Submission to Senate Inquiry into Suicide in Australia

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Executive Summary

This submission addresses the issues surrounding:

the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, and the consequences of any under-reporting on understanding risk factors and providing services to those at risk;

Based on our experience in managing and maintaining the NCIS, we believe the following factors may contribute to the under-reporting of possible suicides in Australia.

a) Non-standard collection of information by police when reporting a death
b) Coronial determinations of Intent
c) Recording of intent on the NCIS
d) ABS coding practices
e) Reluctance to use initial investigatory information to identify "possible/probable suicides"

It is hoped the recommendations proposed in this submission will go some way to reducing the impact of some of these factors and enhance the accuracy of the identification and recording of suicides in Australia. The recommendations made in this submission include:

- National implementation of the standardised police form to report a death to a coroner
- Amending Coroner's Acts in each State/Territory to include a requirement for Coroners to consider the intent surrounding a death.
- Professional education for Coroners about their role in the recording of accurate suicide statistics.
- More real-time entry of the *Intent Notification* field on the NCIS
- Research to be conducted to determine of reliability of initial "Intent at Notification" coding.
- A clearer, agreed distinction made about the terms "intentional self harm" and "suicide/intent to die"
- Intent coding performed in the absence of a clear coronial statement to be clearly identified, compared to those based on coronial decisions.
- An increase in resources to be provided for Coroners' Offices which undertake NCIS coding to allow improved timeliness of data entry on the NCIS.
- Support for the recent decision by ABS to implement a revision process for Australian Cause of Death statistics.

1. Background

The National Coroners Information System (NCIS) is a database which contains information concerning every death reported to a coroner in Australia since 1 July 2000.[1]

Based on standardised coding performed at Coroners' Offices around Australia, authorised users of the NCIS are able to view details about deaths reported to a coroner using a web based interface. This national collection of death data allows for the identification of mortality trends and patterns, and permits the examination of circumstances surrounding preventable death, which can lead to the formation of evidence based injury prevention initiatives.

One of the fields collected within the NCIS pertains to the "intent" surrounding a fatality. Coded only when a death is deemed to be from non-natural causes, intent allows for an indication as to whether the death was considered to be from unintended circumstances ("Unintentional"), from an Intentional Act by the deceased or others ("Intentional Self Harm" [2] or "Assault") or other scenarios.

Prior to the NCIS, only Australian Bureau of Statistics (ABS) mortality data indicated the frequency of suicide deaths in Australia on a national scale. As ABS mortality data is not compiled until 13 months after the period in question, and published at 15 months (i.e. latest available ABS mortality data relates to 2007) the NCIS offers an opportunity for more timely review of suspected and confirmed suicides within the Australian community. Importantly, the NCIS also provides detailed coded and narrative information on demographics, location, mechanism and circumstances of death. With police, medical, scientific (autopsy, toxicology reports) and coronial reports also attached to the system wherever possible, the NCIS is proving to be a popular tool for government and researchers to examine the nature, frequency and rate of suicide in Australia.

However there are currently significant limitations in collecting uniform and accurate data about suicide deaths reported to a coroner. This submission will therefore focus on the second point of reference of the Senate Inquiry into Suicide in Australia that NCIS most clearly relates to, namely:

the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, and the consequences of any under-reporting on understanding risk factors and providing services to those at risk;

[1] Queensland data commences from 1 January 2001.

[2] A reference to Intentional Self Harm on the NCIS essentially correlates to the concept of "suicide". The difficulty surrounding interchangeable use of these terms (and the lack of specific definitions to distinguish them from each other) is noted later in this submission.

2) The accuracy of suicide reporting in Australia

Likely under-reporting of the number of deaths arising from suicide has come to the attention of the mortality research community over the past few years[3]. In part, this was caused by a noticeable decrease in the number of deaths classified as suicide in the national statistics compiled by the Australian Bureau of Statistics from 2002, with a comparable increase in the number of deaths associated with an "Accidental/Unintentional" event (AIHW, 2009).

Recent estimates report that the annual suicide figure may be under-reported by up to 16% nationally (equating to 348 deaths) based on examination of deaths reported to a coroner in 2004 (AIHW, 2009). This is based primarily on an examination of difference between ABS published figures (where at the time of compilation not all information about every death is available), and later figures obtained from the NCIS (where additional data had since been added to the system). While a delay in the ABS obtaining complete data about all deaths reported to a coroner is a significant factor in the accuracy of production of suicide statistics, it is not the only factor. It therefore may follow that under-reporting of the number of suicide deaths is even greater than the 16% estimate indicated in the AIHW report.

3) Factors that may impede accurate identification and recording of possible suicides

We believe there are several factors currently impeding accurate identification and recording of possible suicides. These are outlined below.

f) Non-standard collection of information by police when reporting a death
g) Coronial Determinations of Intent
h) Recording of intent on the NCIS
i) ABS coding practices
j) Reluctance to use initial investigatory information to identify "possible/probable suicides"

a) Non-standard collection of information by police when reporting a death

Unfortunately there is not yet a nationally uniform approach towards reporting suspected suicide deaths to a coroner by police. Until recently, every State/Territory had their own police death reporting form, and many of these forms did not contain a standard indication if the death was a suspected suicide (and/or allow for the consistent collection of supporting information to assist the investigators with this assessment). Police members (who may be attending their first fatality) were left to use their own judgement

[3] For example: De Leo (2007); LifeLine Australia (2009); AIHW (2009)

about what information may be relevant for collection and reporting. This has led to a wide variation in the quality of information available to death investigators in the coronial system to conclude whether a death was the result of an intentional act of self-harm.

In recent years, efforts to standardise the police notification of death forms have been partially successful, with four of the eight States/Territories using a version of a standard form to report a death to the coroner[4]. To date, Western Australia, South Australia, the Northern Territory and Victoria are yet to implement a version of this form, however efforts and/or undertakings to use a version of the form have been made from most of these jurisdictions.

We believe uniform adoption of this national form would provide more consistent identification by police to pathologists and coroners of suspected suicide deaths, as well as collecting standard information surrounding the background of the deceased, and reasons for the suspicion of suicide. The increased amount and consistency of information relating to suspected suicides may make the task of determining whether a suicide has occurred more straightforward, and will contribute to the amount of information available for later research about characteristics and risk factors surrounding suicide.

Recommendation:

- Jurisdictions which are not yet using a version of the standardised form to report a death to police, implement the form as soon as possible.
- There be a regular assessment of the fields contained on the standard form for death reporting to ensure the information collected remains relevant and appropriate.

b) Coronial Determinations Of Intent

i) Coroners are not required to make a determination as to the intent of the deceased

Coroners are presently the only legal entity who make a formal determination as to whether a death was a suicide. If such a determination is made, a statement will be made by the Coroner in their finding or similar document. However none of the Coroners' Acts in the eight States/Territories requires a Coroner to make a specific determination about the intent surrounding a death. The three major components specified in the Acts which are legislatively required to be determined by a coroner are i) identity, ii) date/location of death and iii) how the person died/cause of death. It is the individual interpretation by each Coroner surrounding the scope of the third element (being the manner/cause of death) as to whether the "intent" surrounding the death is a factor that should be referenced in their finding.

[4] In 2000, the development of a national, standardised police form to report a death to a coroner was proposed and developed with a range of stakeholders, and funded by the Australian Department of Health and Ageing (see Appendix 1).

Some coroners currently believe they are either precluded from making a statement as to whether a death was a suicide, or they prefer to be silent on the matter (due to family concerns or the impact such a decision may have on life insurance claims etc.) Therefore there is currently lack of uniformity as to determination of intent within coronial findings around Australia.

It is suggested that legislative change could be combined with professional education for coroners, to reinforce the important role they have in ensuring accurate identification of suicide deaths within the community, and the means to make this finding. This would hopefully avoid only technical compliance with any legislative changes (e.g. a standard statement of "the intent of the deceased is unknown") which would not be of any additional assistance in identifying possible suicide deaths.

Recommendation:

An amendment to Coroners Acts in each State/Territory be considered to require a determination about intent be made in a coroner's finding[5] combined with professional education for coroners about the importance of their suicide determinations.

ii) The legal test applied by Coroners before they will determine a deceased intended to take their own life.

As a rule, coroners adhere to the principles outlined in the "Briginshaw test" when considering the standard of proof required to make a determination of suicide.

The "Briginshaw test" implies that when matters to be determined are of a serious nature, they should be made on the "upper scale" of the balance of probabilities (Freckleton & Ranson, 2006). As a determination of suicide can have significant ramifications emotionally and legally for the family of a deceased, most Coroners will expect a reasonable degree of evidence pointing to such a circumstance before they will make a finding of suicide.

This test of probability can result in some instances where it is "possible" that a suicide occurred although was not determined as such by a coroner, with a statement such as "I am unable to determine whether the deceased intended to take their own life" seen in some coronial findings.

Particular causes of death may result in a determination as to suicide being less often made by Coroners, due to the inherent nature of these deaths. In cases of drug overdose/toxicity, it is often problematic to determine whether the level and/or combination of drugs ingested was for "recreational purposes" or as a "suicide attempt".

[5] A determination could still be that with all due consideration and effort, the intent of the deceased is unable to be determined.

This may not be clear even in instances of excessive levels of drugs detected in individuals who may have an extensive history of drug taking and built up tolerance.

Single vehicle collisions where the deceased driver was the only occupant, with no evidence of braking can also be difficult to separate between a possible loss of consciousness due to a medical condition or fatigue, or a deliberate intention to crash the vehicle.

In contrast, particular causes of death are more confidently determined to be suicides such as hangings, motor vehicle exhaust poisonings or suffocation due to plastic bag asphyxiation.

iii) Length of time of coronial investigation

The length of time for a coronial investigation to be completed can vary considerably, depending on a number of factors such as whether it is determined an inquest will be held, the depth of investigation undertaken by the coroner, general coronial workload, and possible delays in obtaining statements and reports or briefs from relevant parties.

As an example of the period of time coronial investigations can take, Table 1 indicates around 58% of investigations into intentional harm deaths reported to coroner nationally in 2007 took more than 6 months (180 days) to be completed.

Table 1. Length of coronial investigation (nationally) for deaths reported in 2007 that were classed on the NCIS as involving intentional self harm

Time between coronial notification and finding (days)	% Intentional Self Harm Deaths Reported to a coroner in 2007
Less than or equal to 90 days	8.1
Between 91 to 180 days	32.5
Between 181 to 360 days	40.8
Between 361 and 720 days	16.4
Greater than 720 days	2.2

While the appropriate depth and length of investigation into death may not be possible to streamline or curtail without sacrificing a quality investigation into death, this factor does influence the availability of timely statistics about the number of deaths due to suicide (as coronial findings are the optimal manner in which a finding of suicide is to be determined).

c) Recording of intent on the NCIS

The processes and timeliness surrounding the recording of intent on the NCIS have a significant impact on the ability to record deaths classed as suicide within the official national statistics (via ABS) and for other government entities and researchers.

Since 2006 the ABS has used the NCIS as its primary source of information for assigning causes of death (and intent) for fatalities reported to a coroner, so any delays within the coronial system or in NCIS processes will affect ABS reporting.

i) Lack of completion of Intent Notification field

There are two fields on the NCIS that pertain to the intent of the deceased– *Intent Notification*, and *Intent Completion. Intent Notification* is designed to be completed at the time the death is first reported to a coroner, based on the initial information available (i.e. the police notification of death form) as to the circumstances of death. This field was included on the NCIS to allow timely data collection as to the prevalence of "suspected" suicides, without the need to wait until all coronial findings are completed. Use of this information would permit early identification of trends and patterns concerning suicide (acknowledging this initial determination may be subject to change).
The *Intent Notification* field however is not currently populated by some Coroners' Offices on the NCIS until the investigation has been completed with the coroner. This therefore reduces the ability of the *Intent Notification* field to inform timely pattern or trend identification regarding suspected suicide.

ii) When Coroners are silent on intent, or it is unclear if the deceased intended to die

Populating the *Intent Completion* field on the NCIS is relatively straightforward when a Coroner has made a determination about intent in their finding (e.g. "the deceased intended to take their own life" would be coded as "Intentional Self Harm").[6] Coding becomes more problematic when no statement is made by the coroner about the intent of the deceased. As noted earlier, coroners are not currently required to make a determination about the intent of a deceased in their finding, though this is subject to interpretation.

In the cases where no statement as to intent has been made by a coroner, a conservative process of assigning intent has to be undertaken by the coronial clerks entering the codes on NCIS. Essentially, in the absence of a coroner's statement about intent, a death will only be assigned as "Intentional Self Harm" if a suicide note was located, or the method of death is clearly indicative of an intentional act, *and no suspicious circumstances are noted* e.g. motor vehicle exhaust poisoning, hanging, shot gun injury to head. This current method of determination of intent is ultimately unsatisfactory, as it places the onus of determination for suicide on a coronial clerk, and only allows for capture of the most unambiguous self harm events. Yet this type of judgement has been required to avoid a situation of further under-reporting of suicides, which would occur if coding were based solely on instances where a coroner had clearly indicated an intent by the deceased to take their own life in a finding.

[6] The NCIS does not use the term "suicide", as the values for the Intent field are based upon the International Classification for External Cause Injury (or ICECI), which uses the term "Intentional Self Harm."

To illustrate this point, in an informal review of almost 1,000 coronial findings into non-natural deaths conducted by the NCIS Unit, it was found that 29% of findings had no mention of intent made by the coroner.

Furthermore of the cases coded as Intentional Self Harm on the NCIS, 39% did not have any determination of intent made within the coroner's finding, despite the fact the majority of these deaths resulted from hanging or motor vehicle exhaust poisoning (NCIS, 2008).

To better identify which determinations have been made by coroners in their findings, and those made by coronial clerks based on relevant guidelines, separate fields could be used to code these two possibilities I.e. Coroners Determination as to Intent; Likely Intent (where non-coroner).

A further difficulty for coding intent can occur when a coroner states the deceased engaged in self-harm behaviour, yet it cannot be determined the deceased intended to die/take their own life. This scenario can be particularly pronounced in cases where the deceased is young, or may have a mental impairment which creates concern about the deceased's ability to understand the full ramification of their actions. At present, the code "Intentional Self Harm" does not adequately reflect such a finding by a coroner (as despite the coroner determining intentional self harm did occur, the criteria to classify it as "suicide" has not been reached. This would not be of concern, except it is known the code "intentional self harm" will be directly interpreted to equate to suicide by researchers). Accordingly, such a scenario will often be coded as "Unintentional", "Undetermined Intent" or "Unlikely to be Known" on the NCIS, to reflect the coronial comment about the inability to confirm a desire to die. This of course means this death will not be included in traditional suicide statistics, which is problematic.

In circumstances where there is a statement by a coroner that a deceased "intentionally hung themselves" with no other statement about intent to die, an intent to die will be assumed and the death be coded as "intentional self harm."

iii) Backlog with NCIS coding

Assignment of the *Intent Completion* field on the NCIS cannot be undertaken until the coronial investigation has been completed. However there are a number of Coroners' Offices which have significant backlogs in terms of coding data onto the NCIS once an investigation has been completed. This occurred most notably in New South Wales, Victoria and Queensland during 2008-09.[7]

The implications of a delay in completing the coding on the NCIS for cases which have been finalised by the Coroner is that the ABS (and other researchers) are not able to access the final intent determination surrounding fatalities, and/or the full text reports that

[7] During 2008-09, the percentage of cases closed on the NCIS/Local Coroners' Systems within 60 days of the coroner completing their finding was 8% in Queensland, 26% in Victoria and 31% in New South Wales.

are attached to each case. For researchers using the NCIS to examine suicide deaths (and the circumstances surrounding them) this delay can significantly hamper their ability to identify possible risk factors or trends in a timely manner.

Recommendations:

- Coronial Offices are encouraged to populate the *Intent Notification* field on the NCIS to allow initial analysis of suspected suicides in a timely manner (this may be possible via the uploading of data from the police notification of death form, once this is in use by the jurisdiction)
- A clearer, agreed distinction be made about the terms "intentional self harm" and "suicide/intent to die" by communities/researchers associated with compiling or interpreting suicide statistics, with this distinction able to be applied both to findings made by Coroners, and the NCIS coding of intent.
- Consideration of separate intent coding on the NCIS in the absence of a clear coronial statement in the finding, based on nationally/internationally agreed guidelines.
- An increase in resources to be provided for Coroners' Offices which undertake NCIS coding to allow improved timeliness of data entry on the NCIS.

d) ABS coding practices

As noted above, since 2006 the Australian Bureau of Statistics (ABS) has used the NCIS as its primary source of information for coding causes of death for cases reported to a coroner.

This reliance on the NCIS, combined with a more stringent interpretation of the international coding guidelines applied to data coded to ICD-10, the time period involved in completing some coronial investigations, and delayed data entry on the NCIS, is believed to have significantly impacted upon the accurate recording of suicides in Australia by ABS over the past few years.

i) Coding of cases still open on the NCIS

The ABS assigns cause of death codes based on ICD-10 (International Classification of Diseases, Version 10) for all deaths registered with Births, Deaths and Marriages over a particular period. If the information on deaths that have been reported to a coroner are incomplete at the time of coding (either due to the death still being under investigation and/or open on the NCIS), the ABS will code the cause of death associated with this case based on the information that is available.

The difficulty surrounding this practice for open cases often relates to the classification of intent. If a case is still open on the NCIS, but the *Activity at Incident* field is coded as "Self Harm", the *Intent Notification* field indicates Intentional Self Harm, or the attached information indicates a likelihood of suicide, the ABS will assign an Intent of "Intentional Self Harm".

The intent on these cases therefore has the potential to change once the coronial investigation and coding is completed on the NCIS. Until recently however, such changes were not revisited or updated in the ABS mortality statistics.

Recent changes in ABS practice in this regard however have been well received, and should reduce the impact of such practices over time.

In the 2007 ABS Cause of Death Report, it is noted that all coroner certified deaths registered after 1 January 2007 will be subject to a revision process. The revision process will enable the use of additional information relating to coroner certified deaths as it becomes available over time resulting in increased specificity of the assigned ICD-10 codes (ABS, 2009, Technical Note 1, page 76).

This will thus allow the change in assignment of intent codes from unintentional to intentional, should the coronial investigation and/or NCIS coding on cases that were originally not completed on the NCIS, to reflect such a determination. Revision of ICD-10 codes for non-natural deaths will be performed for up to 3 subsequent years from the initial Cause of Death reference period, to allow for the sometimes lengthy period of a coronial investigation to be completed and/or any backlog in NCIS coding to be processed by the Coroners' Offices.

ii) Previous assignment of open cases without a determined intent to "unintentional"

According to ICD-10 coding rules, to classify a death as a suicide, specific documentation from a medical or legal authority must be available regarding both the self-inflicted nature and suicidal intent of the incident. When there is no information to indicate the death was intentional, as a default the death then should be coded to accidental (ABS, 2007).

The ABS has recently announced a change to this practice, so that when information about intent is not yet available when first classified by ABS, an assignment of "Undetermined" rather than "Unintentional" will be made (ABS, 2009, Technical Note 1, page 76). This should help reduce confusion when interpreting ABS Cause of Death statistics in future, concerning the proportion of deaths which genuinely occurred in an unintentional setting, as compared to those which were classified as unintentional only due to a lack of information about intent on cases still under investigation or open on the NCIS.

Recommendation:

To support the recent decision by ABS to implement a revision process for Australian Cause of Death statistics , and to change the default intent code for open cases with an unspecified intent from "Unintentional" to "Undetermined".

e) Reluctance in using initial investigatory information to identify "suspected suicides" or non-coronial determinations

At present, there is a concern by some parties that provision of information to researchers based on an initial assessment as to likely intent surrounding a death may prove to be misleading or incorrect once a coronial determination has been made.

It could be argued that an initial assessment as to "suspected suicides" could at least provide a guide to current trends or patterns occurring surrounding such instances in the community, which could later be revised/confirmed once coronial investigations are complete.

It would be a matter for research to determine whether the initial assessment made by police upon notification is generally reliable enough for these purposes, or whether a more detailed review of each death at notification would need to be undertaken by an appropriate group/unit (using nationally agreed criteria) to ascertain whether the death could reasonably be judged a "suspected suicide."

A similar process could be undertaken at the completion of each death investigation, with the non-coronial determination captured in a separate field on the NCIS to that of the Coroner, to clearly delineate between the two sources of the finding as to intent. This process at completion of the death investigation would only be necessary if the coroner was silent on the issue of intent in the finding.

Recommendation:

Support for research to determine the reliability of initial intent notification codes which have been based on police notifications and/or initial clerk assessment.

If found to be unreliable as a future predictor of coronial or clerk findings as to intent; establish guidelines for the "determination of intent" (which could be applied by police; or coronial clerks).

If this is still unsuccessful after a trial period, consider establishing a standardised review process examining likely intent at the beginning and completion of a coronial investigation (by a group internal or external to the Coroners Office, using nationally agreed criteria) to obtain more consistently applied indications as to whether the death is a "suspected" or "possible" suicide.

4) The consequences of any under-reporting on understanding risk factors and providing services to those at risk

Particular factors outlined above may result in a higher level of under-reporting of suicide amongst certain States/Territories, or across particular mechanisms of death.

For example, if a particular State/Territory has interpreted their legislation and/or created a culture where coroners feel able to confidently make a determination as to intent (or to produce more detailed findings about death investigations), it may be easier to identify suicides for those States/Territories than for jurisdictions where such a culture is not present.

Similarly, in jurisdictions which do not currently use a version of the standard police form for reporting a death, death investigators may not always receive consistently detailed information from police to support a suspicion of a suicide. This could reduce the likelihood of a coroner being able to determine a death was a suicide (based on the high probability scale of the 'Briginshaw Test' used). A reduced amount of information collected in a consistent, searchable format about suspected suicides may also later limit the ability of researchers to identify risk factors for suicide.

The above may result in some States/Territories showing higher levels of suicide than others, which may not accurately reflect the real situation across jurisdictions.

Particular mechanisms of death may not be as clearly indicative of an intentional act as others (e.g. single occupant vehicle crashes, drug toxicity) which could influence the identification and reporting of suicide in these cases. This may flow on to more research and support initiatives being undertaken by the Suicide Prevention Community surrounding the more indicative methods of suicide, with a lesser focus on preventing or researching mechanisms of death where it is often unclear if the death is a result of intentional self harm.

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Appendix 1 – National Reporting Form Template (suspected suicide section only)

Section 13 – SUSPECTED SUICIDE

a) What evidence is there to indicate that the deceased intended suicide? (tick the relevant box(es))

☐ Statement to Family/Friends ☐ Statement to Health Professional

☐ Note / Letter ☐ Other (specify):

b)(i) Has the deceased previously attempted suicide? ☐ No ☐ Yes ☐ Unknown

b)(ii) If yes, approx number of times:

c)(i)Has the deceased previously been hospitalised for self harm? ☐ No ☐ Yes ☐ Unknown

c)(ii) If yes, approx number of times:

d) Is there any possible motive / trigger for the suicide? (tick the relevant box(es))

☐ Relationship Breakdown ☐ Sexual Abuse ☐ Financial Problems

☐ Loss of a Loved One ☐ Illness ☐ Prospect of Criminal Sanction

☐ Alcohol / Drug Dependency ☐ Unknown ☐ Other (specify)

e) Was deceased being treated / seen by any of the following professionals? (tick relevant box(es))

☐ General Practitioner ☐ Psychiatrist ☐ Psychologist ☐ Case Manager

f)(i) Was the death accompanied by the murder / suicide of other person(s)? ☐ No ☐ Yes

f)(ii) If yes, what was the relationship between the deceased and the person(s)?