City Council
Crownhill Court
Plymouth
PL6 5DH
Tel: 01752 307346
odph@plymouth.gov.uk

Date: January 2025 (v1.0)

Prepared by: Office of the Director of Public Health
For queries relating to this document please email: odph@plymouth.gov.uk

Acknowledgements: We are grateful to those colleagues and partners who have contributed to this report. In particular, the Public Health Team wishes to thank the following agencies and individuals for supporting the local suicide audit process: HM Coroners Office, General Practitioners, Graham Burton (Clinical Risk Advisor, Livewell Southwest) and Justin Whyatt (University Hospitals Plymouth NHS Trust).

Plymouth Suicide Audit – Summary

Based on deaths registered in 2021, 2022 and 2023

Deaths by suicide and undetermined intent

Purpose and focus

This report provides a city-wide overview of the deaths of Plymouth residents by suicide and undetermined intent. It updates the information provided in our previous report covering 2020 to 2022.¹ Local suicide audits are undertaken to monitor local trends and to compare these with national data, and also to support suicide prevention initiatives. The Plymouth Suicide Prevention Strategic Partnership, a multi-agency group led by Plymouth City Council, has responsibility for suicide prevention in the city.

Deaths of Plymouth residents are included in this audit whether they died in Plymouth or elsewhere in the UK. The information presented refers to the deaths of residents (aged 10 years and older) registered during calendar years 2021, 2022 and 2023. However, not all of these deaths will have occurred during these three years as deaths by suicide and undetermined intent are registered only after an inquest has taken place.

Definition of suicide

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their own life (using a lower civil standard of proof,² from mid-2018). Deaths that are ‘undetermined’ are where the coroner at inquest reaches an open or

narrative verdict because the intention of the person is uncertain. The Office for National Statistics currently defines as suicide ‘all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over’.³

Audit process and data sources

Our local suicide audit process involves monitoring all deaths where the coroner has given a conclusion of suicide, or an open or a narrative conclusion. During the year information is collected from weekly death registrations, from the Primary Care Mortality Database, and from HM Coroners Office.

Deaths included in this audit have been checked and verified using mortality data for Plymouth residents provided by NHS Digital. Deaths from suicide are confirmed using the International Classification of Diseases (ICD10) codes X60-X84 (‘intentional self-harm’) and deaths from undetermined intent are identified using ICD10 codes Y10-Y34, excluding Y33.9 (‘event of undetermined intent’).⁴

Information on the trend in mortality rates is drawn from the Public Health Outcomes Framework and the Health Profiles produced by the Office for Health Improvement & Disparities.

Number of deaths 2021, 2022 & 2023

- 60 deaths in total: 51 Plymouth residents died by suicide and 9 residents died by undetermined intent (UI)
- More deaths were registered in 2021 than in 2022 or in 2023 (28 deaths in 2021 compared to 20 deaths in 2022 and 12 deaths in 2023)

- for males it is 13.4 deaths per 100,000 population aged 10+ (in line with the England rate of 16.4)
- for females it is 3.7 deaths per 100,000 population aged 10+ (in line with the England rate of 5.4)
- Trends in mortality rates from 2002 to 2023 are shown in the chart (below)

Average number & rates

- The average number of deaths per year from 2003 to 2023 is 23
- The directly age-standardised mortality rate for the period 2021 to 2023 for persons is 8.4 deaths per 100,000 population aged 10+ (in line with the England rate of 10.7)

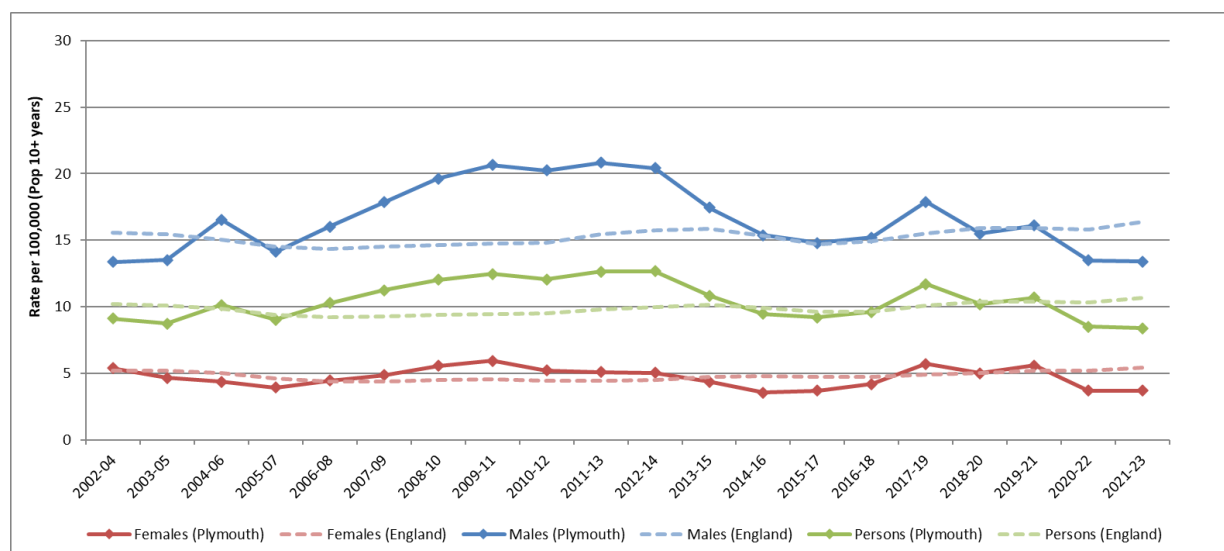
Sex differences

- 46 males and 14 females died (just over three times as many males than females)
- 12 females died by suicide and 2 by UI
- 39 males died by suicide and 7 by UI

Place of birth

28 people who died were born in Plymouth, 22 were born elsewhere in the UK, and 10 were born outside the UK.

Trends in mortality from suicide/ UI, England & Plymouth, 2002-04 to 2021-23



Source: Suicide Prevention Profile (January 2025)

Delay in registration for suicide

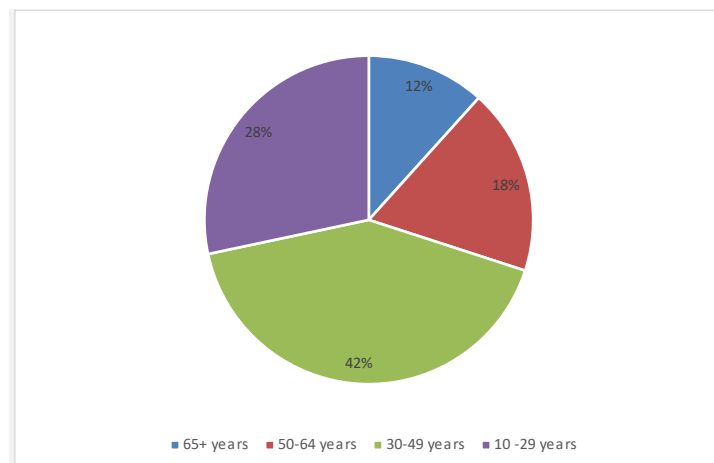
- Across the last few years in Plymouth the delay in registration has increased i.e. the time between date of death and a suicide conclusion at the coroner's inquest. For suicide deaths that were registered in 2023 Plymouth has one the longest delays in the country with a median delay of 566 days compared to 199 for England.⁵

Age groups

- 17 people who died were younger than 29
- 7 people who died were older than 65
- The majority of those who died were below the age of 50

Place of death

- 28 people died at home and 18 died elsewhere in the city
- 7 people had their place of death noted as Derriford Hospital
- 7 Plymouth residents died outside the city



Source: NHS Digital

Plymouth Suicide Audit summary reports present data for deaths registered in particular calendar years combined for three-year periods. This enables comparisons to be made with national mortality data which is also presented by year of registration. Death by suicide/ UI is a rare event in Plymouth and the numbers of deaths fluctuate from year to year.

Where they lived

Death by suicide and undetermined intent is a concern across the city:

- 19 of the 20 wards in the city had at least one resident die by suicide/ UI**

Four wards had the highest number of residents die by suicide/ UI: 'St Peter & the Waterfront' (9 deaths) followed by 'Budshead' (6 deaths), 'Stoke' (6 deaths) and 'Sutton & Mount Gould' (5 deaths in each ward). There were no deaths by suicide/ UI in one ward.

Note: For information one undetermined intent death is not included in this report as their age is below ONS definition of 15+.

References

- Hoad, S. (2024) Plymouth Suicide Audit Summary (2020-2022). Plymouth City Council: ODPH.
- Office for National Statistics (2019): Suicides in the UK: 2018 registrations.
- Office for National Statistics (2020): Suicides in England and Wales: 2019 registrations.
- World Health Organisation (2010) International Statistical Classification of Diseases and Related Health Problems, 10th Revision. Geneva: WHO.
- Office for National Statistics (2024): Suicides in England and Wales by local authority.