# Coroners Court of Victoria

**Court Reference:** COR 2012 0760, COR 2012 2094, COR 2011 4546, COR 2011 4552, COR 2011 2926, COR 2012 1649, COR 2011 0999, COR 2012 0735, COR 2011 4167, COR 2011 3703, COR 2011 3601.

## CORONIAL INVESTIGATION REPORT – CASEY AND CARDINIA SUICIDE CLUSTER

I, AUDREY JAMIESON, Coroner, having completed the coronial investigations into the deaths by suicide of twelve young people in the City of Casey and Cardinia Shire that occurred in 2011 and 2012, direct that:

1. A copy of the investigation summary completed by the Coroners Prevention Unit, Comments and Recommendations from the Findings Without Inquest are published on the internet; and

2. The identity of the deceased persons, the cause of the deaths and the circumstances in which the deaths occurred are not published.

The Coroners Court of Victoria is committed to reducing preventable deaths and promoting public health and safety for the Victorian community. Evidence collected as part of my investigation indicates that some of these young people had been previously exposed to suicide. Research suggests this exposure may increase the suicide risk of an individual. To mitigate this potential risk, I have determined that full disclosure of the Findings Without Inquest is not necessary and may be a barrier during the recovery phase in these communities.

Signature: _____

**Date: 30 July 2015**

**Audrey Jamieson**

**Coroner**

## CORONERS PREVENTION UNIT

1. On 23 November 2011, a member of the public contacted the Coroners Court of Victoria's Coroners Prevention Unit (CPU)[1] to convey concern about a perceived increased frequency of youth[2] suicide in the City of Casey and Cardinia Shire and the impact that this may be having on young people in those communities.

2. Following a briefing to the then State Coroner, the CPU was requested to:

   a) identify previous and monitor subsequent suspected suicides of usual residents of the City of Casey and Cardinia Shire aged 13 to 24 years;

   b) conduct a review of the scientific research literature on the role of exposure to suicidal behaviour in the social network and an individual's risk of suicide; and

   c) liaise with the stakeholders leading the post-vention response.

*Analysis of suspected suicide and self-harm in the City of Casey and Cardinia Shire*

3. The CPU conducted a retrospective case series examination of suspected suicides and hospitalisation for self-harm amongst usual residents of the City of Casey and Cardinia Shire aged 24 years and under for the period 2007 to 2013 (see Attachment A).

4. For suspected suicide, the analysis showed that compared to previous years, the frequency and rate per 100,000 population was elevated in 2011 in both the City of Casey[3] and Cardinia Shire. Specifically, six suspected suicides were identified amongst usual residents of the City of Casey compared to one in 2010 and three in 2009. Similarly, four suspected suicides were identified amongst usual residents of the Cardinia Shire compared to one in 2010, two in 2009, and zero in both 2008 and 2007.

5. In the two years subsequent to 2011, the frequency of suspected suicides reduced slightly but remained higher than 2009 and 2010 in both Local Government Areas (LGAs) (four in 2012 and 2013 for the City of Casey and three in both 2012 and 2013 for Cardinia Shire).

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1 The Coroners Prevention Unit is a specialist service for coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

2 The Centres for Disease Control and Prevention defines youth in the context of suicide as between the ages of 10 and 24. However, there is a general consensus amongst Coroners in Victoria that persons under the age of 13 years are too young to form the requisite intent. For the purposes of this investigation, youth was defined as between the ages of 13 and 24 years.

3 The exception to this was the City of Casey in 2007, where seven deaths occurred (13.4 / 100,000 population).

6. This retrospective examination showed that during 2011, the City of Casey and Cardinia Shire experienced an elevated frequency of suspected suicide amongst persons 24 years and under and that this met the Centres for Disease Control and Prevention's definition of a suicide cluster.[4]

7. In addition to an examination of suspected suicides, the CPU also examined the frequency of hospital admissions for self-harm amongst usual residents of the City of Casey and Cardinia Shire. A data request on the frequency and rate / 100,000 population of hospital admissions for intentional self-harm was provided by the Victorian Injury Surveillance Unit (VISU) from their Victoria Admitted Episodes Dataset (VAED).[5]

8. For the City of Casey this showed that the frequency and rate per 100,000 population of self-harm hospitalisation amongst persons 24 years and under doubled between 2009 and 2010 (from 30 [53.2 / 100,000 population] to 69 [119.8 / 100,000]. Since 2010, the frequency of self-harm hospitalisation in this group has remained at over 60 per year. For the Cardinia Shire, the frequency and rate per 100,000 population of self-harm hospitalisation amongst persons 24 years and under peaked 2010 and 2011 (17 [107.9 / 100,000 population] and 19 [116.6 / 100,000] respectively. Since 2011, the frequency of self-harm hospitalisation in this group has reduced.

*Exposure to suicide via the social network as a risk factor*

9. The CPU identified and reviewed 54 original research studies conducted between 1967 and 2009 that examined the association between exposure to suicidal behaviour[6] in the social network[7] and an individual's risk of suicide. The CPU concluded that although no study reported evidence of a direct causal relationship between exposure to suicidal behaviour of a person in the social network and suicide, an association was reported in the majority of studies. Despite the absence of a cause and effect relationship, the CPU advised that a risk management approach should be applied immediately following a

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4 *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

5 The Victorian Injury Surveillance Unit (VISU) is the repository for de-identified injury surveillance data in Victoria, outsourced by the Victorian Department of Health and Human Services. Research staff analyse and disseminate data and information on injury for prevention and research purposes. The Victorian Admitted Episodes Dataset includes all admissions to public and private hospitals in Victoria and is coded to the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM).*

6 Suicide behaviour was defined in accordance with the Centre for Disease Control and Prevention as suicide, suicide attempt or suicidal ideation.

7 Social network was defined as a formal or informal linkage, association, or network of individuals or groups that share common interests, contacts, knowledge or resources.

suicide in accordance with the established body of evidence on effective post-vention responses to maximise the safety of persons exposed to and affected by the suicide of an individual in their social network.

*Post-vention Response*

10. The community concern about the increased frequency of suspected suicides amongst young people in the City of Casey and Cardinia Shire also came to the attention of the local council. On 15 December 2011, the City of Casey convened an all agency response meeting. During this meeting it was identified that several agencies knew key details of individual suicides, without any one agency being aware of them all.[8]

11. In the absence of an identifiable lead agency, the City of Casey formed the Casey Youth Suicide Steering Committee (the Steering Committee) comprising: Southern Health (as it then was); Victoria Police; Department of Human Services; Department of Education & Early Childhood Development; Independent Schools Victoria; and Catholic Education. An Advisory Committee was also established comprising representatives from local schools and non-government agencies to identify, develop and deliver short, medium and long term responses to the issue. The CPU liaised with the City of Casey during the investigation and I was ultimately provided with a detailed submission from the Chair of the Casey Youth Suicide Steering Committee, Ms Colette McMahon.

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8 Submission on behalf of Casey Youth Suicide Steering Committee, 28 March 2014, page 2.

## COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

12. I commend the City of Casey, Victoria Police, Southern Health (as it then was) and other members of the Casey Youth Suicide Steering Committee and Advisory Committee for the leadership and support provided to the community during a period of considerable difficulty for their young people and their families. This post-vention model, comprising a co-ordinated multi-disciplinary and ongoing response led by local government may have application to other localities in Victoria. This may be particularly useful to identify and mobilize a response prior to and / or during periods of elevated rates of suicide and suicide attempts requiring hospitalisation. However, this is contingent on the timely and ongoing provision of intelligence on suspected suicides to these responders.

13. State Coroner, His Honour Judge Ian Gray, identified in his recent findings into the suicides of seven young residents of the City of Greater Geelong in 2009, that:

> *[...] there is an opportunity to reinvigorate suicide prevention activity in Victoria. What appears to be lacking is:*
>
> - *ongoing gathering of real time intelligence on the frequency and rate of suicide in local communities*
> - *exchange of intelligence and advice between local community organisations and the state and national organisations responsible for suicide prevention*
> - *a nuanced understanding of the presence and combination of risk factors that might influence suicidal activity amongst groups in the community*
> - *a co-ordinated local response and recovery strategy in place that can be activated when concerns are raised in the community about elevated levels of suicidal behaviour.*[9]

14. There is a legislative requirement for all suspected suicides to be reported to a coroner without delay.[10] As such, the Coroners Court of Victoria operates as a central repository of important and timely information about these suicides. The Coroners Prevention Unit systematically records incident, socio-demographic and location (usual residence and incident) information for every reportable death to provide up to date statistics as part of their role to support coroners with their prevention mandate. This information has broader utility and can inform essential prevention and post-vention activities of agencies

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9 Investigation into the death of Chanelle Amy Rae COR 20093500.

10 The requirement to report is contained in Part 3 of the Coroners Act. Sections 4 defines 'reportable death' to include a death that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly, from an accident or injury.

such as local government, Victoria Police and the Department of Health and Human Services.

15. While there are some barriers to the provision of information about active coronial investigations outside of the Court, avenues could be meaningfully explored to overcome these in the interests of reducing the considerable burden of suicide in Victoria.

## RECOMMENDATIONS

16. Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

**Recommendation 1**

As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipal Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.

**Recommendation 2**

With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipal Association of Victoria in consultation with the City of Casey develop a suicide prevention and post-vention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

## ATTACHMENT A

### City of Casey

**Table 1: Annual frequency and rate / 100,000 population of suspected suicides and self-harm hospital admissions amongst 10-24 year olds in the City of Casey, Victoria 2007-2013**

| | | Suspected suicides | | Self-harm hospital admissions | |
|---|---|---|---|---|---|
| Year | Population | Frequency | Rate | Frequency | Rate |
| 2007 | 52142 | 7 | 13.4 | 46 | 88.2 |
| 2008 | 54210 | 2 | 3.7 | 35 | 64.6 |
| 2009 | 56355 | 3 | 5.3 | 30 | 53.2 |
| 2010 | 57591 | 1 | 1.7 | 69 | 119.8 |
| 2011 | 58211 | 6 | 10.3 | 65 | 111.7 |
| 2012 | 58792 | 4 | 6.8 | 64 | 108.9 |
| 2013 | 59541 | 4 | 6.7 | 64 | 107.5 |
| **Average** | **56692** | **3.9** | **6.8** | **53.3** | **94.0** |

### Cardinia Shire

**Table 2: Annual frequency and rate / 100,000 population of suspected suicides and self-harm hospital admissions amongst 10-24 year olds in the Cardinia Shire, Victoria 2007-2013**

| | | Suspected suicides | | Self-harm hospital admissions | |
|---|---|---|---|---|---|
| Year | Population | Frequency | Rate | Frequency | Rate |
| 2007 | 13520 | - | - | 7 | 51.8 |
| 2008 | 14280 | - | - | 15 | 105.0 |
| 2009 | 15193 | 2 | 13.2 | 10 | 65.8 |
| 2010 | 15762 | 1 | 6.3 | 17 | 107.9 |
| 2011 | 16298 | 4 | 24.5 | 19 | 116.6 |
| 2012 | 16953 | 3 | 17.7 | 12 | 70.8 |
| 2013 | 17496 | 3 | 17.1 | 11 | 62.9 |
| **Average** | **15643** | **1.9** | **11.9** | **13.0** | **83.1** |