Coroners Court of Victoria

Development of the Victorian Suicide Register to Advance Suicide Prevention

Lyndal Bugeja
Manager, Coroners Prevention Unit
Coroners Court of Victoria

Outline

Part 1:

- Coroners mandate to investigate suicide
- Recommendations to improve suicide data
- Coroners role and contribution to suicide prevention

Part 2:

- Development of the VSR
- Evaluation of the VSR
- Strengthening the investigation of suicide
- Future directions for the VSR

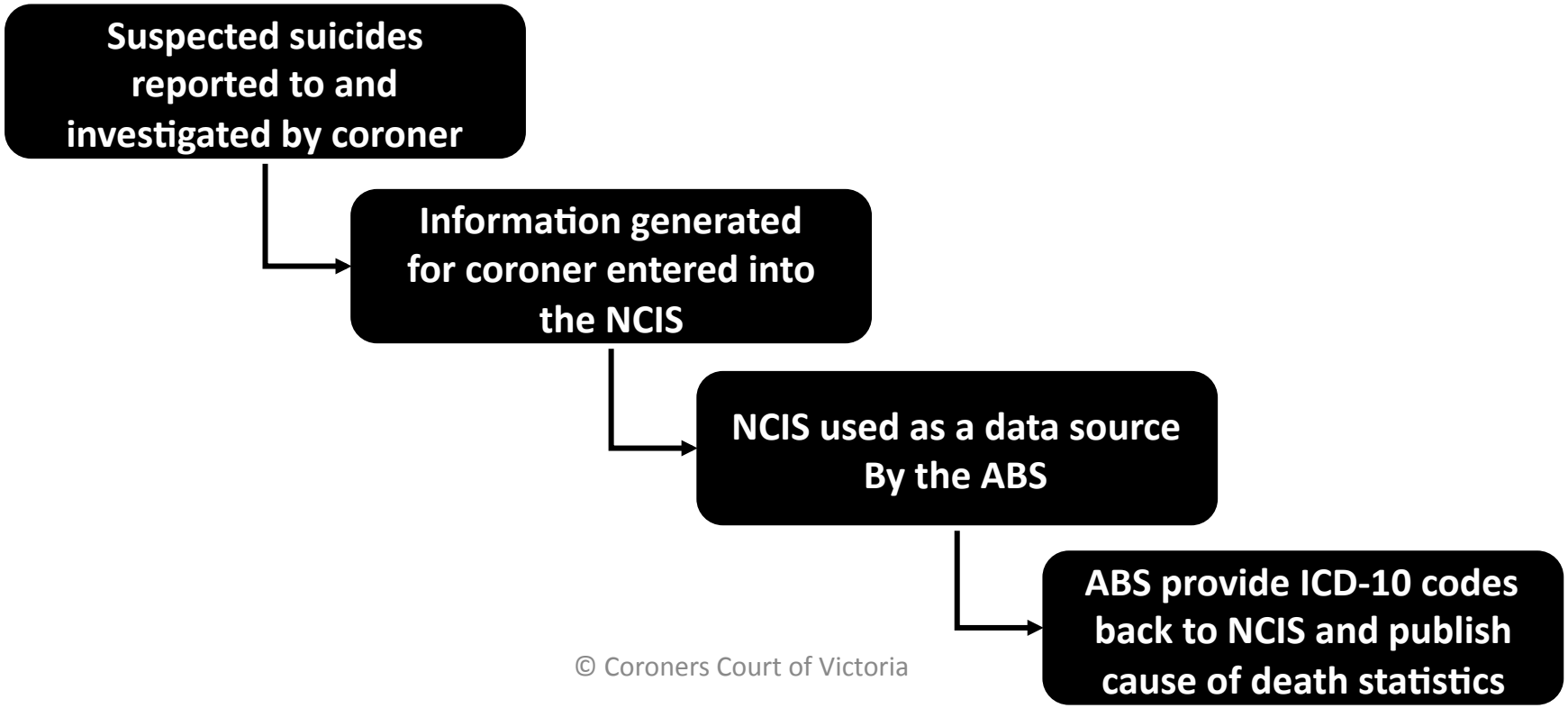
Part 1:
The Role of the Coroner in Suicide Prevention

Coroners Mandate to Investigate Suicide

- Coroners <u>must</u> investigate all suspected suicides

  *a death that appears to have been **unexpected**, **unnatural** or **violent** or to have resulted, directly or indirectly, from an accident or **injury***

- Coroners' findings form the basis of official mortality statistics



Coroners Mandate to Investigate Suicide

- Coroners must make a finding
- Coroners may make a finding with circumstances
- Coroners are not required to make a finding of intent
- Coroners may make recommendations on public health and safety
- Coroners determinations of the relevant circumstances, contributing factors and intent of the deceased is crucial for suicide prevention

Recommendations to Improve Suicide Data

- Recommendation 2: *[…] Commonwealth, State and Territory governments, in consultation with the National Committee for Standardised Reporting on Suicide, implement reforms to improve the accuracy of suicide statistics.*

  The Hidden Toll: Suicide in Australia, Senate Standing Committee on Community Affairs, Australian Government, 2010

- Implement the "National Police Form" in all jurisdictions

- Amend legislation to require coroners to include circumstances for suicide in their findings

- Amend coronial legislation to require coroners to include a determination of intent in their findings, either:
  - Unintentional
  - Intentional Self-Harm
  - Unable to be Determined

The Rationale for the VSR

- Recognition of the important role of Coroners in suicide prevention
- Prevention function of Coroners was elevated in Victoria
- Suicide most frequent request for Coroners Prevention Unit assistance by Coroners
- Existing datasets limited to completed cases and socio-demographic and death event variables
- Queensland Suicide Register shown to be valuable

The Rationale for the VSR

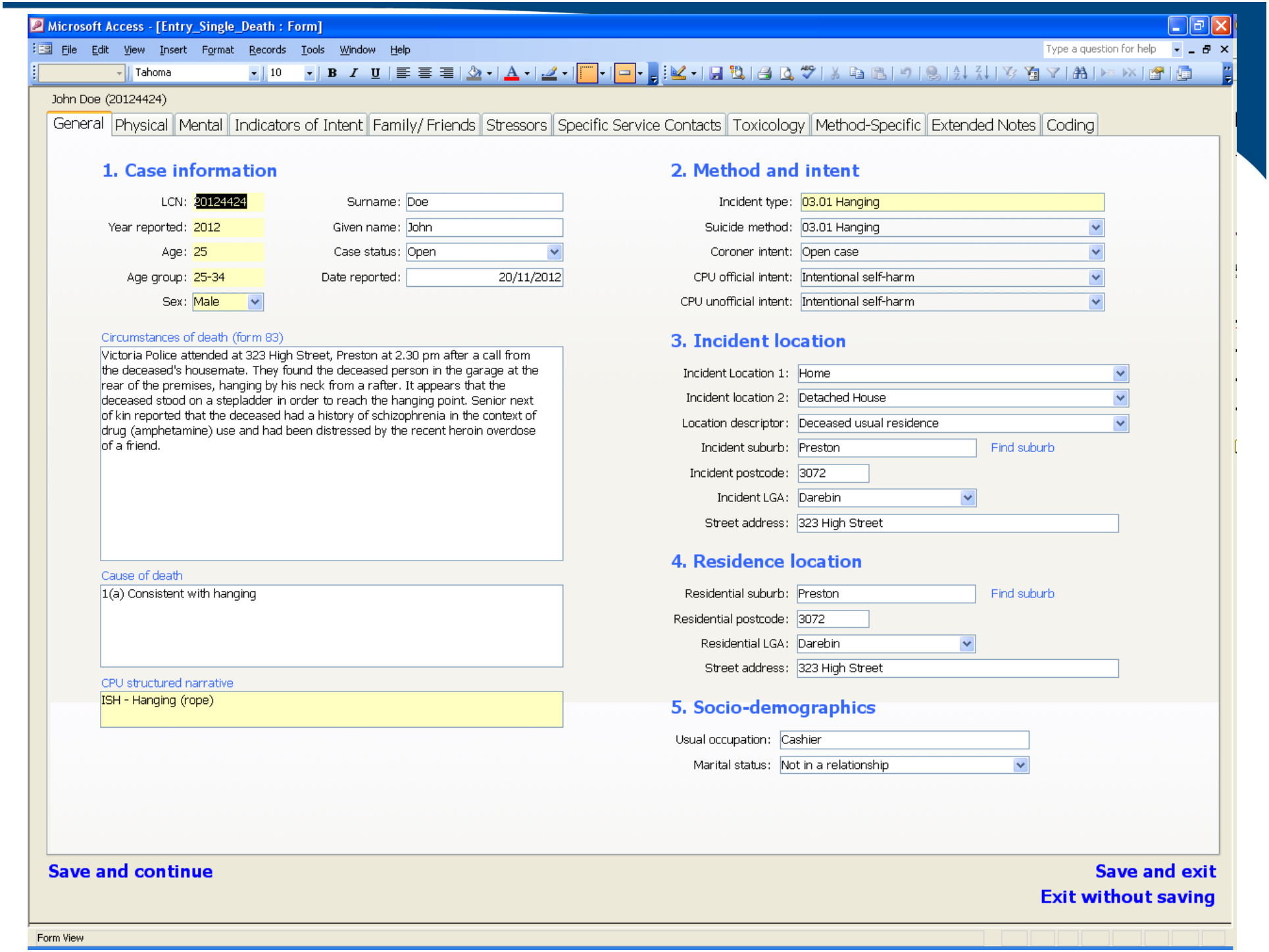
> 5. At present, much of the discussion on youth suicide prevention appears directed towards identifying *at risk* groups for targeted interventions. The CPU report carries a number of implications in this regard. For example, the research confirms that many known risk factors for youth suicide - including particularly mental illness, previously expressed suicidal ideation, exposure to traumatic events and experiences, and relationship breakdowns - appear to be commonly present amongst youth suicides in Victoria, but this does not substantially advance our ability to predict suicide. Every year, thousands of young Victorians suffer a mental illness, for example, or break up with a boyfriend or girlfriend, but do not suicide in response. There would be gains to public health and safety therefore, if youth suicide research could re-direct some focus beyond identifying and quantifying the presence of known risk factors, to understanding why one youth may suicide in circumstances where others do not.

Coroner Paresa Spanos, *Finding without Inquest into Death of B*, Case 20093651, published 10 August 2011

Part 2:
The Victorian Suicide Register

VSR Development

- Dataset development
- Information Technology Infrastructure
- Dataset refinement
- Socio-demographic data population
- Pilot coding
- Data Dictionary
- Quality Assurance Program


Microsoft Access - [Entry_Single_Death : Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Tahoma 10
John Doe (20124424)
General Physical Mental Indicators of Intent Family/ Friends Stressors Specific Service Contacts Toxicology Method-Specific Extended Notes Coding
1. Case information
LCN: 20124424
Year reported: 2012
Age: 25
Age group: 25-34
Sex: Male
Surname: Doe
Given name: John
Case status: Open
Date reported: 20/11/2012
Circumstances of death (form 83)
Victoria Police attended at 323 High Street, Preston at 2.30 pm after a call from the deceased's housemate. They found the deceased person in the garage at the rear of the premises, hanging by his neck from a rafter. It appears that the deceased stood on a stepladder in order to reach the hanging point. Senior next of kin reported that the deceased had a history of schizophrenia in the context of drug (amphetamine) use and had been distressed by the recent heroin overdose of a friend.
Cause of death
1(a) Consistent with hanging
CPU structured narrative
ISH - Hanging (rope)
2. Method and intent
Incident type: 03.01 Hanging
Suicide method: 03.01 Hanging
Coroner intent: Open case
CPU official intent: Intentional self-harm
CPU unofficial intent: Intentional self-harm
3. Incident location
Incident Location 1: Home
Incident location 2: Detached House
Location descriptor: Deceased usual residence
Incident suburb: Preston
Find suburb
Incident postcode: 3072
Incident LGA: Darebin
Street address: 323 High Street
4. Residence location
Residential suburb: Preston
Find suburb
Residential postcode: 3072
Residential LGA: Darebin
Street address: 323 High Street
5. Socio-demographics
Usual occupation: Cashier
Marital status: Not in a relationship
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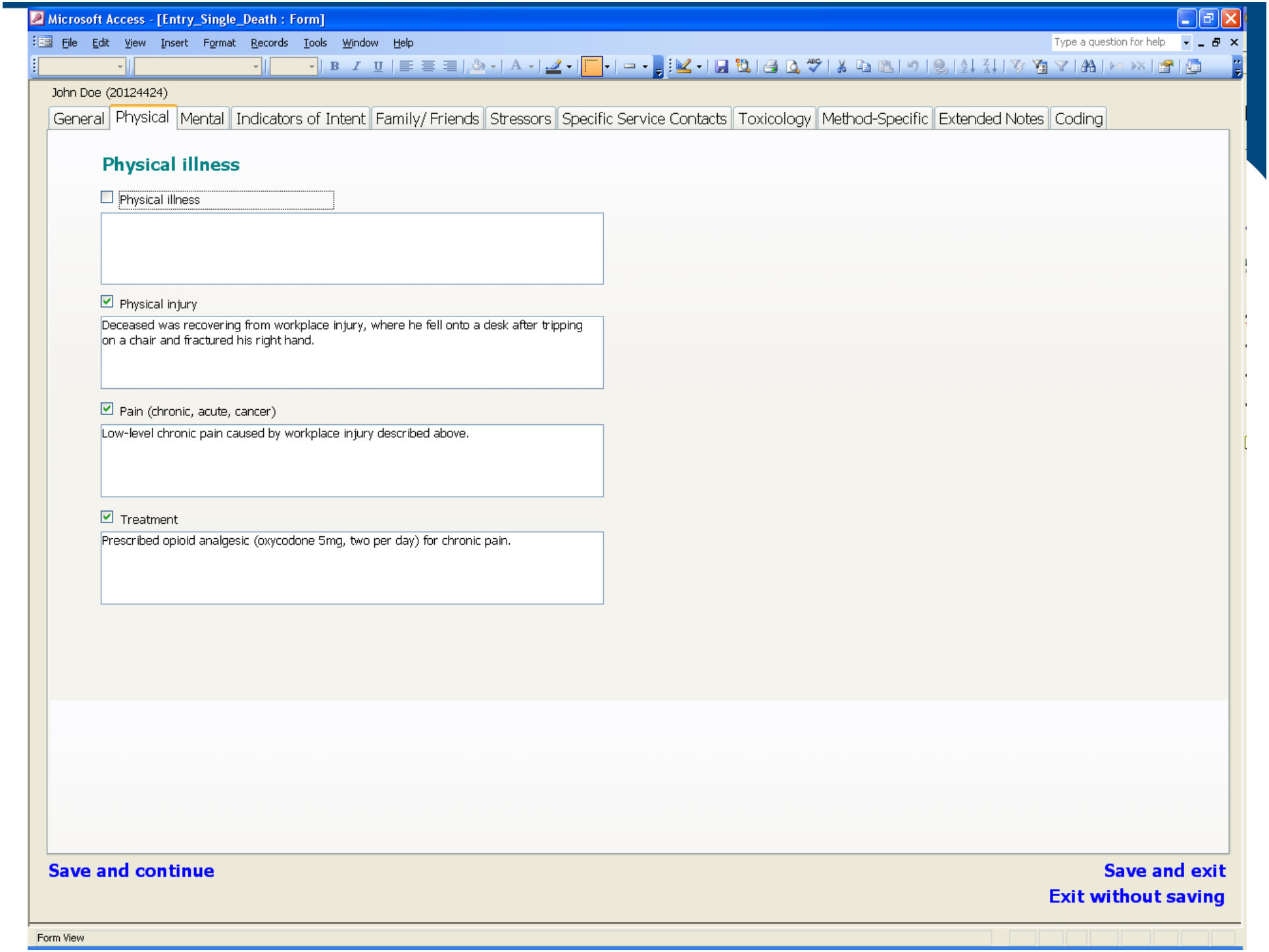
Form View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File Edit View Insert Format Records Tools Window Help
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John Doe (20124424)
General Physical Mental Indicators of Intent Family/ Friends Stressors Specific Service Contacts Toxicology Method-Specific Extended Notes Coding
Physical illness
Physical illness
Physical injury
Deceased was recovering from workplace injury, where he fell onto a desk after tripping on a chair and fractured his right hand.
Pain (chronic, acute, cancer)
Low-level chronic pain caused by workplace injury described above.
Treatment
Prescribed opioid analgesic (oxycodone 5mg, two per day) for chronic pain.
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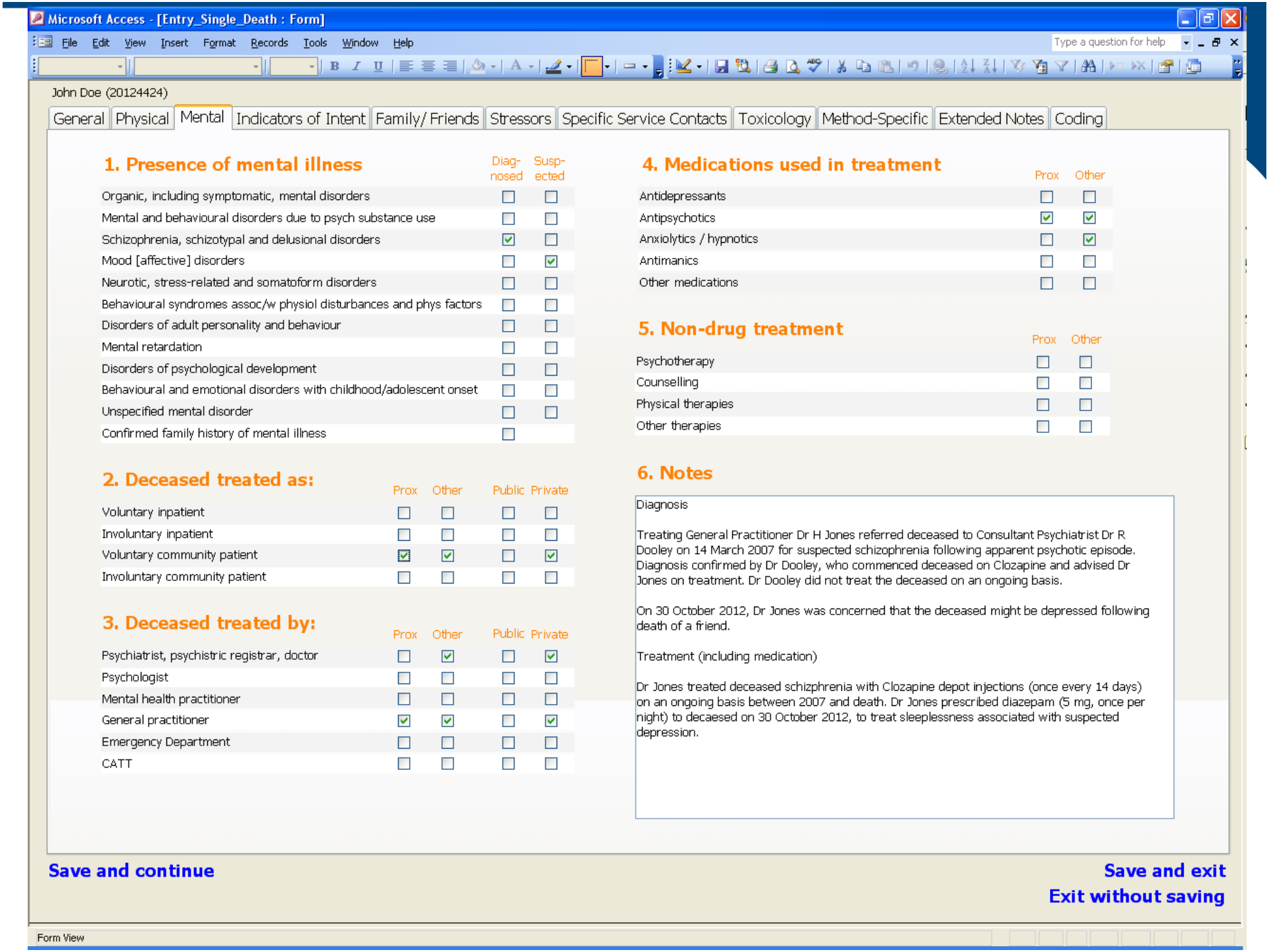
Form View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File Edit View Insert Format Records Tools Window Help
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John Doe (20124424)
General Physical Mental Indicators of Intent Family/ Friends Stressors Specific Service Contacts Toxicology Method-Specific Extended Notes Coding
1. Presence of mental illness
Diag-nosed
Susp-ected
Organic, including symptomatic, mental disorders
Mental and behavioural disorders due to psych substance use
Schizophrenia, schizotypal and delusional disorders
Mood [affective] disorders
Neurotic, stress-related and somatoform disorders
Behavioural syndromes assoc/w physiol disturbances and phys factors
Disorders of adult personality and behaviour
Mental retardation
Disorders of psychological development
Behavioural and emotional disorders with childhood/adolescent onset
Unspecified mental disorder
Confirmed family history of mental illness
2. Deceased treated as:
Prox
Other
Public
Private
Voluntary inpatient
Involuntary inpatient
Voluntary community patient
Involuntary community patient
3. Deceased treated by:
Prox
Other
Public
Private
Psychiatrist, psychistric registrar, doctor
Psychologist
Mental health practitioner
General practitioner
Emergency Department
CATT
4. Medications used in treatment
Prox
Other
Antidepressants
Antipsychotics
Anxiolytics / hypnotics
Antimanics
Other medications
5. Non-drug treatment
Prox
Other
Psychotherapy
Counselling
Physical therapies
Other therapies
6. Notes
Diagnosis
Treating General Practitioner Dr H Jones referred deceased to Consultant Psychiatrist Dr R Dooley on 14 March 2007 for suspected schizophrenia following apparent psychotic episode. Diagnosis confirmed by Dr Dooley, who commenced deceased on Clozapine and advised Dr Jones on treatment. Dr Dooley did not treat the deceased on an ongoing basis.
On 30 October 2012, Dr Jones was concerned that the deceased might be depressed following death of a friend.
Treatment (including medication)
Dr Jones treated deceased schizphrenia with Clozapine depot injections (once every 14 days) on an ongoing basis between 2007 and death. Dr Jones prescribed diazepam (5 mg, once per night) to decaesed on 30 October 2012, to treat sleeplessness associated with suspected depression.
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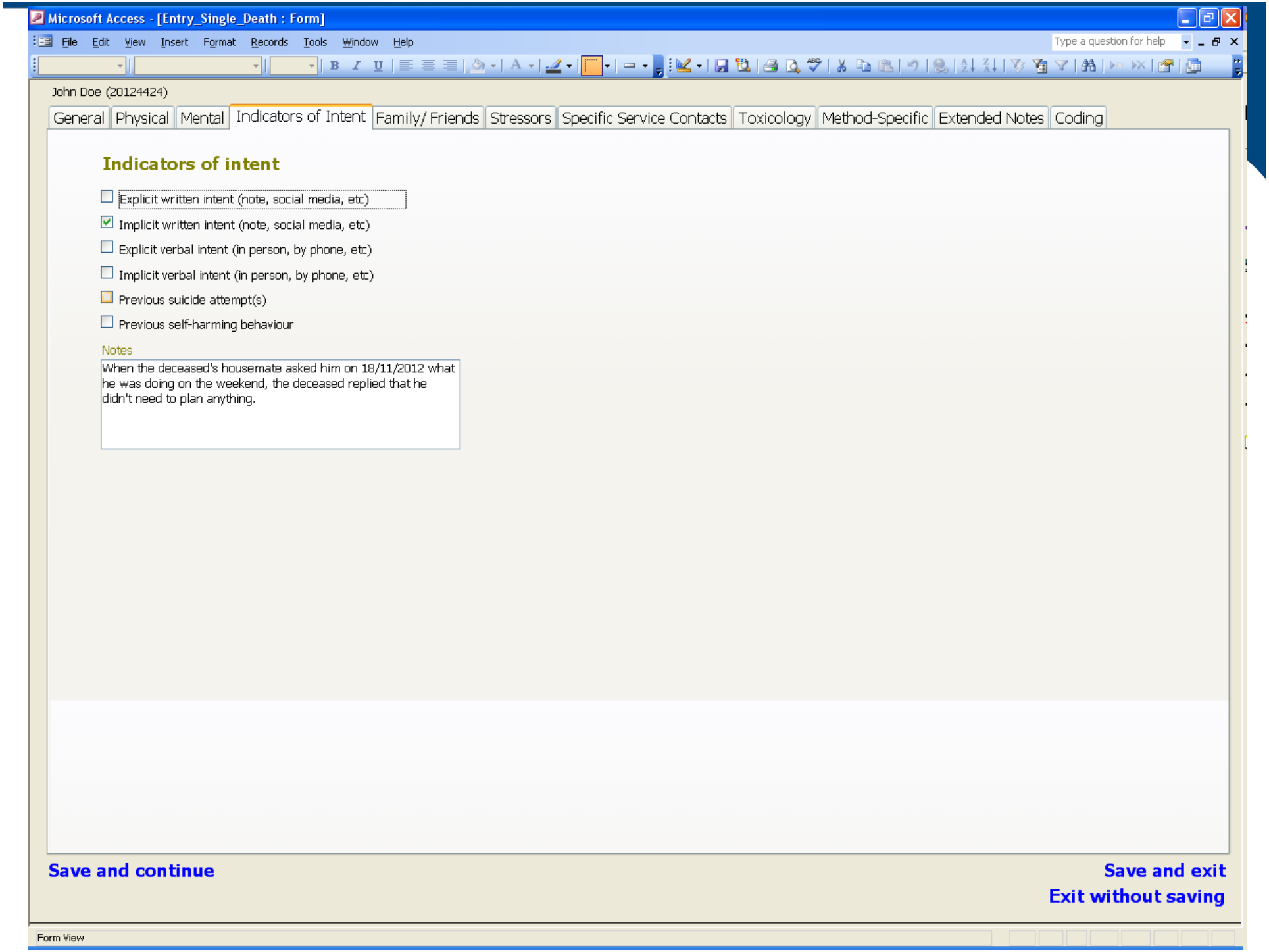
Form View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Indicators of intent
Explicit written intent (note, social media, etc)
Implicit written intent (note, social media, etc)
Explicit verbal intent (in person, by phone, etc)
Implicit verbal intent (in person, by phone, etc)
Previous suicide attempt(s)
Previous self-harming behaviour
Notes
When the deceased's housemate asked him on 18/11/2012 what he was doing on the weekend, the deceased replied that he didn't need to plan anything.
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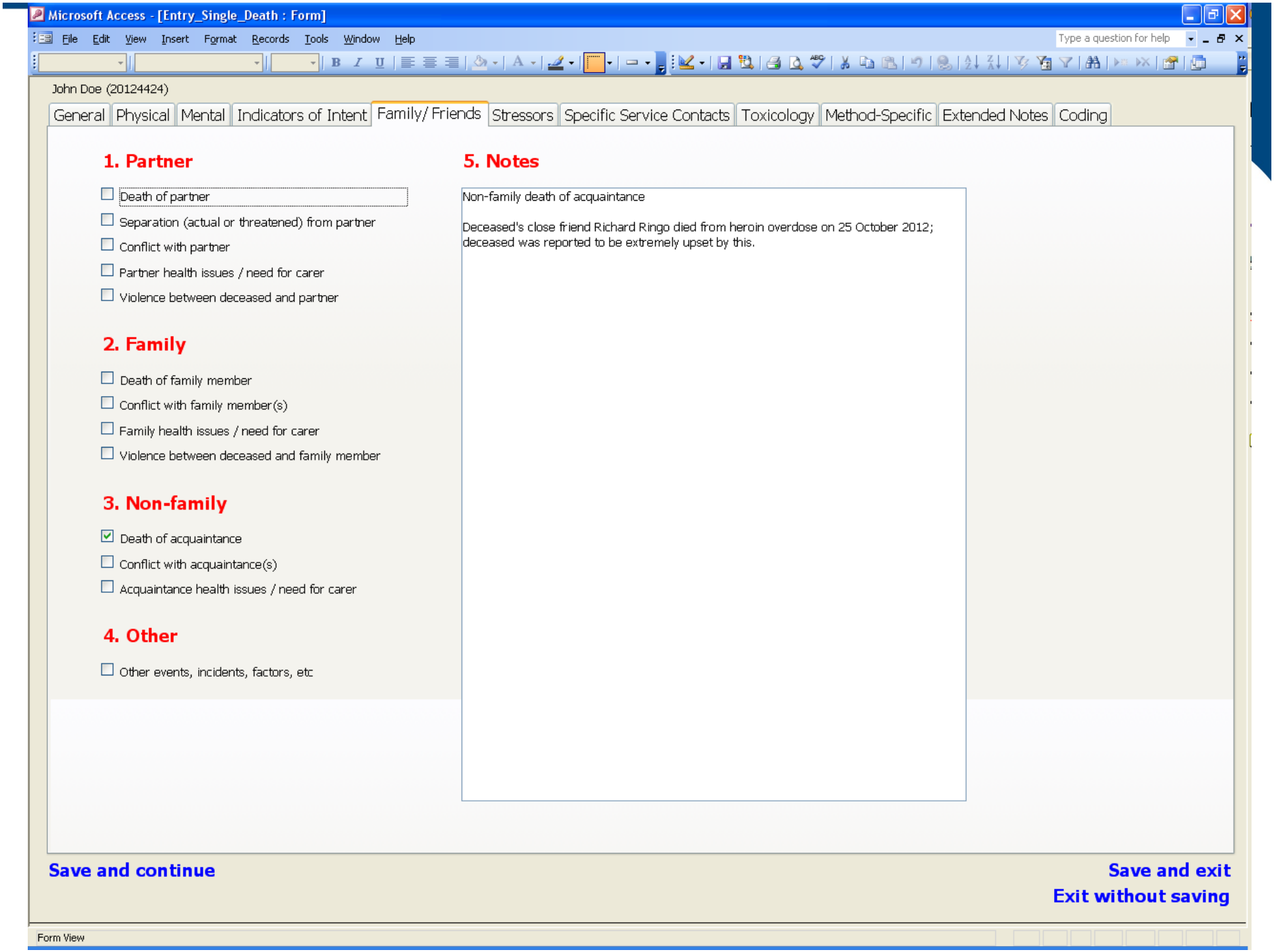
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1. Partner
Death of partner
Separation (actual or threatened) from partner
Conflict with partner
Partner health issues / need for carer
Violence between deceased and partner
2. Family
Death of family member
Conflict with family member(s)
Family health issues / need for carer
Violence between deceased and family member
3. Non-family
Death of acquaintance
Conflict with acquaintance(s)
Acquaintance health issues / need for carer
4. Other
Other events, incidents, factors, etc
5. Notes
Non-family death of acquaintance
Deceased's close friend Richard Ringo died from heroin overdose on 25 October 2012; deceased was reported to be extremely upset by this.
Save and continue
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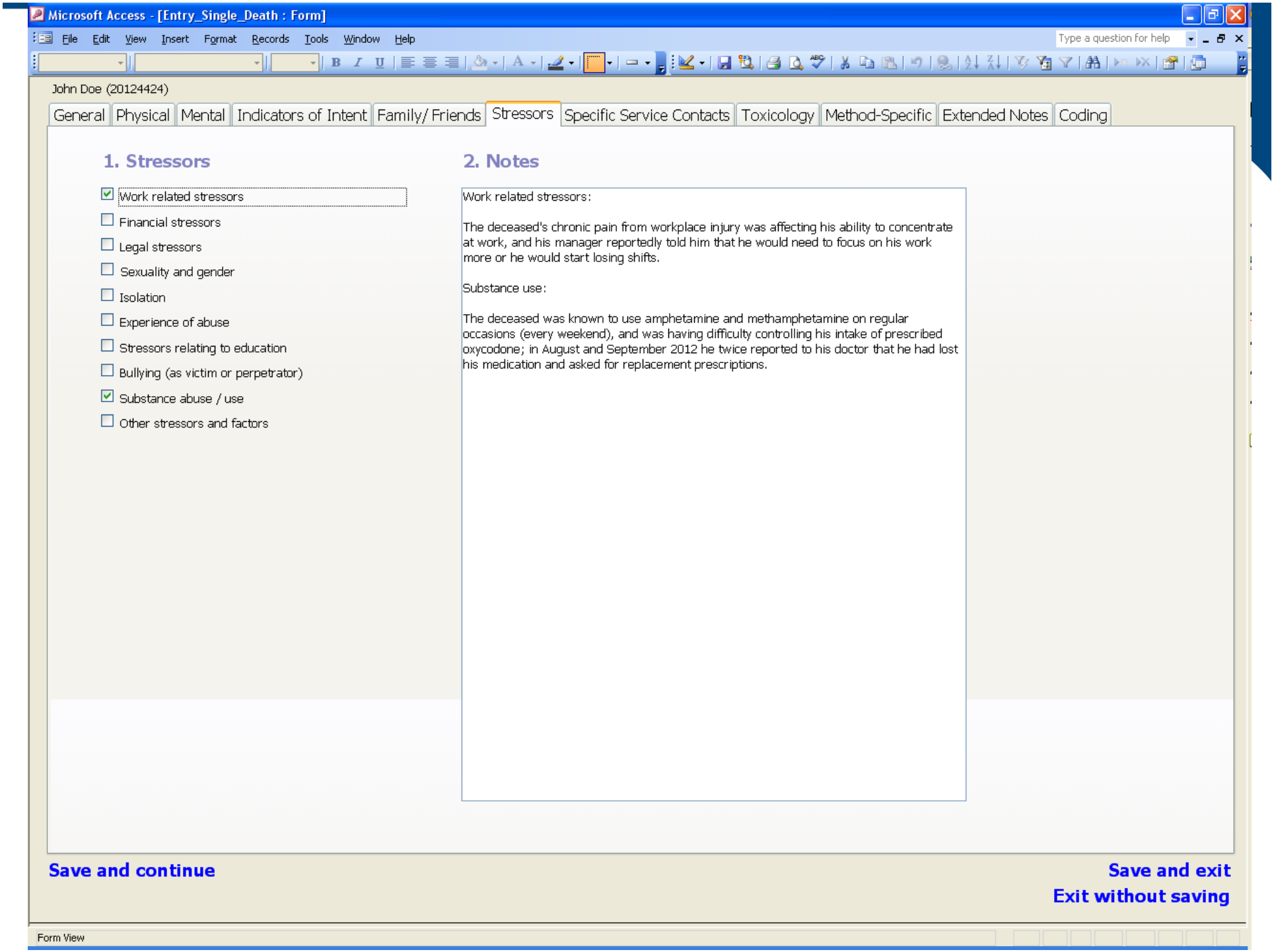
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1. Stressors
Work related stressors
Financial stressors
Legal stressors
Sexuality and gender
Isolation
Experience of abuse
Stressors relating to education
Bullying (as victim or perpetrator)
Substance abuse / use
Other stressors and factors
2. Notes
Work related stressors:
The deceased's chronic pain from workplace injury was affecting his ability to concentrate at work, and his manager reportedly told him that he would need to focus on his work more or he would start losing shifts.
Substance use:
The deceased was known to use amphetamine and methamphetamine on regular occasions (every weekend), and was having difficulty controlling his intake of prescribed oxycodone; in August and September 2012 he twice reported to his doctor that he had lost his medication and asked for replacement prescriptions.
Save and continue
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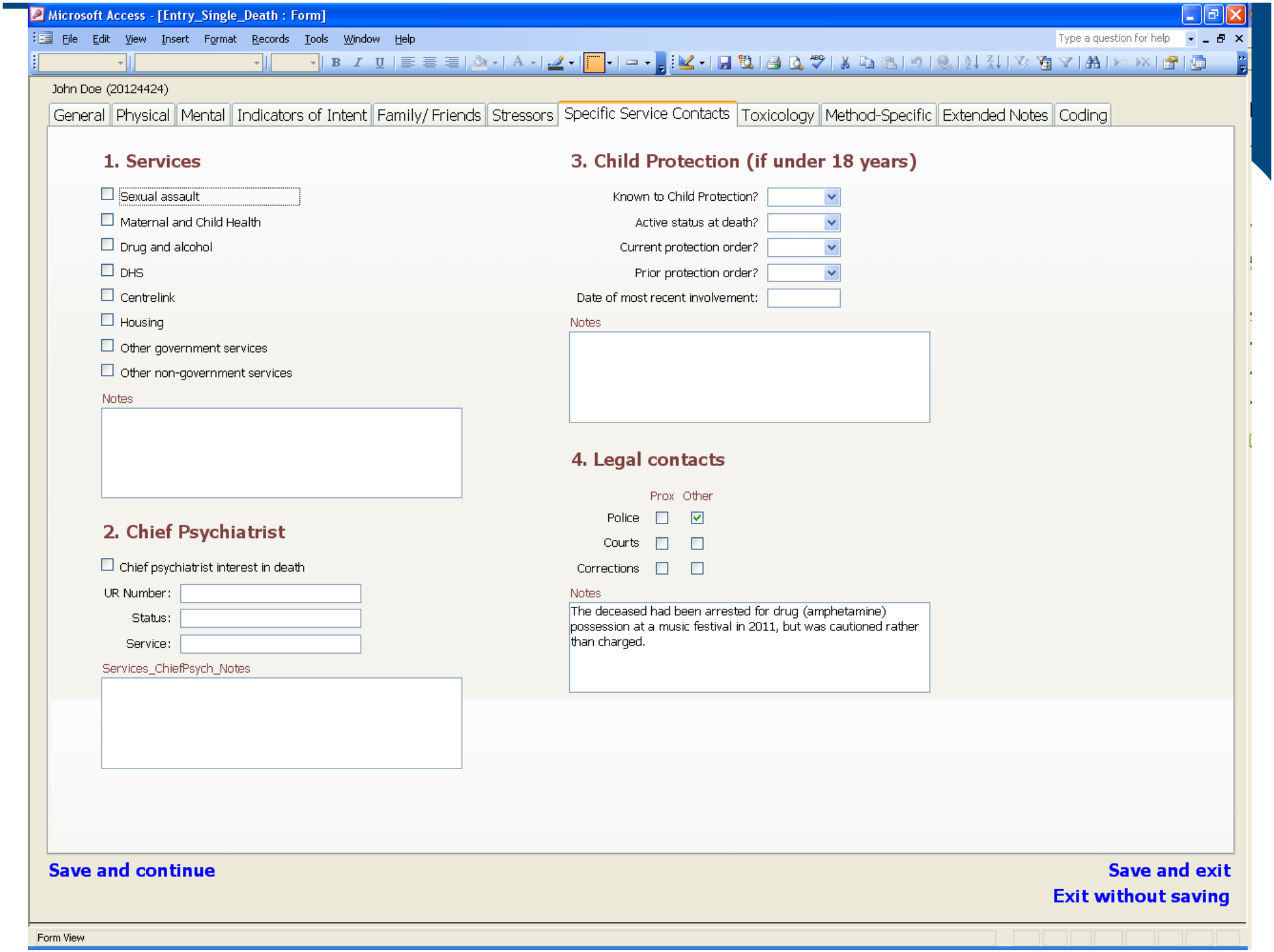
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1. Services
Sexual assault
Maternal and Child Health
Drug and alcohol
DHS
Centrelink
Housing
Other government services
Other non-government services
Notes
2. Chief Psychiatrist
Chief psychiatrist interest in death
UR Number:
Status:
Service:
Services_ChiefPsych_Notes
3. Child Protection (if under 18 years)
Known to Child Protection?
Active status at death?
Current protection order?
Prior protection order?
Date of most recent involvement:
Notes
4. Legal contacts
Prox Other
Police
Courts
Corrections
Notes
The deceased had been arrested for drug (amphetamine) possession at a music festival in 2011, but was cautioned rather than charged.
Save and continue
Save and exit
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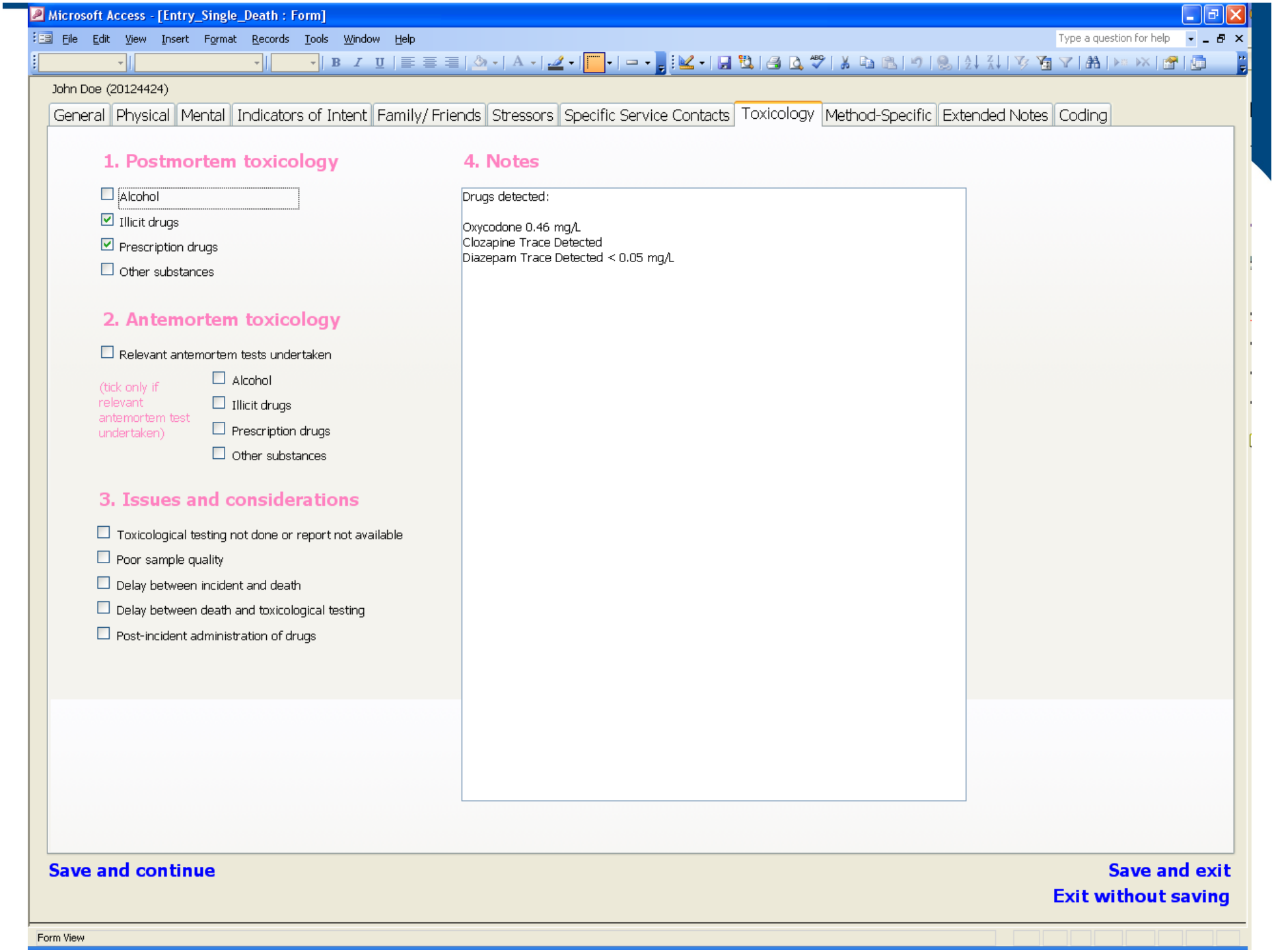
Form View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John Doe (20124424)
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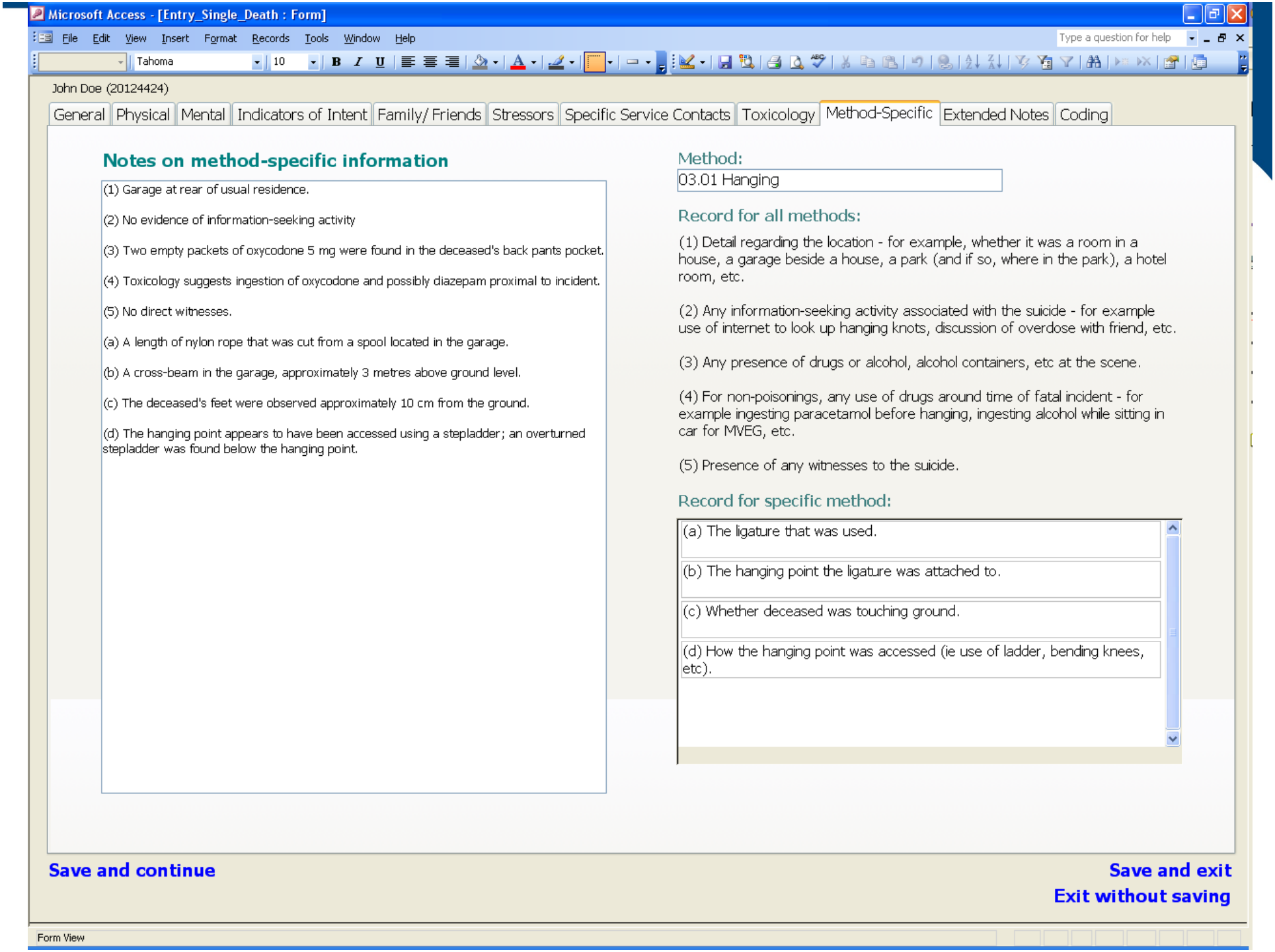
1. Postmortem toxicology
Alcohol
Illicit drugs
Prescription drugs
Other substances
2. Antemortem toxicology
Relevant antemortem tests undertaken
(tick only if relevant antemortem test undertaken)
Alcohol
Illicit drugs
Prescription drugs
Other substances
3. Issues and considerations
Toxicological testing not done or report not available
Poor sample quality
Delay between incident and death
Delay between death and toxicological testing
Post-incident administration of drugs
4. Notes
Drugs detected:
Oxycodone 0.46 mg/L
Clozapine Trace Detected
Diazepam Trace Detected < 0.05 mg/L
Save and continue
Save and exit
Exit without saving
Form View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Tahoma
10
John Doe (20124424)
General
Physical
Mental
Indicators of Intent
Family/ Friends
Stressors
Specific Service Contacts
Toxicology
Method-Specific
Extended Notes
Coding
Notes on method-specific information
(1) Garage at rear of usual residence.
(2) No evidence of information-seeking activity
(3) Two empty packets of oxycodone 5 mg were found in the deceased's back pants pocket.
(4) Toxicology suggests ingestion of oxycodone and possibly diazepam proximal to incident.
(5) No direct witnesses.
(a) A length of nylon rope that was cut from a spool located in the garage.
(b) A cross-beam in the garage, approximately 3 metres above ground level.
(c) The deceased's feet were observed approximately 10 cm from the ground.
(d) The hanging point appears to have been accessed using a stepladder; an overturned stepladder was found below the hanging point.
Method:
03.01 Hanging
Record for all methods:
(1) Detail regarding the location - for example, whether it was a room in a house, a garage beside a house, a park (and if so, where in the park), a hotel room, etc.
(2) Any information-seeking activity associated with the suicide - for example use of internet to look up hanging knots, discussion of overdose with friend, etc.
(3) Any presence of drugs or alcohol, alcohol containers, etc at the scene.
(4) For non-poisonings, any use of drugs around time of fatal incident - for example ingesting paracetamol before hanging, ingesting alcohol while sitting in car for MVEG, etc.
(5) Presence of any witnesses to the suicide.
Record for specific method:
(a) The ligature that was used.
(b) The hanging point the ligature was attached to.
(c) Whether deceased was touching ground.
(d) How the hanging point was accessed (ie use of ladder, bending knees, etc).
Save and continue
Save and exit
Exit without saving
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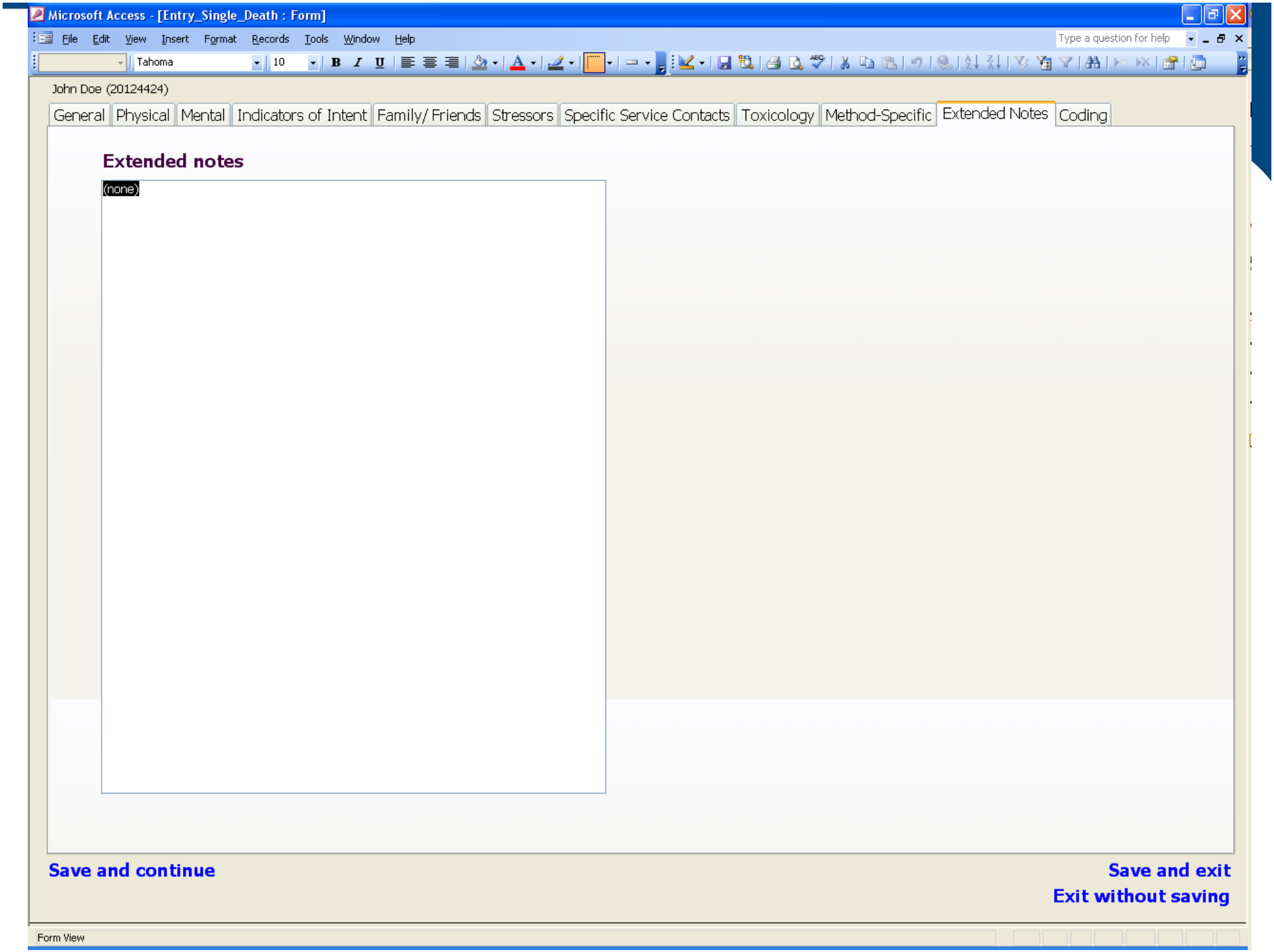
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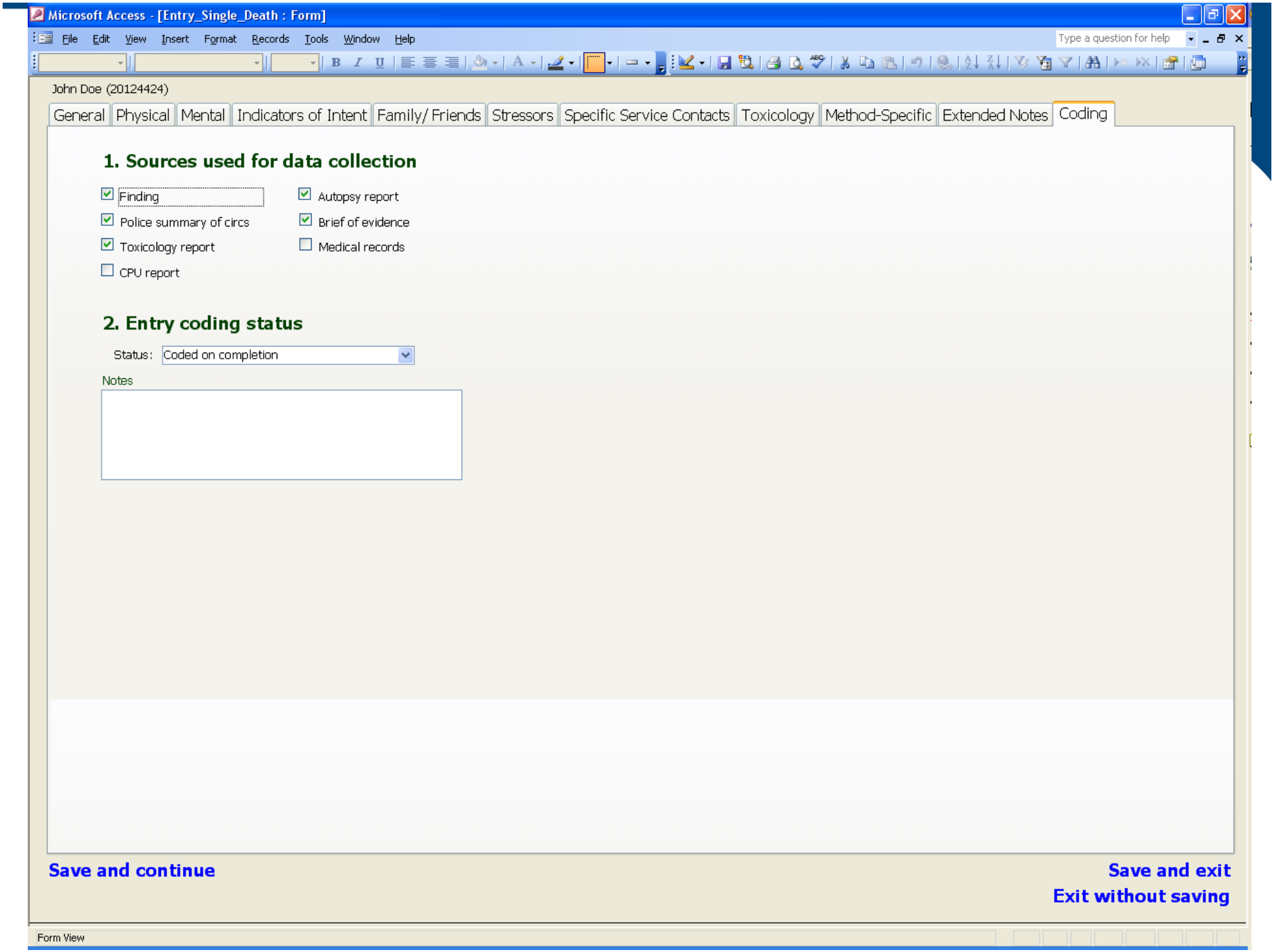
John Doe (20124424)
General
Physical
Mental
Indicators of Intent
Family/ Friends
Stressors
Specific Service Contacts
Toxicology
Method-Specific
Extended Notes
Coding
Extended notes
(none)
Save and continue
Save and exit
Exit without saving
Form View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1. Sources used for data collection
Finding
Police summary of circs
Toxicology report
CPU report
Autopsy report
Brief of evidence
Medical records
2. Entry coding status
Status: Coded on completion
Notes
Save and continue
Save and exit
Exit without saving
Form View

QUESTIONS?