

PLYMOUTH SUICIDE AUDIT – SUMMARY

Deaths registered 2022 to 2024



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Plymouth Suicide Audit – Summary

Based on deaths registered in 2022, 2023 and 2024

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 2021 to 2023.¹ 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 2022, 2023 and 2024. 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 2022, 2023 & 2024

- 49 deaths in total: 44 Plymouth residents died by suicide and 5 residents died by undetermined intent (UI)
- More deaths were registered in 2022 than in 2023 or in 2024 (20 deaths in 2022 compared to 17 deaths in 2024 and 12 deaths in 2023)

- for males it is 10.9 deaths per 100,000 population aged 10+ (lower than the England rate of 16.8)
- for females it is 2.9 deaths per 100,000 population aged 10+ (lower than the England rate of 5.5)
- Trends in mortality rates from 2003 to 2024 are shown in the chart (below)

Average number & rates

- The average number of deaths per year from 2004 to 2024 is 23
- The directly age-standardised mortality rate for the period 2022 to 2024 for persons is 6.8 deaths per 100,000 population aged 10+ (lower than the England rate of 10.9)

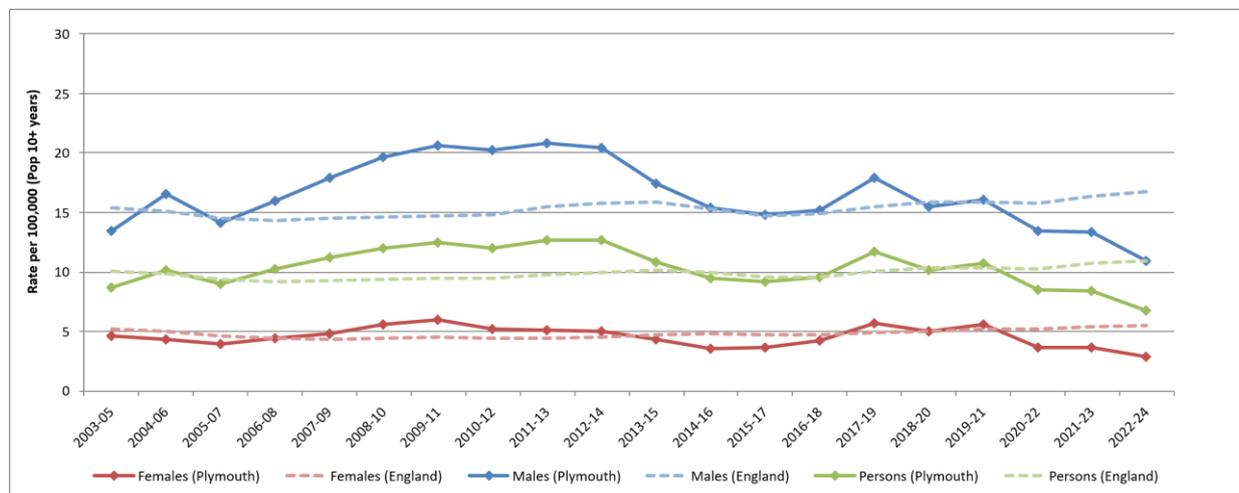
Sex differences

- 38 males and 11 females died (just over three times as many males than females)
- 11 females died by suicide
- 33 males died by suicide and 5 by UI

Place of birth

- 19 people who died were born in Plymouth, 21 were born elsewhere in the UK, and 8 were born outside the UK.

Trends in mortality from suicide/ UI, England & Plymouth, 2003-05 to 2022-24



Source: Suicide Prevention Profile (January 2026)

Delay in registration for suicide

- Across the last few years in Plymouth the delay in coroner 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 2024 Plymouth has one the longest delays in the country with a median delay of 698 days compared to 199 for England.⁵

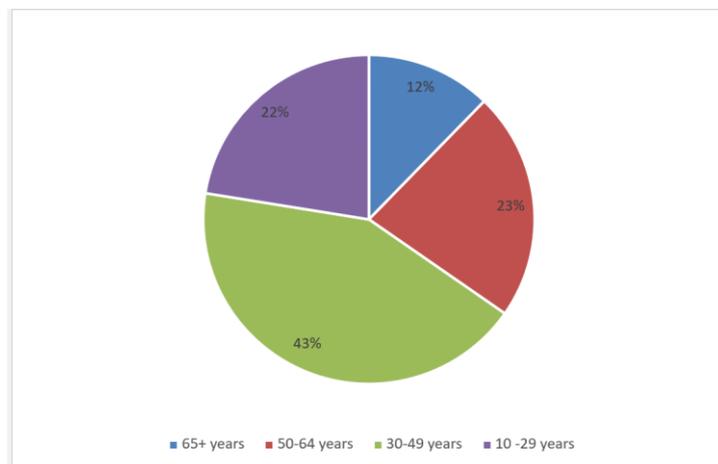
- The increasing coroner registration delay is likely to artificially be reducing the official suicide statistics for Plymouth
- They delay has been due to an inherited backlog by the Coronial Service. The Coroner services for Plymouth, Torbay and Devon merged into a single County of Devon Coroner area as of April 1, 2024.

Age groups

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

Place of death

- 27 people died at home and 11 died elsewhere in the city
- 4 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:

- **18 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’ (8 deaths) followed by ‘Stoke (5 deaths), and ‘Drake (5 deaths). There were no deaths by suicide/ UI in two wards.

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

References

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