

Chapter 7: Suicide

“Despite recent decreases ... young people in Queensland have the highest rates of youth suicide in Australia” (Queensland Government, 2003:9).

From 1 January 2004 to 30 June 2005, 19 children and young people were suspected of committing suicide¹⁴⁰. This cause of death was responsible for 23.8% of external deaths among children aged 10 to 17 years. Suicide accounted for the highest number of external deaths of children aged 10 to 14 years and the second highest for children aged 15 to 17 years, exceeded only by transport fatalities.

History and legislation

For most of the past two millennia, Western cultures have persecuted individuals and families of individuals suspected of committing suicide (Cantor et al., 1999:11). For example, in the past in England, a person who suicided may have been given a humiliating burial, and their estate forfeited to the king. Degrading burials were not outlawed until 1823, and forfeiture was not formally stopped until 1870 (Cantor et al., 1999:11). Further, attempting suicide was considered an offence in Queensland until the late 1970s and many religions continue to act as inhibitors to suicide (Tatz, 1999:49). This history associated with suicide has a direct bearing on current legislation and has reportedly made coroners more reluctant to find suicide as a cause of death (Cantor et al., 1999:11).

Queensland legislation

Births, Deaths and Marriages Registration Act 2003

In Queensland, section 37 of the *Registration of Births Deaths and Marriages Act 1962* (repealed) stipulated that “where an entry of the cause of death is made in any register of death pursuant to this Act, and the death in question was self-inflicted, there shall not be added to the entry the word ‘suicide’ or any other word ... expressly indicating that the death was self-inflicted” (Cantor et al., 1999:12). Likewise, section

41(5)(b) of the new *Births Deaths and Marriages Registration Act 2003* prohibits entering “the word ‘suicide’ or words to that effect” into the register.

Coroners Act 2003

Section 46 of the Queensland *Coroners Act 1958* (repealed) expressly prohibited the finding of ‘felo de se’ or “one who feloniously commits suicide” (Cantor et al., 1999:12). Section 24 of the Act, which outlined the scope of an inquest, stipulated that in their findings, coroners must limit themselves to the medical cause of death only (for example, gunshot wound or hanging). A commentary on the circumstances accompanying a finding was allowed, but use of the word ‘suicide’ was prohibited (Cantor et al., 1999:12).

In contrast, section 45 of the *Coroners Act 2003* states that:

“A coroner who is investigating a death or suspected death must, if possible, find
(b) how the person died; and ...
(e) what caused the person to die”.

The use of the term ‘suicide’ or any reference to deliberate self-harm resulting in death is not prohibited by the *Coroners Act 2003*. However, the revised Act does not specifically require that coroners reach a verdict surrounding intent.

Reluctance by coroners to make suicide findings that indicate intent have been attributed to the above Acts, as well as the previous taboo surrounding the official classification of suicide (Cantor et al., 1999:12). “[T]he human factor in coroners will inevitably result in variability with regards to decisions and completing death certificates” (Cantor et al., 1999:14). Other factors which may also influence coroners include a wish to avoid embarrassment and guilt to family members, religious values and cultural attitudes (Australian Bureau of Statistics, 2000:35; Tatz, 1999:49).

The uncertainty surrounding the classification of children’s deaths as suicides, and the variability between findings, is evident in the 2004–05 data.

140 That is, on the police report of death to the coroner (Form 1), a possible suicide was suggested and the relevant suspected suicide section was completed.

Only three of 10 suicides had a coronial finding clearly indicating the intent of the child or young person¹⁴¹ (for example, “Terri¹⁴² died of her own willed act”). While five had a coronial finding that named “hanging”¹⁴³ as the cause of death.

It is possible that some coroners may be reluctant to make a finding of suicide given that the repealed Act prohibited the use of the term suicide or any similar expressions. The State Coroner indicated that if a coroner considers a death to be accidental or undetermined, then this will be expressly stated in the coroner’s findings (for example, ‘accidental hanging’). In cases where the finding simply states the cause of death as ‘hanging’ (and the police Form 1 indicates a suspected suicide), the absence of the term accidental or undetermined should be taken to imply that the death was intentional.

Ambiguity surrounding intent

Children and suicide

Previous suicide research has indicated there may be a reluctance to classify some deaths in children and young adolescents as suicides. This view is based on the belief that children are incapable of formulating concepts of death or understanding its finality and irreversibility (Agritmis et al., 2004:25; Beautrais, 2001:651; Wise & Spengler, 1997:320). The definition of suicide implies an understanding of the finality of death and an awareness that self-destructive actions will result in death (that is, intent). It is known that death is a psychologically difficult concept to comprehend until a certain age of maturity (Agritmis et al., 2004:25). As a result, it is difficult to classify the level of intent of children and younger adolescents.

Ambiguity surrounding intent in childhood suicides may have led to the under-recording of suicide as a cause of child death. It is generally accepted that child suicide statistics are considerably lower than the true numbers, due to misclassification and conservative cause of death coding (Agritmis et al., 2004:25; Beautrais, 2001:651; Wise &

Spengler, 1997:319). The social stigma attached to suicide may also contribute to an erroneous assessment and misclassification of childhood suicide (Wise & Spengler, 1997:319). It is believed that a large portion of childhood suicides are mistakenly recorded as ‘accidents’ (Wise & Spengler, 1997:319). Therefore, it is likely that the number of suicides of children and young people reported is less than the actual number.

Questionable circumstances and causes of death

The reliability of reported suicide numbers may also be under-represented due to uncertainties regarding the circumstances of some deaths (Cantor & Neulinger, 2000:371). A significantly high standard of proof and substantial evidence is needed to support the classification of a death as self-inflicted (Australian Bureau of Statistics, 2000:35; De Leo & Evans, 2002:19). The intention of the deceased is often difficult to establish particularly in cases of drug overdose, single-vehicle crash or a fall. This is compounded by uniform criteria for determining suicides and conducting investigations (Australian Bureau of Statistics, 2000:35). When uncertainties arise, suspected suicides may be misclassified as accidental or undetermined deaths (Australian Bureau of Statistics, 2000:35; Queensland Government, 2003:9).

The following case study illustrates the difficulty of determining intent for some child deaths.

Jessie¹⁴⁴, 12 years of age, died as a result of hanging. Jessie was reported to have an impaired mental capacity and also experienced learning and intellectual difficulties. The precipitating incident to the event appears to have been a minor disagreement with the child’s parents.

The coronial findings in this matter have ruled Jessie’s death to be the result of ‘hanging’. However, Jessie’s family indicated that they did not believe the child had the capacity to understand the consequences and irreversibility of his actions.

141 In cases where the police ‘Form 1’ has indicated the case is a suspected suicide.

142 Terri is a pseudonym.

143 This includes where a coroner has stated that death is due to some other injury as a result of hanging, for example, hypoxic brain injury due to hanging, but does not clearly state intent.

144 Jessie is a pseudonym.

During the 18 month reporting period, the Commission identified nine suicides of children under the age of 15 years (47.4% of all child and adolescent suicides)¹⁴⁵. The young age at which children are intentionally taking their own lives in Queensland is of particular concern to the Commission. The key trends and patterns surrounding suicides of children under 15 years are examined further in the suicide trends and patterns, 2004–05 section of this chapter. The risk factors and vulnerabilities affecting suicidal children and adolescents will continue to be a key focus area for the Commission.

Defining suicide

There is limited consensus on definitions of suicide and suicidal behaviour in the relevant literature. For the purpose of this report, the Commission has adopted the Queensland Government's (2003:10) definition of suicide: “[a] self-inflicted injury that is accompanied by the intention of the individual to die from the result of the action taken.”

In Queensland, a high standard of proof is generally required for a suicide to be labelled as such. However, the substantial evidence required for suicide classifications means that deaths which would ordinarily be categorised as suicides in clinical or research situations may lack sufficient evidence to be considered suicide in a legal sense (De Leo & Evans, 2002:19).

As coronial findings are not available for many of the suspected suicides that occurred during the reporting period, all cases classified as suspected suicides by police¹⁴⁶ will be considered in this section¹⁴⁷. When classifying deaths as suspected suicide, the Commission took into consideration a number of factors, including whether intent was stated previously; the presence of a suicide note; witnesses to the event; prior suicide attempts; and

any significant precipitating factors. As a result, a suicide classification model, based on the suicide flow chart developed by the Australian Institute for Suicide Research and Prevention, was developed¹⁴⁸.

Suicide classification model

The suicide classification model used by the Commission to classify all suspected suicides is included in Appendix Three. Each case considered in this section has been classified into one of three levels of certainty¹⁴⁹ based on the police report of death to the coroner (Form 1).

- **Beyond Reasonable Doubt:** The available information refers to at least one significant factor which constitutes a virtually certain level of suicide classification or coronial investigations have identified the death as a suicide.
- **Probable:** The available information is not sufficient for a judgement beyond reasonable doubt, but is more consistent with death by suicide than by any other means. Risk factors for suicide have been identified.
- **Possible/Undetermined:** The police have indicated (on the Form 1) that the case is a suspected suicide but, due to a lack of information surrounding the circumstances of the death, there is a substantial possibility that the death may be the result of another cause or be of undetermined intent or there is ambiguity surrounding intent due to the young age of the child.

In the reporting period, seven deaths were classified by the Commission as ‘beyond reasonable doubt’, five were categorised as ‘probable’ and seven were ‘possible/undetermined’. All deaths classified as possible/undetermined suicide were of children aged 10 to 14 years¹⁵⁰. These classifications will be detailed further in the suicide trends and patterns 2004–05 section of this chapter¹⁵¹.

145 There were no suicides among children and young people aged 14 years in the reporting period. All nine deaths recorded were among children aged 10 to 13 years. Age categories are reported as under 15 years in line with the literature and to allow comparability over time and interstate.

146 As indicated in the police report of death to the coroner (Form 1). In one case, it was brought to the Commission's attention that the child may have suicided. However, this information was not recorded on the police Form 1.

147 In cases where a coronial finding has been given relating to intent, deaths will be classified as per this finding.

148 This classification model is based on the suicide classification flow chart of De Leo and Evans (2002).

149 Based on the Australian Institute for Suicide Research and Prevention's classification detailed in De Leo & Evans (2002:20). Changes were made to these classification descriptions to fit with the interests of, and information received, by the Commission.

150 One child under the age of 15 years was classified as probable and one as beyond reasonable doubt.

Risk factors for youth suicide

The literature has identified common risk factors and adverse life circumstances that may lead to suicidal behaviour in children and young people (Beautrais, 1999:245). Often multiple risk factors combine to encourage the development of suicidal behaviour. Key factors are outlined below.

Mental health issues

Overwhelming evidence points to the major role that mental health issues play in youth suicide (Beautrais, 1999:188). In fact, studies have estimated that up to 90% of young people who die by suicide, or make suicide attempts, have at least one mental health disorder at the time of the attempt. Mental health issues most frequently associated with youth suicide are mood disorders, substance abuse and antisocial behaviours (Beautrais, 1999:211; Gould & Kramer, 2001:8). Of these, mood disorders (especially depression) are most frequently associated with suicidal behaviour among youth (Beautrais, 1999:192; Wise & Spengler, 1997:325).

Previous suicide attempts and behaviours

Wise and Spengler (1997:323) have indicated that a previous suicide attempt puts a child at high risk for completed suicide. A history of suicidal behaviour has been reported in up to half of those who die by suicide and who make suicide attempts. Prior behaviour is considered one of the strongest predictors of future suicidal behaviour, with estimates that the suicide rate is almost 20 times higher for people with previous attempts than those with no history of attempts (Beautrais, 1999:211).

Childhood abuse

A number of studies have also identified that children and young people who were physically or sexually abused in childhood are at a significantly greater risk of committing suicide than children with no history of abuse. Many studies have found a direct link between abuse and suicidal behaviour (Evans, Hawton & Rodham, 2004:45; Zimetkin, Alter & Yemini, 2001:3121).

Precipitating incident/stressful life events

Studies have found that young people who commit suicide have experienced a higher rate of adverse or stressful life events in the period preceding the suicide, compared to other people of the same age (Beautrais, 1999:227).

Evidence suggests that stressful events are particularly likely to provoke suicidal behaviour in vulnerable individuals. Precipitating incidents most commonly associated with suicide are relationship breakdowns, losses due to bereavement, and arguments with partners, family or friends (Beautrais, 1999:218; Gould & Kramer, 2001:9).

In summary, research has generally found that the risk factors outlined above are all significant predictors of suicidal behaviour. The Commission has used these risk factors to help classify suspected suicides of children and young people through the suicide classification model (see Appendix Three).

151 In Queensland, no identifiable cut-off age limit has been stipulated for children who intentionally self-harm resulting in death. It is generally accepted that suicides rarely occur among children aged under 10 years. The age at which an appropriate understanding of intent to commit suicide is gained is a concern of the Commission as it is acknowledged that every case of childhood suicide differs. In circumstances where a suspected suicide case of a child under 10 arises, the Commission will maintain a conservative view, as found by the majority of the literature, and classify the death as 'possible/undetermined' unless otherwise stipulated by coronial findings.

Suicide trends and patterns, 2004–05

In the 18 month period between 1 January 2004 and 30 June 2005, 19 children (13 males and six females) died from a suspected suicide. About half of these children were aged between 15 and 17 years (52.6%). Table 7.1 illustrates the age and gender breakdown of child suicides.

Table 7.1: Suicide by gender and age category at death

Age at death	Females <i>n</i>	Males <i>n</i>	Total <i>n</i>
10 years	0	1	1
11 years	0	0	0
12 years	1	3	4
13 years	1	3	4
14 years	0	0	0
15 years	0	2	2
16 years	1	1	2
17 years	3	3	6
Total	6	13	19
Rate per 100,000	2.8	5.8	4.3

Data source: Queensland Child Death Register (2004–05)

Note: 1. Rates are calculated based on children and young people aged between 10 and 17 years only.

Gender

Consistent with both the 13 year review (see chapter 2) and national findings, male children and young people were significantly more likely to suicide than females (Beautrais, 2001:647; De Leo & Evans, 2002:35). Male suicides represented 68.4% of all suicides during this period.

Age

The findings indicate that child suicide¹⁵² is almost as likely to occur among children aged under 15 years (nine deaths¹⁵³) as those aged between 15 and 17 years-of-age (10 deaths). There appears to be an increase in the number of children under 15 who have taken their own life in Queensland, conflicting with the findings of the 13 year review (see chapter 2).

152 The reference to child suicide typically refers to children and young people aged under 15 years.

153 No children aged 14 years were suspected of suiciding in the reporting period. All nine deaths which occurred were among children aged 10 to 13 years.

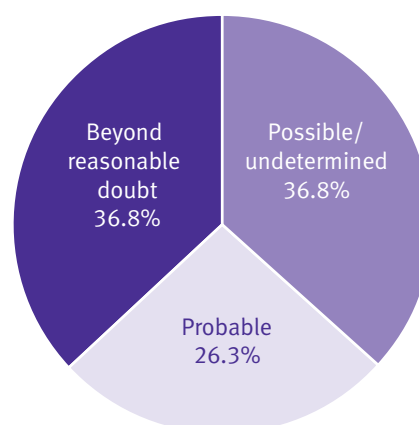
154 Refer to Appendix Three for a copy of the Suicide Classification Model utilised to classify all suspected suicide cases. For a detailed breakdown of each level of evidence required for classification, refer to the suicide classification model section earlier in this chapter.

In contrast, a number of studies have suggested that child suicide is rare (Beautrais, 2001:647; Wise & Spengler, 1997:318) and “not clearly noticeable until the age of 15 years” (Cantor et al., 1999:34). As a result, the literature predominantly examines youth suicide in people over the age of 15 years, with little focus on younger children (Cantor et al., 1999:34). The rise in child suicides in Queensland is of particular concern to the Commission and has been identified as a key focus area for further investigation.

Suicide classification model

Figure 7.1 shows the percentages of suspected suicide deaths in the three classifications described earlier in this chapter.

Figure 7.1: Percentages of suspected suicide deaths by classification



Data source: Queensland Child Death Register (2004–05)

Overall, an equal number of cases were classified by the Commission as beyond reasonable doubt and possible/undetermined (7 cases each)¹⁵⁴. Five cases were classified as being of probable likelihood.

Coronial findings

Post-mortem examinations and toxicological investigations were conducted on all but nine cases in the 18 month period examined. Coronial findings were available for 10 of the children and young people suspected of suiciding. Table 7.2 shows the coroner’s findings for each of these cases and the classification assigned by the Commission using the suicide classification model.

Table 7.2: Coronial findings and classifications of suspected suicides

Coronial finding	Intent stated in findings	Suicide classification
Hanging	No	Probable
Multiple injuries	No	Beyond reasonable doubt
Hypoxic brain injury due to hanging	No	Possible/undetermined
Death by hanging (anoxia)	Yes	Beyond reasonable doubt
Multiple injuries due to motor vehicle accident (pushbike)	No	Probable
Hanging	No	Possible/undetermined
Ligature compression of the neck (hanging)	Yes	Beyond reasonable doubt
Hanging	No	Beyond reasonable doubt
Hanging	Yes	Beyond reasonable doubt
Asphyxia, hanging	No	Possible/undetermined

Data source: Queensland Child Death Register (2004–05)

In all three cases where the coroner clearly identified intent, cases were classified as beyond reasonable doubt. Where the intent of the child or young person was unclear (for example, the finding was ‘hanging’ but there was no comment about intent), two cases were classified as beyond reasonable doubt, two as probable suicides and three as possible or undetermined.

Aboriginal and Torres Strait Islander status

Six¹⁵⁵ children who committed suicide during this period were identified as Aboriginal and/or Torres Strait Islander. This figure accounts for 31.6% of all child suicides, a significant overrepresentation when compared to the non-Indigenous population.

155 In the police Form 1, one child was identified as being Aboriginal. However, this was not recorded in the Births Deaths and Marriages Death Registration.

156 Rates are unable to be calculated for numbers less than four.

The elevated rates of suicide among Indigenous children and young people are consistent with previous Queensland findings (Beautrais, 1999:240; Cantor & Neulinger, 2000:381; Queensland Government, 2003:14; Queensland Paediatric Quality Council, 2004:84). The reasons for such high rates of suicide of Indigenous children are not entirely clear. However, factors may include social and economic deprivation, elevated rates of substance abuse, and the effect of colonialism on the general status and wellbeing of Aboriginal and Torres Strait Islanders (Beautrais, 1999:240). Further, Queensland Health (2005:31) has identified abuse and neglect among Indigenous children to “cause self-harming behaviours”. Child suicide has become a social issue of increasing importance and magnitude for Indigenous communities (Queensland Government, 2003:14). Consequently, the Commission has identified Aboriginal and Torres Strait Islander suicide as a key area for continued focus.

Geographical distribution (ARIA)

Nine suicides of children and young people occurred in regional areas (6.1 deaths per 100,000 children) compared to eight in metropolitan areas (4.7 deaths per 100,000) and two in remote areas¹⁵⁶. These figures are not consistent with the 13 year review (see chapter 2) which found that suicide rates were greatest in remote areas, followed by metropolitan regions. However, rates were unable to be calculated for remote areas as the numbers were too small. Other research has found that suicide rates are greater in rural areas of Queensland which is consistent with the 2004–05 figures (Cantor et al., 1999:51).

Suicide rates for young males, in particular, are higher in rural and remote areas (Cantor et al., 1999:50; De Leo & Heller, 2004:53), while metropolitan regions have overall higher suicide numbers (Cantor et al., 1999:51). However, the Commission found that male suicides were highest in metropolitan areas, with six deaths, compared to five deaths in regional areas and two in remote areas. Females experienced a greater number of suicides in regional areas, with four deaths,

compared to two deaths in metropolitan areas and none in remote areas¹⁵⁷.

Socioeconomic status (SEIFA)

Between January 2004 and June 2005, 10 children and young people who died from suicide were living in a low or very low socioeconomic region¹⁵⁸ (52.6%). Conversely, eight suicides were by children living in high or very high socioeconomic areas while one was residing in a moderate area. This is consistent with research, which has found that risks of suicidal behaviour are increased for individuals from socially disadvantaged backgrounds, characterised by low socioeconomic status, low income and associated factors (Beautrais, 1999:143; Cantor & Neulinger, 2000:378).

Circumstances of death

Method of death

Table 7.3 presents the methods of suicide used by children and young people by gender. Hanging was the most frequently used method of suicide for both males and females, accounting for 89.5% of all suicides (17 deaths). One young person died as a result of jumping from a high place and another rode a pushbike into oncoming traffic.

Table 7.3: Method of suicide deaths by gender

Method	Females		Males		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Hanging	5	83.3	12	92.3	17	89.5
Jumping from a high place	1	16.7	0	0.0	1	5.3
Struck by car/truck	0	0.0	1	7.7	1	5.3
Total	6	100.0	13	100.0	19	100.1

Data source: Queensland Child Death Register (2004–05)

Notes: 1. Percentages are calculated for each column.

2. Total percentage columns may not sum to 100% due to rounding.

In Queensland the number of suicides by hanging has increased over the past decade (De Leo & Heller, 2004:46). This increase was also evident in the 13 year review of child deaths (see chapter 2) which found that hangings overtook firearms in 1996 as young people’s preferred method of suicide. The findings for the current period also support the increased frequency of hanging as the chosen suicide method.

Several explanations for the increase in hangings have been suggested. For instance, the demise of hanging as a form of capital punishment in 1965 may have reduced the previous stigma associated with this method of suicide (Cantor & Neulinger, 2000:380). Others believe hangings may be on the rise due to ‘method substitution’ (De Leo & Heller, 2004:46; Patton & Burns, 1999:321).

Before 1996, the use of firearms was the most popular method of suicide in Queensland. However, changes to gun ownership policy and the introduction of more extensive firearm legislation may have led to difficulty accessing firearms (De Leo & Heller, 2004:46; Patton & Burns, 1999:321). In contrast, access to hanging points and materials are fairly universally available to young people (Cantor & Neulinger, 2000:380).

Despite the fact that hanging is the single most common method of suicide for children and young people in Queensland, and the rate of suicide has increased significantly in the past few decades, there are no clear interventions to reduce suicide by hanging (Beautrais, 1999:236).

“The method which accounts for most youth suicides appears least amenable to restriction. Apart from attempting to limit opportunities for hanging in institutions by ‘suicide proofing’ such environments, hanging remains a widely available method and one to which it is virtually impossible to restrict access” (Beautrais, 1999:236).

157 Rates were unable to be calculated and compared to gender as a number of the categories experienced less than four deaths. Calculating rates for some regions and not others would be inaccurate.

158 Eight of these children were classified as residing in very low socioeconomic regions.

Situational circumstances and risk factors

This section outlines the factors that may have triggered suicidal behaviour in Queensland youth in the 2004–05 period. The analysis contained in this section is based on information recorded in the police Form 1 and coronial findings. The numbers may therefore under-represent the true number of circumstances and risk factors for some of the children and young people who suicided in the reporting period. In 2005–06, the Commission hopes to have developed arrangements with relevant government departments to gain access to information such as health records.

Mental health issues

Seven children and young people who died from suicide experienced some form of mental health issue prior to their death (36.8% of suicides in this period). Possible disorders include depression, psychosis, behavioural problems and substance abuse.

Previous suicidal behaviour

Five young people had previously attempted suicide or engaged in self-harming behaviours (26.3%). Two previous suicide attempts were by some form of poisoning¹⁵⁹ and two children had previously engaged in self-harming behaviour.

History of childhood abuse

Five young people were allegedly victims of physical and/or sexual abuse (26.3%). Perpetrators of abuse were all immediate family members. Three of these children and young people were known to the Department of Child Safety either at the time of death or within three years before their death.

Precipitating incident/life stressors

Precipitating incidents were identified in 16 of the suicides (84.2%)¹⁶⁰. Eight incidents involved either an apparently trivial argument or a relationship

breakdown with a significant person such as a family member, girlfriend/boyfriend or friend. Intoxication was the immediate precipitant in four suicides. In these cases, either evidence of a substance was found at the scene or coroner's findings indicated substance use in the toxicology report. Other significant stressors included family dysfunction and possible feelings of homosexuality. A trigger for the suicide of three young people was unable to be identified or was not recorded.

Known to Department of Child Safety

Four children who suicided were known to the Department of Child Safety (DChS) (21.1%). The department's involvement with those children will be considered by the Queensland Child Death Case Review Committee (CDCRC)¹⁶¹.

Alcohol, drug and substance use

Seven of the children and young people who died from suicide were known alcohol, drug or substance users (36.8%). The most frequently reported substance used was marijuana, with four children and young people identified to have been users. Other substances included alcohol, paint and, in one case, possibly amphetamines.

Intellectual/learning disabilities

Two children and young people were identified to have some form of intellectual or learning impairment. Disabilities included Aspergers Syndrome¹⁶², learning difficulties and speech impairments.

Table 7.4 illustrates a number of circumstances and risk factors common for children and young people who suicided in Queensland. As shown, many of the children experienced multiple factors that place individuals at a higher risk of suicidal behaviours (Beautrais, 1999:245).

159 In one case, it was reported that the child had previously attempted suicide but the mode of attempt was not recorded.

160 Each child and/or young person may have experienced more than one precipitating incident or life stressor. Consequently, numbers may not sum accurately to the number of suicides which occurred in the 2004–05 period examined.

161 Since 1 August 2004, the DChS has been required to conduct a review of its involvement with a child if the child was known to the department within the three years prior to their death. The CDCRC is an independent committee responsible for considering the department's review. The committee is multi-disciplinary and is chaired by the Commissioner.

162 Aspergers Syndrome is a form of autism.

Table 7.4: Summary of risk factors/selected characteristics of all 19 children who were suspected of suiciding in 2004–05

Gender*	Age**	ATSI ^a	Regional/remote	Low SES	Mental health issues	Previous suicidal behaviour	History of childhood abuse	Precipitating incident	Know to DChS	Alcohol/drug use
M	10–13	✓	✓	✓				✓		
F	10–13	✓	✓	✓					✓	
M	10–13	✓	✓	✓			✓	✓	✓	✓
M	10–13		✓	✓				✓		
M	10–13		✓	✓				✓		
M	10–13		✓	✓						
F	10–13		✓		✓	✓		✓		
M	10–13	✓		✓						
M	10–13	✓	✓		✓		✓	✓	✓	
F	15–17							✓		
F	15–17				✓			✓		
F	15–17		✓	✓	✓	✓	✓	✓		✓
M	15–17			✓	✓	✓	✓	✓	✓	✓
F	15–17		✓	✓	✓			✓		✓
M	15–17							✓		
M	15–17				✓	✓		✓		✓
M	15–17							✓		
M	15–17	✓	✓			✓	✓	✓		✓
M	15–17							✓		✓

Data source: Queensland Child Death Register (2004–05)

✓ = Yes, the child has this risk factor.

* M = Male; F = Female

** 10–13 = 10 to 13 years; 15–17 = 15 to 17 years

^a Aboriginal and/or Torres Strait Islander

Notes: 1. Children aged 14 years have not been included in this table as no children of this age were identified in the reporting period.

2. Low SES refers to children and young people who have been classified as residing in either a low or very low socioeconomic region.

The following case study illustrates the presence of multiple factors which may have acted as triggers to this young person's suicide.

Terri¹⁶³, 17 years of age, died from intentional hanging. Terri was reported to have experienced a number of stressful events and precipitating factors prior to the suicide. These included:

- alcohol/drug use
- mental health issues – possible mood disorder
- childhood abuse, and
- prior suicidal behaviours – threats, ideation and attempts.

Additionally, according to the police report of death to the coroner, Terri had previously received hospital treatment for injuries caused by self-harming behaviours. However, a mental health assessment was not conducted on this occasion¹⁶⁴.

163 Terri is a pseudonym.

164 The Commission does not currently have access to medical records and, therefore, has not been able to verify the accuracy of this information.

Other significant factors

Place of incident

During the 18 month period examined, almost two-thirds of suicides occurred at the child or young person's place of residence (12 deaths, 63.2%). Other places of suicide included nearby bushland, parks or paddocks (four deaths), at a cliff face or bridge (two deaths) and on a main highway (one death).

Intent stated (verbally or written)

Many children and young people stated or implied their intent¹⁶⁵ verbally to a family member, friend or health professional before the suicide (9 deaths, 47.4%). Suicide notes were also found in two cases. The high number of children and young people who stated their intent before committing suicide highlights the importance of taking threats or talk of suicide seriously. There needs to be a clear recognition among parents, caregivers and others that children know enough about suicide to attempt it, regardless of whether they appreciate the finality and permanence of death (Beautrais, 2001:652).

Media and technology influences

A growing body of evidence has indicated that media publicity and increased access to information through technology may encourage suicidal behaviour in vulnerable children (Beautrais, 1999:233). One child in this report used the media as a source of information before attempting suicide. Media depiction may increase suicide risk by encouraging imitation and by normalising suicide as a common and acceptable response to resolving problems (Beautrais, 1999:233).

Contagion

There is considerable evidence to suggest that the suicide of one person may trigger suicidal behaviour in those associated with that person or in vulnerable people who become aware of the suicide (Beautrais, 1999:241). In two cases, the child or young person had previously witnessed a family member attempt to take their own life or had found them deceased after a completed suicide. In both cases the method

of suicide used by the family member was the same method used by the child.

Day and time of occurrence

Children and young people were most likely to suicide on a Tuesday (five deaths) or Wednesday (four deaths). Suicides usually occurred in the afternoon between 12pm and 5.30pm (10 deaths)¹⁶⁶. Further, several suicides reported during the 18 month period occurred within 24 hours of each other. Of the 19 suicides, two occurred on the same day in November 2004, two on the same day in January 2005 and four others within a day of each another. The Commission does not have sufficient information to determine possible explanations for this. For example, it is not known whether any of the children and young people were friends or associates.

A number of other factors associated with youth suicide, include:

- disability status
- family circumstances
- school and employment records
- clinical mental health classifications
- prior offending behaviour, and
- previous hospital admissions/assessment for suicidal behaviour.

Unfortunately, due to the lack of access to data from other agencies, the Commission is unable to report on these factors with any degree of accuracy or consistency. Section 89ZG of the *Commission for Children and Young People and Child Guardian Act 2000* provides that a government entity may provide the Commissioner with information reasonably needed to perform Part 4A child death research functions. Identifying risk factors known to be associated with suicidal behaviour requires full case file records from government agencies, including the Departments of Child Safety, Communities, Health, Housing, Police, Education, Disability Services, as well as information from the Office of the State Coroner. The Commission hopes to develop agreements with these agencies in order to report on the above risk factors in 2005–06.

¹⁶⁵ In one case, the child had both stated intent verbally and in a suicide note.

¹⁶⁶ In one case, the approximate time of death is unknown.

Prevention and intervention

Queensland Government Suicide Prevention Strategy (QGSPS)

The Queensland Government developed the *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008* to help reduce the rate of suicide and attempted suicide for people of all ages in Queensland (Queensland Government, 2003:3). The QGSPS (Queensland Government, 2003:6) aims to assist both government and the community to work towards suicide prevention by:

- providing a better understanding of suicide and suicidal behaviour
- identifying priorities for program development
- implementing these priorities in responsive programs that achieve clear outcomes, and
- building frameworks for robust evaluation and monitoring.

Two key priority areas targeted in this strategy include Indigenous people and young people. The Commission will continue to monitor this and other strategies currently implemented in Queensland. Any key findings or further areas of interest will be discussed in future reports.

Protective factors

Researchers have found that family cohesion, well-developed social skills, peer group affiliation, good coping and problem solving skills, positive beliefs and values and attitudes against suicide may protect individuals against the risk of suicide (Queensland Government, 2003:19; Beautrais, 1999:241). Accordingly, development of these factors may help buffer the impact of exposure to risk factors for suicide, particularly among vulnerable youth.

Assessment issues

A recent study by the University of Queensland (Dower et al., 2000) found that many young people who are admitted to hospital for non-fatal deliberate self-harm do not receive mental health assessments or follow-up care. In three of the 19 suicides examined by the Commission, it was reported that the young person who had either attempted suicide and received medical treatment or expressed a wish to suicide to a health professional, did not receive immediate and/or any mental health assessment or were not considered to be at risk¹⁶⁷.

A key recommendation of the University of Queensland study was that all young people who present to emergency departments for non-fatal deliberate self-harm undergo mental health assessments (Dower et al., 2000:49). The study also recommended the availability of follow-up appointments within 48 hours of discharge.

The Commission supports this recommendation given the potential such action could have in reducing suicides. Information surrounding assessment and follow-up will be key issues for the Commission in future reports.

Future directions

The Commission is particularly concerned about the young age at which children are taking their own lives in Queensland and intends to liaise with key agencies in 2005-06 regarding current strategies to prevent childhood suicide.

167 In another case, not included in this count, a young person had visited a health professional the day before the suicide. In this case, the doctor had prescribed medication and had made an appointment for the young person to see a social worker the following day. From the information provided, the Commission is unable to determine whether the gravity of the situation was either communicated or acknowledged.