INQUIRY INTO PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

QUESTIONS ON NOTICE

Q. What is the average time between the passing of someone and the time in which a finding is made? You made a criticism of the reliability of data because of the time taken to get to a formal finding. What is that time?

As noted in the public hearing, the time taken to finalise proceedings in relation to a reportable death is highly variable and depends on a number of factors operating across a number of agencies. As discussed in the hearing, for the most part suicides are dealt with on the papers and are, therefore, finalised more quickly than matters that go to inquest. When a suicide is reported to the Coroner, orders are made, inter alia, to NSW Police for the preparation of a brief of evidence and to the Department of Forensic Medicine for an autopsy report to be prepared. The time taken to complete these investigative tasks varies depending on the complexity of the matter and resourcing issues for those agencies. The six suicide case reviews set out below demonstrate this variability with the time taken to finalise the matters before the Court ranging from 3 to 18 months.

The challenges identified in the public hearing regarding the reliability and timeliness of suicide data collection were not, however, limited to the issue of the time taken from commencement to completion of Coronial proceedings. When a matter is finalised by a Coroner there is a range of administrative tasks that need to be completed by Court staff, one of which is coding the case onto NCIS.

In the past the Court had dedicated resources allocated to completing this task however this no longer the case. NCIS coding is not regarded as core business of the Court and with limited resources it is necessarily afforded a low priority in terms of tasks to be completed by Court staff. As a result there is often a significant backlog and delay in coding and closing finalised matters on NCIS (see for example the Case 5 below where the matter was dispensed with in May 2014 but not closed on NCIS until December 2015). As well as issues around delay, the quality of coding is also compromised and matters are often closed on NCIS without the prescribed documents attached and with errors in the data capture (for example suicide matters not accurately recorded as ‘intentional self-harm’ matters). The cumulative impact of these issues on the timeliness and reliability of suicide data reported by NCIS (and other data systems that rely on NCIS such as the ABS) is self-evident.

Q. Would you see any benefit in having a specialised Coroner who would deal with coronial matters in respect of suicide generally or in respect of youth suicide, where that person would have the expertise or the background in relation to this, which was tailored to a more streamlined resolution of matters?

Coroners are equipped to investigate and make findings with respect to all manner of deaths and it is submitted that appointing a specialist suicide Coroner would not overcome the issues identified above regarding suicide data collection.

Similarly, such an appointment would not address the issue raised in the hearing regarding the current practice (again necessitated due to resources) of Coroners giving very limited reasons for dispensing with suicide matters and the missed opportunity this represents for gaining greater insight into the context and circumstances of suicide deaths.

A specialist suicide Coroner would not fulfil the same role as the suicide mortality review proposed in the hearing and would not yield the same quantitative and qualitative learnings that such a review mechanism would impart. The growing incidence of suicide deaths in New South Wales will only be reduced through targeted, evidence-based, intervention and prevention strategies and it is submitted that the establishment of a multi-disciplinary suicide mortality review body would provide critical information to inform the development of such strategies.

Additional information regarding the Domestic Violence Death Review Team's pilot study of domestic violence as a characteristic in completed suicides is set out below (in response to discussion at pages 6 and 7 of hearing transcript).

NOTE: Set out below is a simplified summary of the Team's suicide study with a focus on the questions and discussion points raised in the hearing. The study is set out in full in the Team's 2015-17 Report which can be accessed on the NSW Coroners Court website.

Background to study

In 2016 the Secretariat of the Domestic Violence Death Review Team commenced an initial 6 month whole-of-population pilot study examining closed suicides in NSW (July-December 2013), with a view to reporting preliminary prevalence and demographic data, histories of police reported domestic violence and suicides where

domestic violence perpetration or victimisation or separation was identifiable as a proximal characteristic of the suicide.

This study represented the first phase of surveillance and analysis of completed suicides by the Secretariat and was undertaken as an initial step towards better understanding the relationship between suicide and domestic violence victimisation and perpetration. The next phase of the project anticipates qualitative review of the cases from the initial 6 month review period so as to derive further data and case characteristics, including information regarding service contact. The ultimate goal of this research is to explore opportunities for intervention and prevention in relation to this cohort.

Methodology

Using both NCIS and JusticeLink data systems the Secretariat identified all reportable deaths in NSW that were coded as intentional self-harm (ISH) for the period 1 July 2013 to 31 December 2013.

Demographic and case characteristic information was captured for each ISH death and this was recorded in the DVDRT ISH database.

Each ISH death was reviewed using the NSW Police Force COPS system to determine whether the deceased person was known to police for domestic violence, either as a victim, an offender or as both (including being exposed to domestic violence between parents).

Findings

Overall

In the 6 month review period there were 330 cases of completed suicides – 245 males and 85 females.

Of the 245 males who suicided, 94 (38%) had prior contact with NSW Police in relation to domestic or family violence (either as a victim, an offender, or both).

Of the 85 females who suicided, 33 (39%) had prior contact with NSW Police in relation to domestic or family violence (either as a victim, an offender, or both).

Young people

Of the 245 males that suicided, three were under the age of 18. Of the 85 females that suicided, three were under the age of 18.

A recorded history of domestic violence was identified in two of the six cases where a young person suicided (both girls). A précis of each of the six cases is set out below based on information derived the police report of death to the Coroner (p79A form), the police database COPS and JusticeLink.

It is requested that each précis be redacted in total to protect the identity of the parties.

[redacted]

[redacted]

I am satisfied that the death is not suspicious and that the deceased died as a

[redacted]

[redacted]

[redacted]