

A decorative graphic at the top of the page. On the left, a green silhouette of a train with several rectangular cars is shown. To the right, a green silhouette of a city skyline with various building shapes is visible. Below these elements is a thin white line.

SUICIDE, SUSPECTED SUICIDE AND ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK 2001-2021

SEPTEMBER 2022 (V2)

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INTRODUCTION

This report has been prepared by the TrackSAFE Foundation to increase knowledge and inform prevention activities in order to reduce fatalities, injuries and near misses on the Australian heavy rail network.

The TrackSAFE Foundation, established by the Australasian Railway Association and UGL in 2012, is Australia's only harm prevention charity focused on reducing deaths, injuries and near misses on the rail network. TrackSAFE also works to improve the wellbeing of rail employees.

Every life lost and injury on the rail network is a tragedy and the impacts on family, friends, communities, rail and recovery staff and witnesses can be profound. These incidents together with thousands of near hits each year can cause trauma and work-related stress and illness to rail and recovery staff.

They also cause disruption and delays to hundreds of services each year impacting customers and economic efficiency. The average annual economic burden of railway safety incidents in Australia during the period 2007-2015 was estimated to be approximately \$360.1 million¹.

Working closely with rail organisations, the TrackSAFE Foundation is actively engaged in a wide range of rail safety activities including public awareness campaigns and facilitation of the annual Rail Safety Week. To prevent suicides on the rail network, it advocates for fencing and other barriers to reduce access to the rail corridor, encourages individuals to seek help before and at the time of crisis and is currently exploring bystander intervention options. It also promotes the responsible reporting of suspected and attempted suicides by the media.

In partnership with Lifeline Australia, TrackSAFE implements public awareness campaigns to encourage individuals to contact Lifeline on 13 11 14 whether they are in crisis or just needing someone to talk to. The [Pause.Call.Be Heard](#) signage is used widely in the rail corridor as well as being delivered digitally in bursts to those in and near the corridor.

More information on TrackSAFE's prevention activities is available via its [website](#).

This Queensland report complements an Australia wide report that is available [here](#).

Some people may find the content of this report confronting or distressing. The information included here places an emphasis on data, and as such, can appear to depersonalise the pain and loss behind the statistics. If this material raises concerns for you contact Lifeline on 13 11 14.

1. RISSB 2015 AS 7644. 2015. Rail Corridor Access Infrastructure Standard p4.

NOTES ON THE DATA IN THIS REPORT

- Fatality, injury and near miss data in this report has been sourced from either the National Coronial Information System (NCIS) or the Office of the National Rail Safety Regulator (ONRSR).
- Where data is described as 'suicide', the data has been sourced from a report commissioned by the TrackSAFE Foundation from the NCIS for the period 2000-2017. Information about the limitations of this data can be provided by TrackSAFE.
- Where a fatality is described as 'suspected suicide', the data has been obtained by ONRSR and includes incidents notified to the Regulator by rail operators as required by the Rail Safety National Law National Regulations. These incidents are notified to ONRSR shortly after the incident. The Coroner may make a different determination about the cause of death.
- The number of suicides in 2016 & 2017 (76 & 82 respectively) as determined by Coroners' and included in the NCIS report is lower than the suspected suicides reported in the ONRSR database (77 & 94 respectively).
- There is some variability in the time period used for the analysis included in this report due to the form and availability of data.
- Some of the information presented in this report for 2016-2021 has been interpreted and coded from free-form text in the ONRSR database by TrackSAFE. This includes sex, location and action.
- TrackSAFE has calculated the railway suicide/suspected suicide rate per 100,000 population using Australian Bureau of Statistics (ABS) annual June population estimates. The ABS advises that care should be taken comparing 2019 suicide data with previous years as some ABS data has been subject to quality improvement processes and revisions.
- Two amendments were made to the ONRSR occurrence database by TrackSAFE. A 2017 Victorian tram incident that resulted in a serious injury is excluded and suspected suicide fatality in NSW in 2016 was misclassified as a minor injury.

SUMMARY

- Between 2001-2021 there were 1,588 suicides (2001-2017) and suspected suicides (2018-2021) on the Australian heavy rail network, an average of 74 per year and equivalent to 71% of all fatalities. More occurred in Victoria than in any other state (45%) followed by 29% in New South Wales, 12% in Queensland, 9% in Western Australia and 5% in South Australia. Nationally, 67% (1,037) of suicides and suspected suicides occurred on the track between stations and 32% (497) occurred at a station.
- Between 2001- 2021 there were 252 fatalities on the Queensland heavy rail network, 188 suicides or suspected suicides (75%) and 64 other fatalities (25%). This is a total average of almost 12 fatalities per year.
- Of the Queensland suicides and suspected suicides, 58% occurred on the track between stations and 36% at a station and 6% other location or unknown.
- There has been a decrease in the Queensland rate of suicide/suspected suicide on the rail network per 100,000 of the population from 0.24/100,000 in 2010 to 0.10/100,000 in 2021.
- There has been a decrease in the proportion of suicide and suspected suicide deaths on the Queensland rail network of total deaths by suicide from 1.87% in 2010 to 1.19% in 2021.
- In Queensland between 2016-2021 and based on notifications to the Office of the National Rail Safety Regulator:
 - 45 (88%) of a total of 51 fatalities were suspected suicides
 - there were 84 other occurrences reported including 49 attempted suicides (21 serious injuries, 12 minor injuries and 16 no injuries) and 16 serious injuries and 19 minor injuries
 - 67% of suspected and attempted suicides occurred from midday onwards, with more (21%) occurring between 3 – 6pm and 9 – 12pm
 - in 71% of the attempted suicides, the individual was struck by a train, with 64% resulting in a fatality. Of those that were not struck by a train, 93% survived
 - 63% of attempted suicides that occur on the track result in a fatality and 61% of attempted suicides that occur from a station, the individual survives.

SUICIDE IN AUSTRALIA

- Suicide is rare and preventable.
- However, it is the leading cause of death for Australians aged between 15-45 years¹.
- The number of people dying by suicide has increased from 2,480 in 2010 to 3,139 in 2020, or around 9 lives lost per day to suicide². It is estimated that each suicide death affects up to 135 people³.
- In 2020 suicide accounted for 1.9%² of all deaths in Australia.
- In Queensland, the number of people dying by suicide has increased from 588 in 2010 to 759 in 2020⁴.
- The cause of suicidal behaviour is complex and multifaceted. In 2020, some of the comorbidity factors occurring with suicide include: 40.3% mood disorders, including depression, 29.3% drug and alcohol use, 23.5% suicide ideation, 23.2% problems with relationships, 23.1% chronic psychoactive substance use disorders³. The psychosocial risk factors associated with suicide were age dependent and differed throughout the lifespan. This includes a personal history of self-harm, disruption of family by separation and divorce and problems in relationship with spouse or partner⁴.
- Male suicides make up three-quarters of all suicides. In 2020 there were 2,384 male deaths (18.6 per 100,000) and 755 female deaths (5.8 per 100,000).
- Suicide is the 10th leading cause of death for males and the 22nd leading cause for females².
- The median age of death due to suicide was 43.5 years, compared to 81.7 years for all causes of death². However, the median age of death by suicide of Aboriginal and Torres Strait Islander peoples was 31.3 years.
- For every death by suicide, it is estimated that there may be another 30 attempted suicides each day³ and many more people will experience suicidal distress.
- 28% of suicides occur in public places including on rail tracks and from rail stations⁵. The proportion of deaths by suicide that have occurred at a rail location of total deaths by suicide has declined over the last decade, from 3.06% in 2010 to 1.85% in 2020 and in Queensland, 1.87% in 2010 to 1.19% in 2020.

1. <https://www.blackdoginstitute.org.au/resources-support/suicide-self-harm/facts-about-suicide-in-australia/>

2. <https://www.suicidepreventionaust.org/news/statsandfacts>

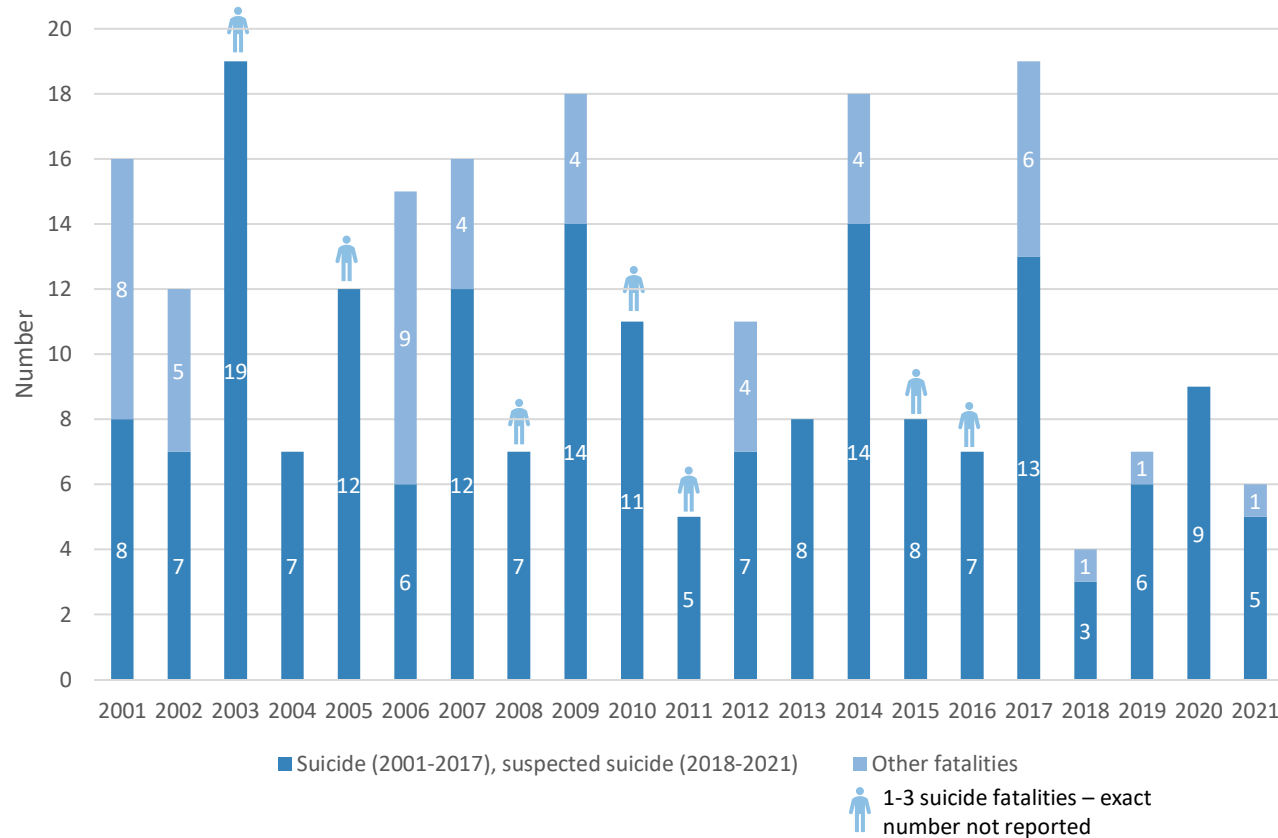
3. Suicide Prevention Australia, University of New England, 2016, The ripple effect: understanding the exposure and impact of suicide in Australia

4. <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-Australia>. See notes from the ABS on issues with the Victorian data.

5. <https://mindframe.org.au/suicide/data-statistics/abs-data-summary-2020>

6. Too, LS, Spittal, MJ, Bugeja, L, McClure, R, Milner, A, 2016, Individual and community factors for railway suicide: a matched case-control study in Victoria, Australia, Social Psychiatry and Psychiatric Epidemiology, 51:849-856.

FATALITIES ON THE QUEENSLAND HEAVY RAIL NETWORK 2001-2021^{1,2,3}



Between 2001 - 2021 there were 252 fatalities – 188 (75%) suicides or suspected suicides and 64⁴ (25%) other fatalities. This is a total annual average of almost 12 fatalities per year.

STATE DISTRIBUTION OF FATALITIES



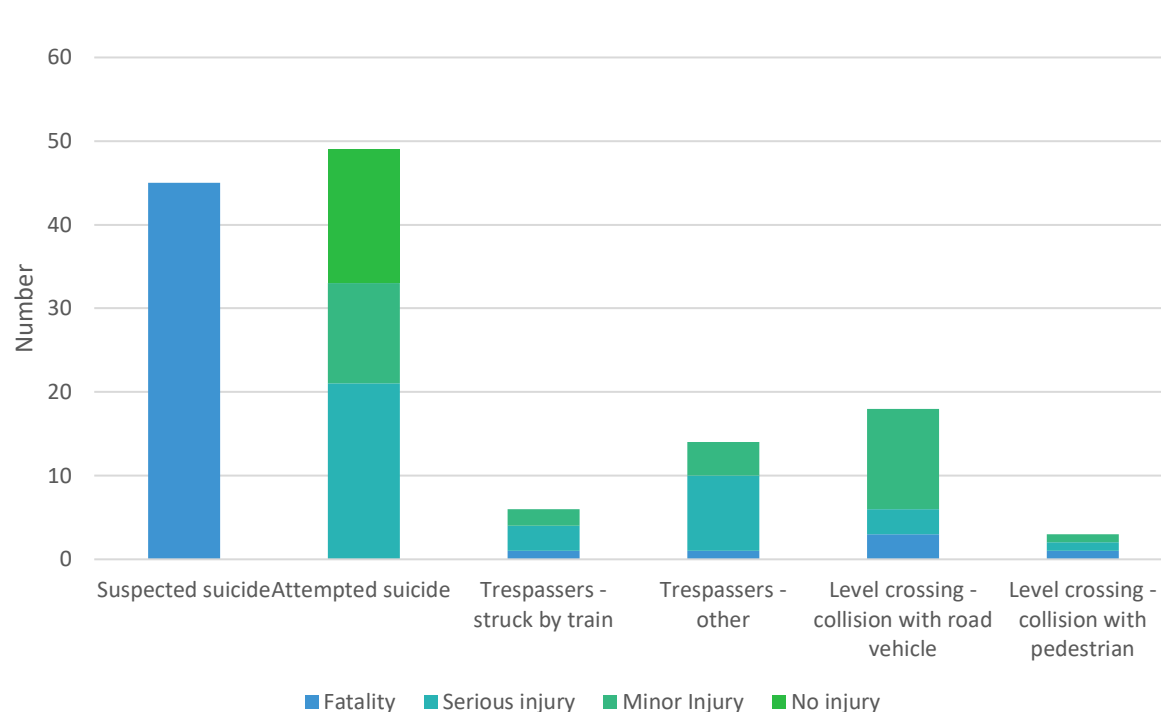
In addition, there were 5 fatalities in TAS, 7 in the NT and 2 in the ACT.

1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia (for 2001-2017 suicide data), National Coronial Information System, 2021, Non-intentional self-harm deaths at Australian railway locations 2000-2017 (DR20-43), February, Melbourne Australia (for 2001-2017 other fatality data). The exact number per year is not reported if it is less than 4.
2. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021 (for 2018-2021 data). The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.
3. NCIS report for Australia less suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 report by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR).
4. This includes between 1-3 fatalities that occurred in various years between 2001-2000, the exact annual number is not reported.

FATALITIES & INJURIES BY CAUSE ON THE QUEENSLAND HEAVY RAIL NETWORK 2016-2021¹

In this period there were:

- 135 fatalities, injuries and attempted suicides with no injury reported to the Office of the National Rail Safety Regulator, an average of 23 per year.
- 88% of fatalities were suspected suicides.



	Fatality	Serious injury	Minor Injury	No injury	Total
Suspected suicide	45				45
Attempted suicide		21	12	16	49
Trespassers - struck by train	1	3	2		6
Trespassers - other	1	9	4		14
Level Xing - collision with road vehicle	3	3	12		18
Level Xing - collision with pedestrian	1	1	1		3
Total	51	37	31	16	135

STATE DISTRIBUTION OF OCCURENCES

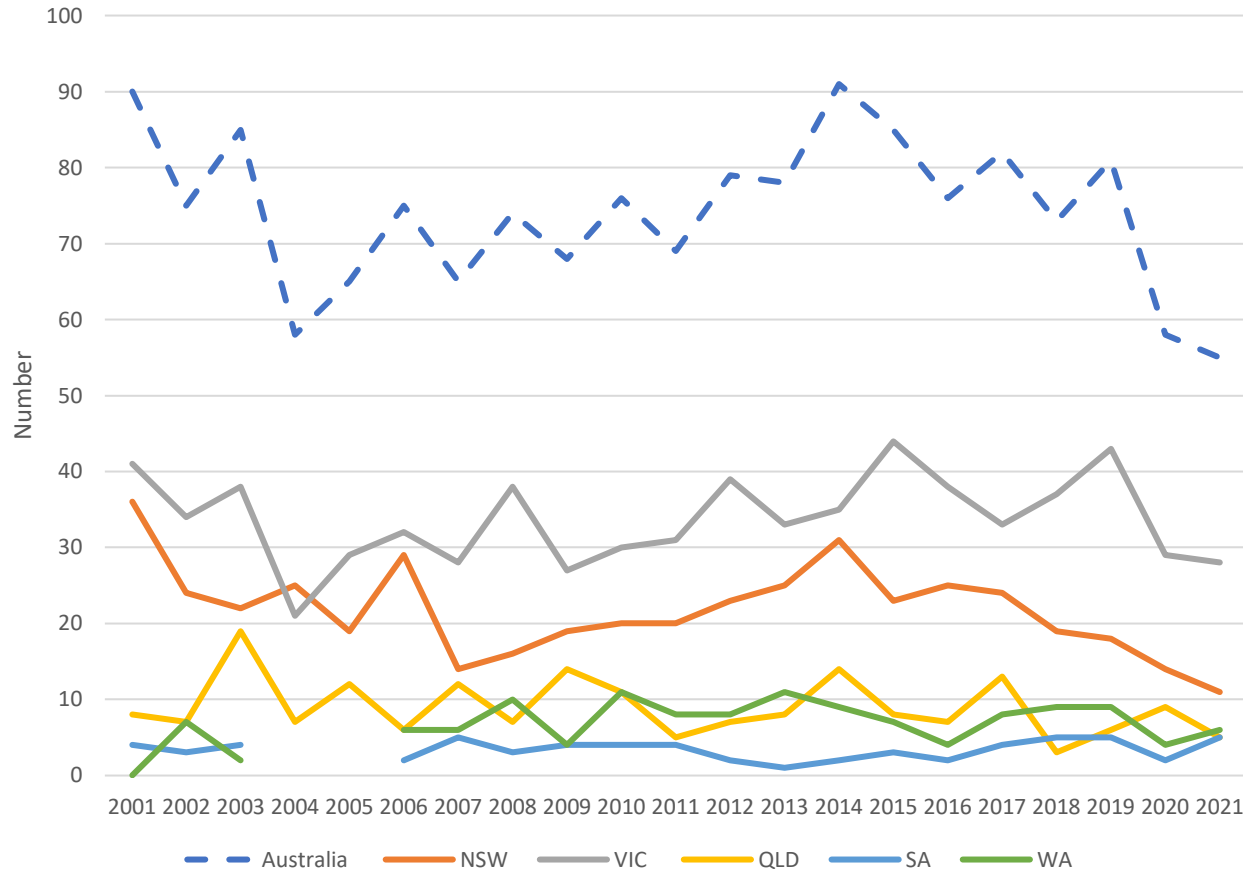


There were 2 injury incidents in NT, 1 in TAS and 0 in ACT

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences.

Note: NCIS report less Australian suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 report by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR). National Coronal Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia

SUICIDES (2001-2017)^{1,2} & SUSPECTED SUICIDES (2018-2021)^{3,4} ON THE AUSTRALIAN HEAVY RAIL NETWORK BY STATE⁵



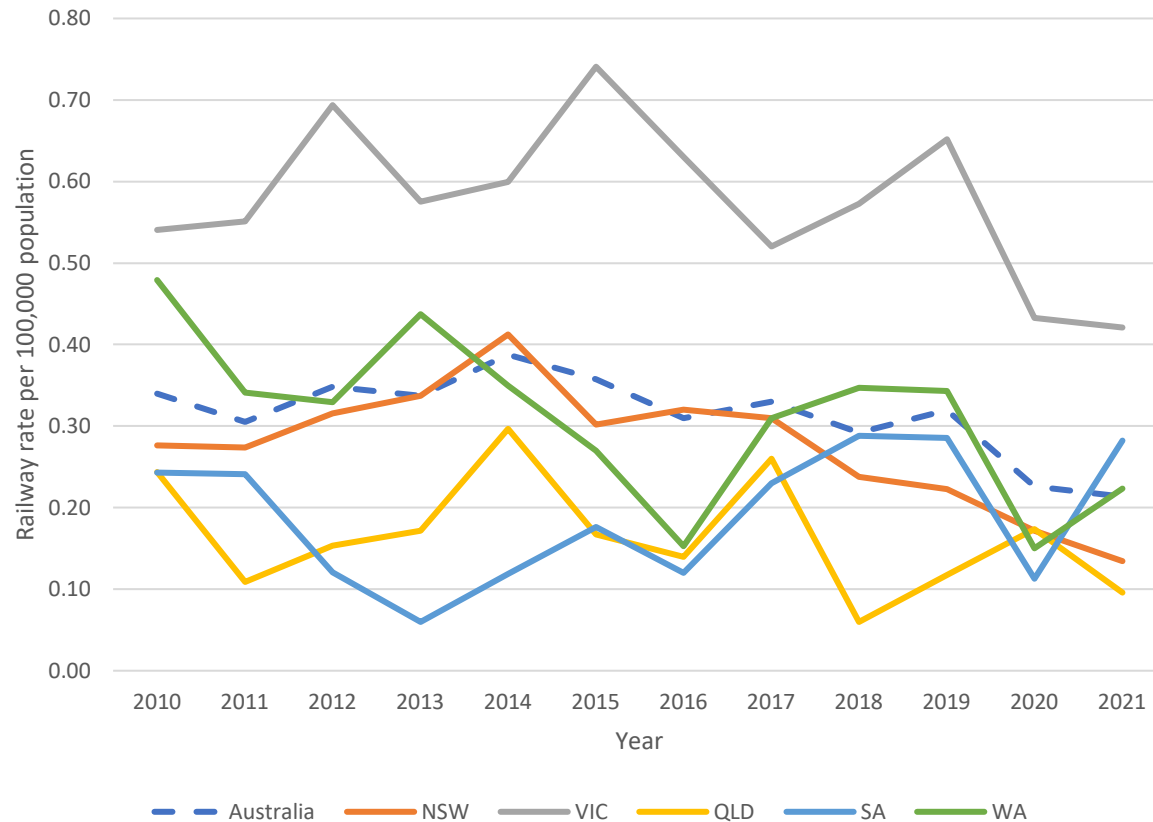
In this period there were 1,558 suicides & suspected suicides, an average of 74 per year and equivalent to 71% of all fatalities.

STATE DISTRIBUTION OF SUICIDES & SUSPECTED SUICIDES⁵



1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia.
2. ONRSR data used for SA & WA in 2016 as NCIS report <4
3. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021 (for 2016-2021 data). The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.
4. NCIS report less suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 reported by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR).
5. In 2004 & 2005 there were a total of 5 deaths by suicide in SA & WA. This 5 is included in the Australian totals but is excluded from the state distribution graphs. These graphs also excludes 1 suicide in the ACT in 2001 and 1 suicide in TAS 2011 however these are included in the Australian totals.

RATE OF SUICIDE (2010-2017)^{1,2} AND SUSPECTED SUICIDE (2018-2021)³ ON THE AUSTRALIAN HEAVY RAIL NETWORK PER 100,000 POPULATION⁴ BY STATE



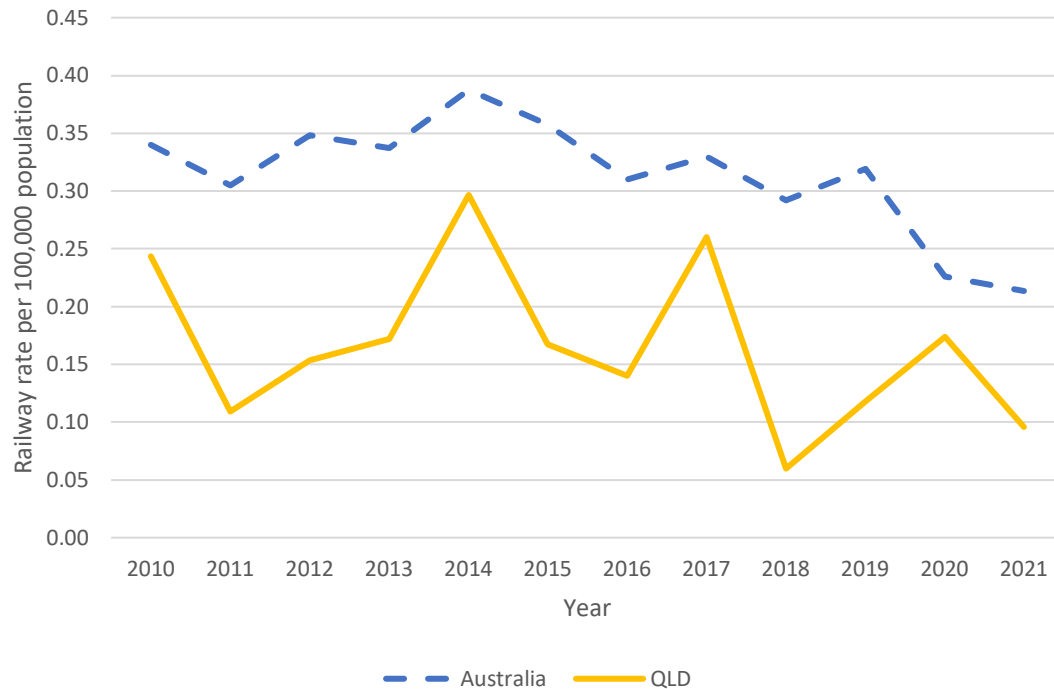
Nationally, and in each state except SA, the rate of suicide/suspected suicide is less in 2021 than it was in 2010.

	2010	2019	2021
Australia	0.34	0.32	0.21
NSW	0.28	0.22	0.13
VIC	0.54	0.65	0.42
QLD	0.24	0.12	0.10
SA	0.24	0.29	0.28
WA	0.48	0.34	0.22

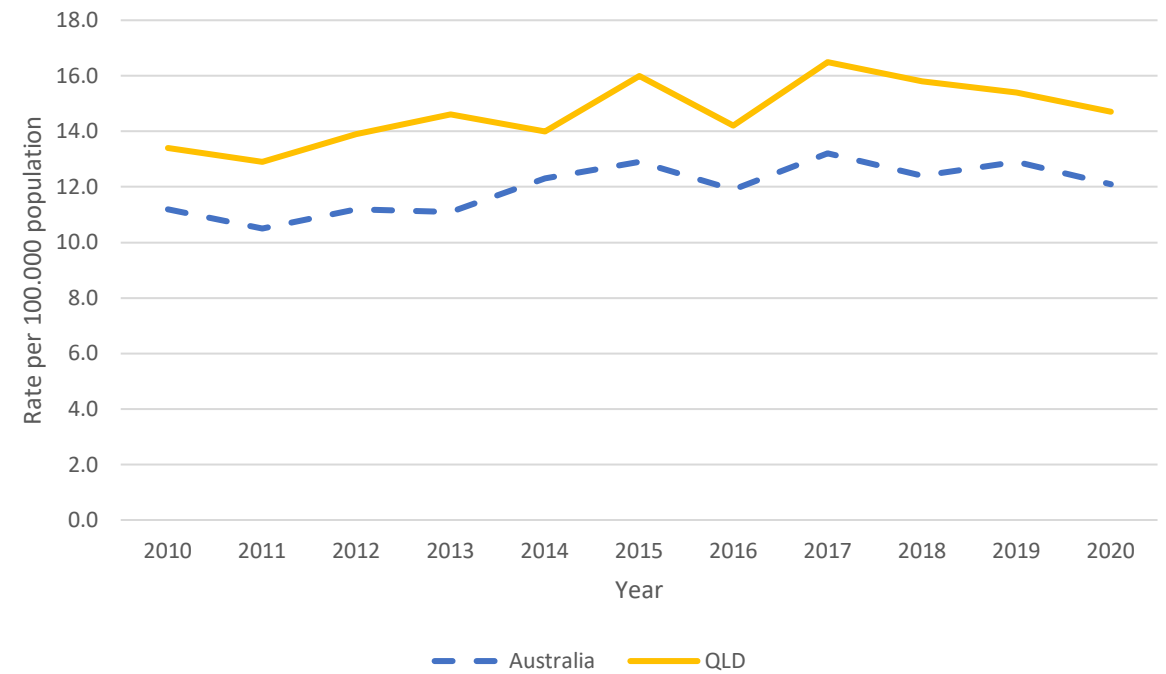
1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia.
2. ONRSR data used for SA & WA in 2016 as NCIS report <4
3. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR. NCIS report less suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 reported by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR).
4. Australian Bureau of Statistics, Australian Demographic Statistics, [Estimated resident population, June each year](#)

RATE OF SUICIDE (2010-2017)^{1,2} AND SUSPECTED SUICIDE (2018-2021)³ ON THE AUSTRALIAN HEAVY RAIL NETWORK PER 100,000 POPULATION⁴ – QUEENSLAND

SUICIDE & SUSPECTED SUICIDE RATE ON RAIL

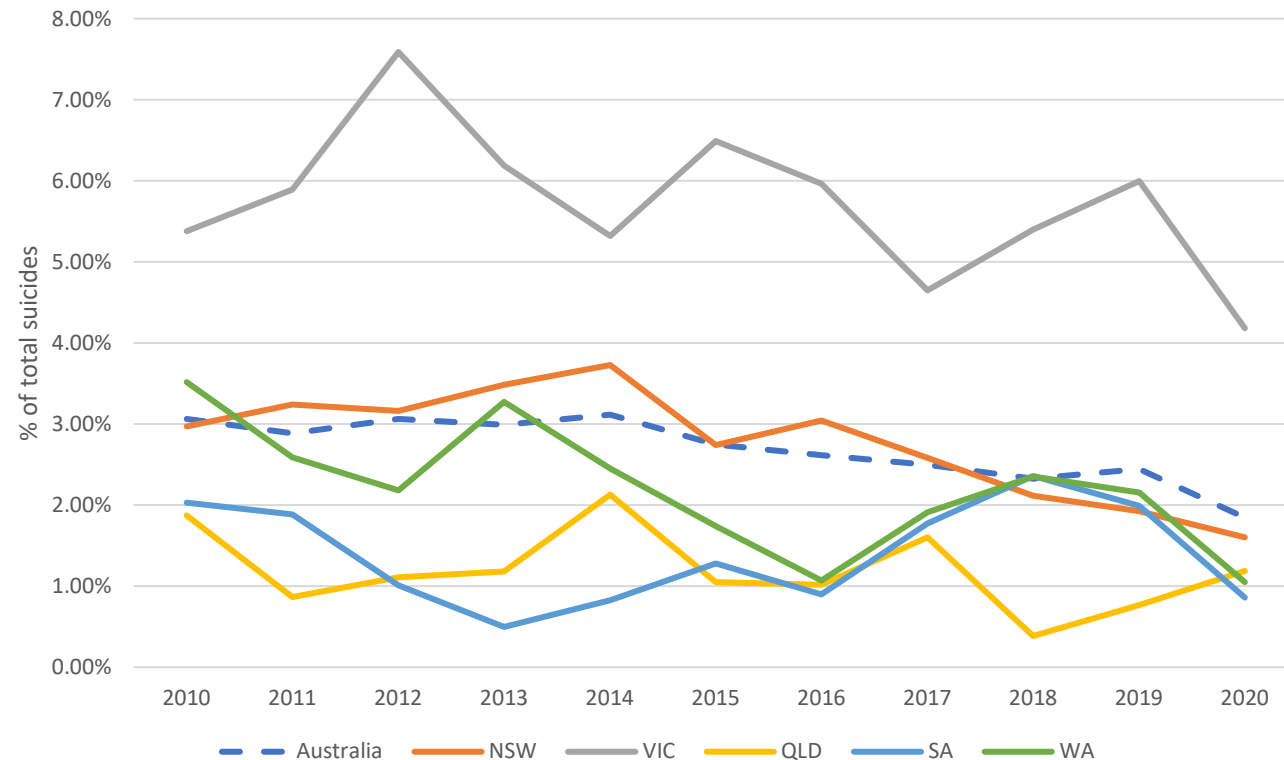


AGE STANDARDISED DEATH RATES FOR SUICIDE^{5,6}



1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia.
2. ONRSR data used for SA & WA in 2016 as NCIS report <4
3. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR. NCIS report less Australian suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 reported by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR).
4. Australian Bureau of Statistics, Australian Demographic Statistics, [Estimated resident population, June each year](#)
5. Australian Bureau of Statistics, 2021, Causes of Death, Australia, <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2020>
6. Australian Bureau of Statistics, 2020, Causes of Death, Australia <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2019#intentional-self-harm-suicides-key-characteristics>

PROPORTION OF SUICIDES (2010-2017)^{1,2} & SUSPECTED SUICIDES (2018-2020)³ OCCURRING ON THE AUSTRALIAN HEAVY RAIL NETWORK OF TOTAL INTENTIONAL SELF-HARM DEATHS⁴ BY STATE



The proportion of suicide and suspected suicide deaths on rail of total deaths by suicide has decreased nationally and in each state between 2010 and 2020.

	2010	2019	2020
Australia	3.06%	2.44%	1.85%
NSW	2.97%	1.92%	1.60%
VIC	5.38%	6.00%	4.18%
QLD	1.87%	0.77%	1.19%
SA	2.03%	1.99%	0.85%
WA	3.51%	2.15%	1.05%

1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia
2. ONRSR data used for SA & WA in 2016 as NCIS report <4
3. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021 (for 2016-2021 data). The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR. NCIS report less suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 reported by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR).
4. Australian Bureau of Statistics, [Cause of Death](#). 2021 data not available until October 2022

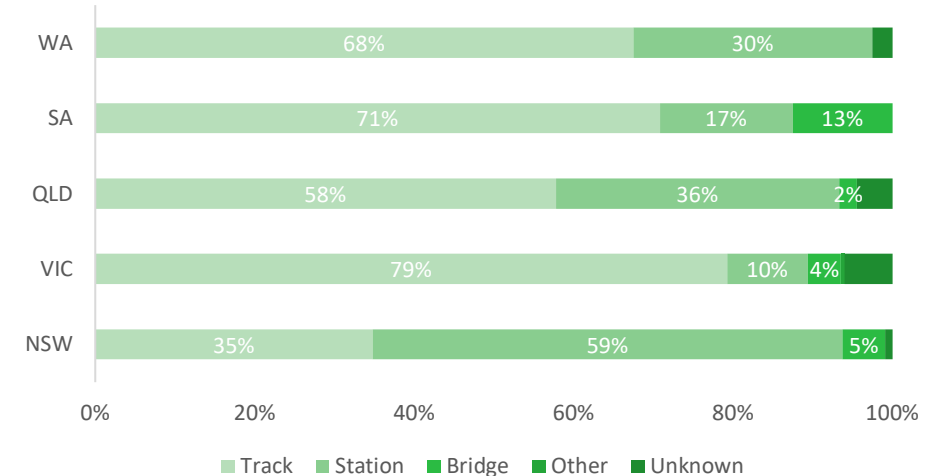
SUICIDE (2014-2017)¹ & SUSPECTED SUICIDE (2016-2021)² ON THE AUSTRALIAN HEAVY RAIL NETWORK BY LOCATION BY STATE

More suicides and suspected suicides occur on the track (between stations) than from a station. Between 2016-2021, across Australia 64% of suspected suicides occurred on the track and 27% from the station. In Queensland, 58% (26) of incidents occurred on the track, 36% (16) and 6% (3) from a bridge, other or unknown location.

2014-2017

	VIC		NSW		QLD		WA		SA		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Station	21	14%	57	60%	21	54%	5	21%	<5	27%	107	34%
Open track	103	69%	35	37%	16	41%	14	58%	6	55%	174	55%
Level or ped crossing	24	16%	<5	*	<5	*	5	21%	<5	*	35	11%
Overpass	<5	*	0	0	<5	*	0	0	0	0	<5	*

2016-2021

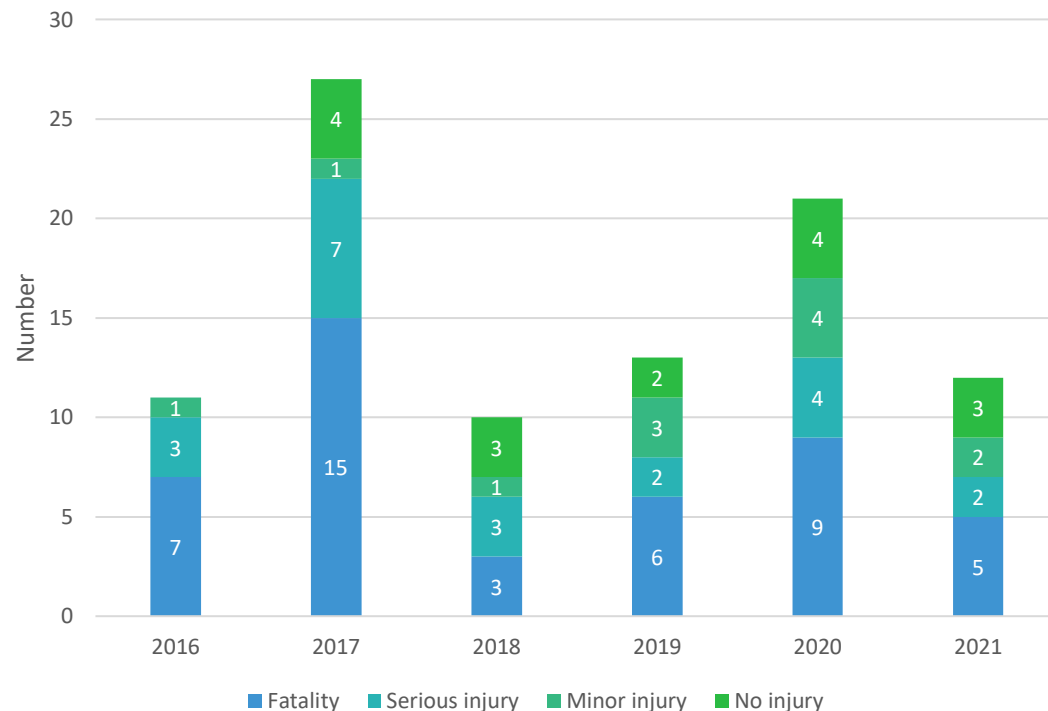


1. National Coronial Information System, Pirkis, J & Clapperton, A, 2020, Suicide in public places project
2. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021 (for 2016-2021 data). Incidents coded by TrackSAFE 'Track', 'Station', 'Bridge/Other/Unknown'. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See here for information about notifiable occurrences to ONRSR.

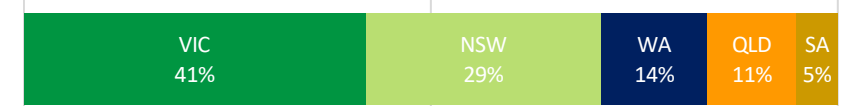
SUSPECTED AND ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK 2016-2021¹

In this period:

- there were 94 suspected and attempted suicides resulting in 45 fatalities, 21 serious injury, 12 minor injuries and 16 incidents with no injury
- there was an average of almost 8 suspected suicides and 8 attempted suicides each year
- in addition to the attempted suicides included in this data that meet the reporting threshold and are notified to the ONRSR, rail operators advise that there are additional attempted suicides and threats of self-harm that do not meet the regulatory reporting requirements.



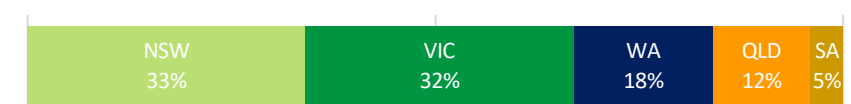
STATE DISTRIBUTION OF SUSPECTED & ATTEMPTED SUICIDES



STATE DISTRIBUTION OF SUSPECTED SUICIDES



STATE DISTRIBUTION OF ATTEMPTED SUICIDES



1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

Note: NCIS report less Australian suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 report by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR). National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia (for suicide deaths 2016-2017)

SUSPECTED AND ATTEMPTED SUICIDE ON THE AUSTRALIAN HEAVY RAIL NETWORK 2016-2021¹

	NSW		QLD		SA		VIC		WA		TOTAL	
	Suspected suicide	Attempted suicide	Suspected suicide	Attempted suicide	Suspected suicide	Attempted suicide	Suspected suicide	Attempted suicide	Suspected suicide	Attempted suicide	Suspected suicide	Attempted suicide
2016	23	28	7	4	2	3	41	14	4	7	77	56
2017	27	29	15	12	5	4	39	29	8	12	94	86
2018	19	27	3	7	5	3	37	20	9	22	73	79
2019	18	15	6	7	5	6	43	16	9	19	81	63
2020	14	15	9	12	2	1	29	21	4	9	58	58
2021	11	19	5	7	5	1	28	30	6	3	55	60
TOTAL	112	133	45	49	24	18	217	130	40	72	438	402

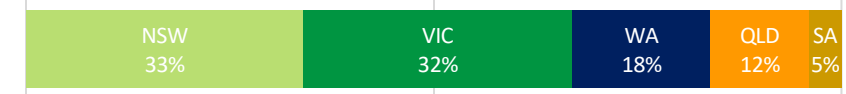
STATE DISTRIBUTION OF SUSPECTED SUICIDES



STATE DISTRIBUTION OF SUSPECTED & ATTEMPTED SUICIDES



STATE DISTRIBUTION OF ATTEMPTED SUICIDES



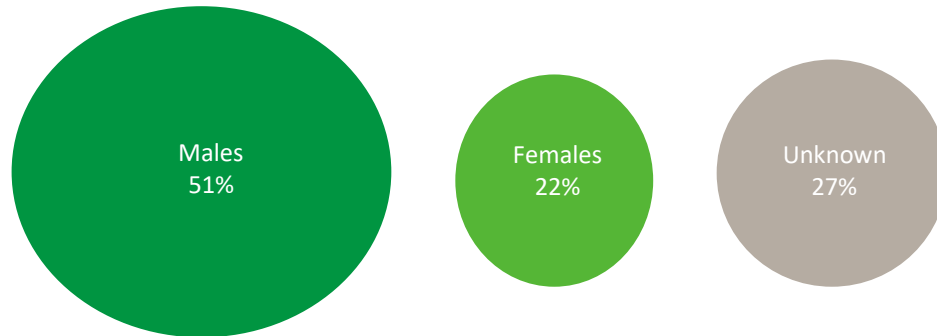
1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences.

Note: NCIS report less suicides in 2016 & 2017 compared to ONRSR suspected suicides (76 and 82 reported by NCIS for 2016 and 2017 respectively compared to 77 and 94 suspected suicides reported by ONRSR). National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia (for suicide deaths 2016-2017)

SUSPECTED & ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK - GENDER 2016-2021¹

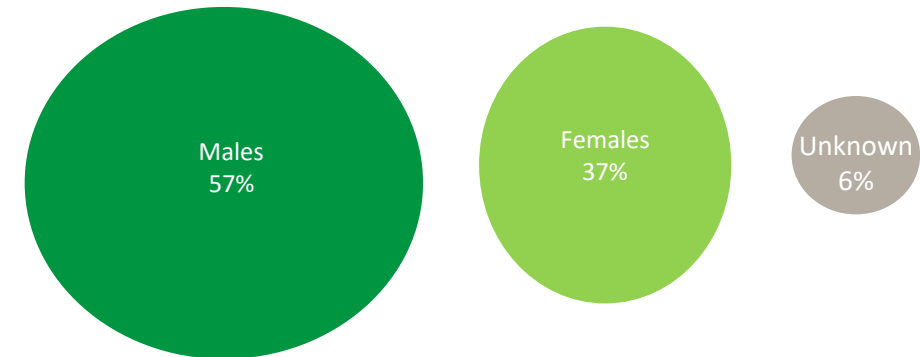
Australia wide for the period 2001-2017, 74% of suicides on the rail network were male which is consistent with the general population trend. This Queensland data for suspected suicides 2016-2021 includes too many unknowns to allow a comparison with the national trend. Of the attempted suicides nationally, 44% were male, 42% were female and 14% unknown.

SUSPECTED SUICIDE



Total 45

ATTEMPTED SUICIDE

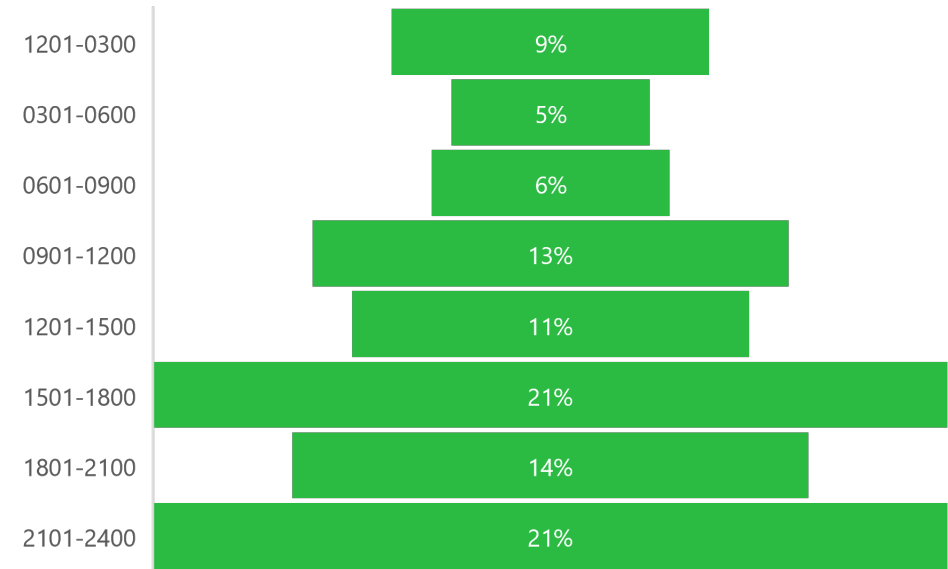
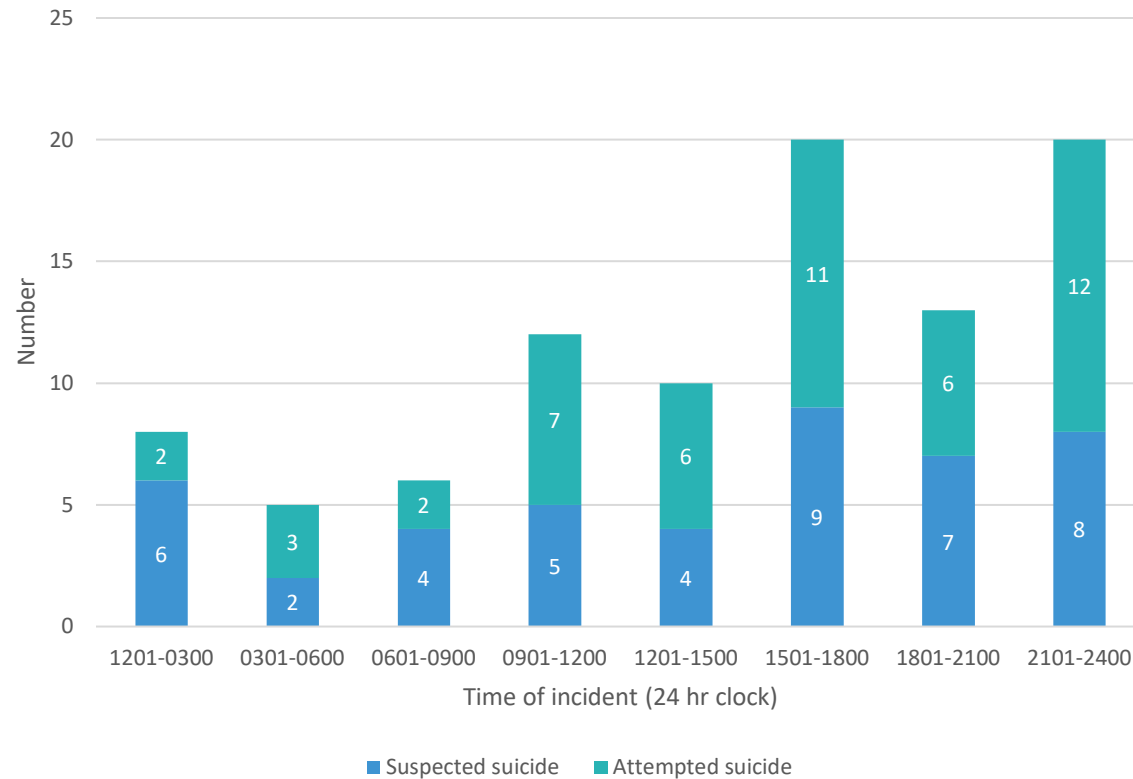


Total 49

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

SUSPECTED & ATTEMPTED SUICIDES ON THE QUEENSLAND HEAVY RAIL NETWORK – TIME OF DAY 2016-2021¹

67% of incidents occurred from midday onwards with more occurring between 3 – 6pm and 9 – 12pm (21%) than any other period. Australia wide, 69% of incidents occurred from midday onwards with more incidents occur between 3 – 6pm (20%) than any other period.



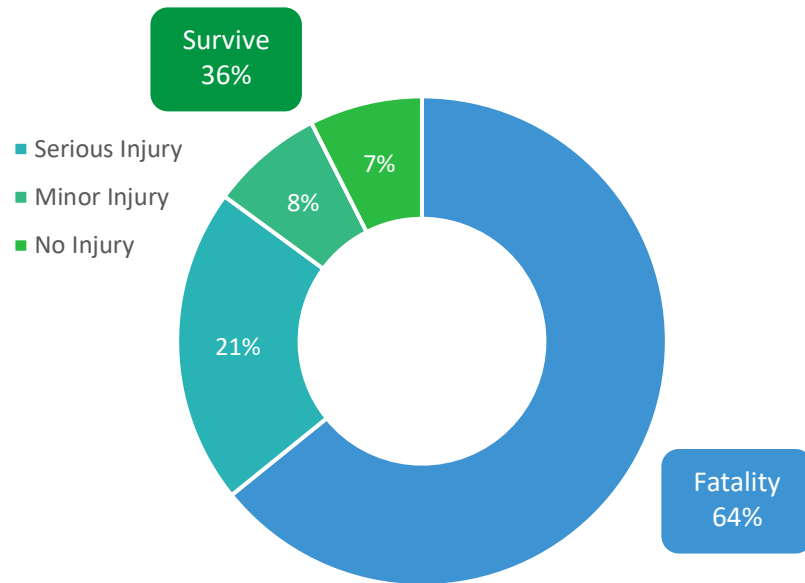
Total 94

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

SUSPECTED & ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK – OUTCOME INDIVIDUAL STRUCK BY TRAIN 2016-2021¹

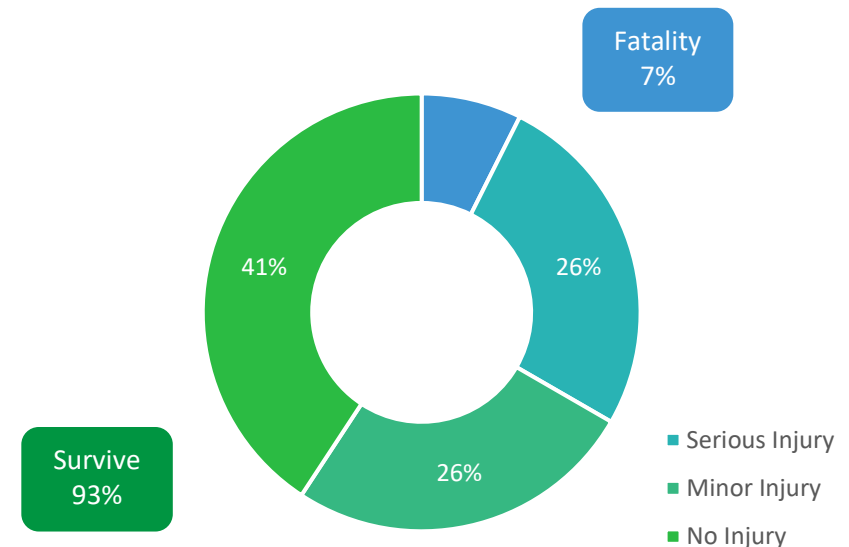
In 71% of the attempted suicides, the individual was struck by a train, with 64% resulting in a fatality. Of those that were not struck by a train, 93% survived

INDIVIDUAL STRUCK BY TRAIN



Total 67

INDIVIDUAL NOT STRUCK BY TRAIN



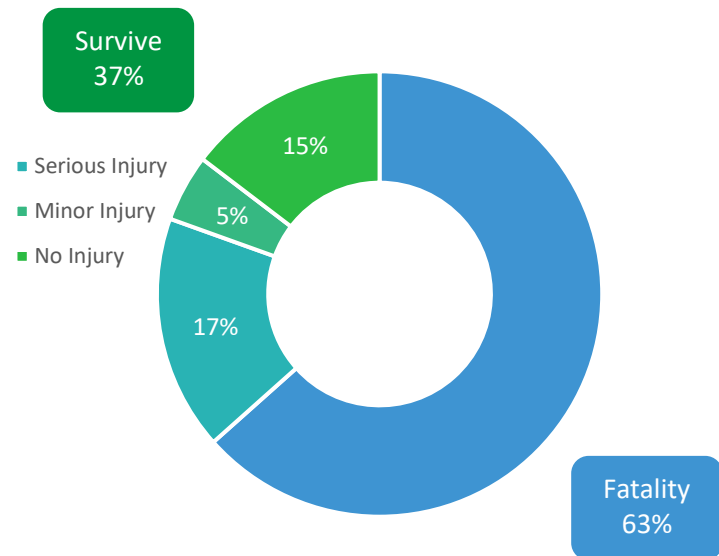
Total 27

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

SUSPECTED & ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK – OUTCOME BY LOCATION 2016-2021¹

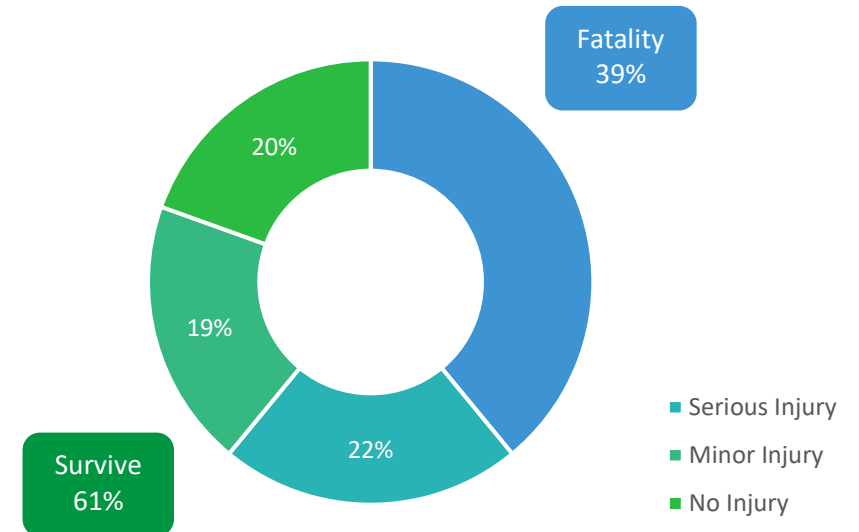
63% of attempted suicides that occur on the track result in a fatality and 61% of attempted suicides that occur from a station, the individual survives.

OUTCOME OF INCIDENTS THAT OCCUR ON THE TRACK²



Total 41

OUTCOME OF INCIDENTS THAT OCCUR FROM A STATION²

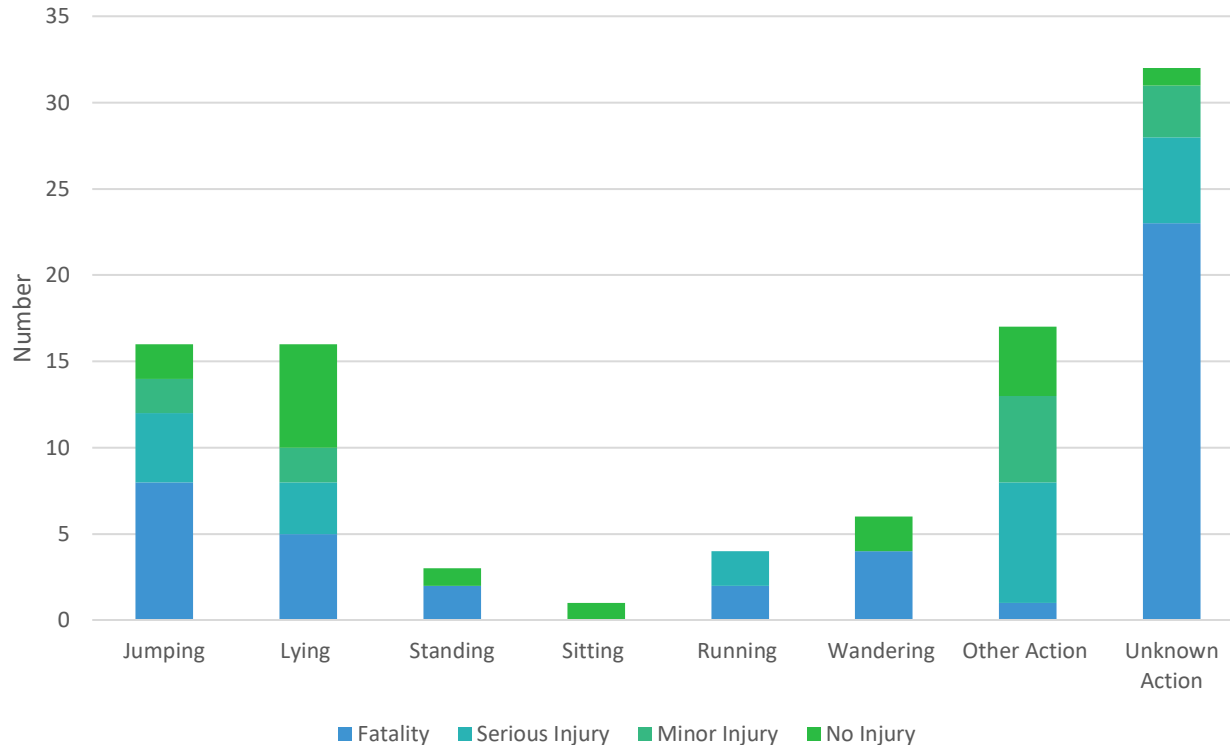


Total 41

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

2. These graphs do not include 12 occurrences that occur at a bridge, other or unknown location resulting in 3 fatalities, 5 serious injuries, 2 minor injuries and 2 no injuries.

SUSPECTED & ATTEMPTED SUICIDE ON THE QUEENSLAND HEAVY RAIL NETWORK – OUTCOME BY BEHAVIOUR 2016-2021¹



Understanding patterns of behaviour prior to an attempted suicide is important as different intervention strategies can be developed for different behaviours². For example, when individuals jump directly into the path of a train there is generally less time to enact response measures compared with cases where individuals are stationary or wandering on tracks and intervention mechanisms such as approaching the individual or slowing the train can be deployed³.

Unfortunately the information available is insufficient to be useful.

1. Office of the National Rail Safety Regulator, Occurrence extract-fatalities, serious injuries, minor injuries, attempted suicide no consequence July 2015–December 2021. Coding of data in accordance with Appendix in Gregor, S, Beavan, G, Culbert, A, Kan John, P, Viet Ngo, N, Keating, B, Sum, R & Radwan, I, 2019, Patterns of pre-crash behaviour in railway suicides and the effect of corridor fencing: a natural experiment in New South Wales, *International Journal of Injury Control and Safety Promotion*. The requirements for operator reporting of notifiable occurrences are set out in the Reporting Requirements for Notifiable Occurrences. See [here](#) for information about notifiable occurrences to ONRSR.

2. Radbo, Svedung & Andersson, 2005, Suicides and other fatalities from train-person collisions on Swedish railroads: A descriptive epidemiologic analysis as a basis for systems-oriented prevention. *Journal of Safety Research*, 36(5), 423-428.

3. Gregor, S, Beavan, G, Culbert, A, Kan John, P, Viet Ngo, N, Keating, B, Sum, R & Radwan, I, 2019, Patterns of pre-crash behaviour in railway suicides and the effect of corridor fencing: a natural experiment in New South Wales, *International Journal of Injury Control and Safety Promotion*.

LOCATION OF INCIDENT BY QUEENSLAND LOCAL GOVERNMENT AREAS – 2000-2017¹

LGA of incident	2013–2017	Total 2000–2017
Brisbane (C)	33	86
Logan (C)	<4	20
Moreton Bay (R)	4	12
Ipswich (C)	4	9
Gold Coast (C)	<4	8
Sunshine Coast (R)	0	4
Toowoomba (R)	0	4
Bundaberg (R)	0	<4
Cairns (R)	0	<4
Carpentaria (S)	0	<4
Cassowary Coast (R)	0	<4
Charters Towers (R)	0	<4
Cloncurry (S)	<4	<4

LGA of incident	2013–2017	Total 2000–2017
Fraser Coast (R)	0	<4
Gladstone (R)	<4	<4
Hinchinbrook (S)	0	<4
Livingston (S)	0	<4
Lockyer Valley (R)	0	<4
Mackay (R)	0	<4
Palm Island (S)	0	<4
Redland (C)	<4	<4
Scenic Rim (R)	0	<4
South Burnett (R)	0	<4
Not available	0	<4
Total	50	166

Note: The data presented in this and the next table are not mutually inclusive. E.G. the state/territory or LGA where the incident occurred does not necessarily relate to the deceased person's state/territory or LGA of residence.

'C' denotes City Council, 'T' Town Council, 'RC' Regional Council.

1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia. The exact number per year is not reported if it is less than 4.

RESIDENCE OF QUEENSLAND RESIDENT BY QUEENSLAND LOCAL GOVERNMENT AREA – 2000-2017¹

LGA of residence	2013–2017	Total 2000–2017
Brisbane (C)	28	68
Logan (C)	<4	24
Moreton Bay (R)	5	17
Ipswich (C)	4	10
Gold Coast (C)	4	8
Redland (C)	<4	4
Sunshine Coast	0	4
Toowoomba (R)	<4	4
Bundaberg (R)	<4	<4
Cairns (R)	0	<4
Carpentaria (S)	0	<4
Cassowary Coast (R)	0	<4
Charters Towers (R)	0	<4

LGA of residence	2013–2017	Total 2000–2017
Cloncurry (S)	<4	<4
Fraser Coast (R)	0	<4
Gladstone (R)	<4	<4
Gympie (R)	0	<4
Hinchinbrook (S)	0	<4
Lockyer Valley (R)	0	<4
Mackay (R)	0	<4
Murweh (S)	0	<4
Palm Island (S)	0	<4
Townsville (C)	0	<4
Not available	0	7
Total	51	165

Source: NCIS. The data presented in this and the previous table are not mutually inclusive. E.G. the state/territory or LGA where the incident occurred does not necessarily relate to the deceased person's state/territory or LGA of residence.

'C' denotes City Council, 'T' Town Council, 'RC' Regional Council, 'DC' District Council.

1. National Coronial Information System, 2020 Intentional Self-harm deaths at Australian railway locations 2000–2017, (DR20-31 and DR20-31A), November, Melbourne Australia. The exact number per year is not reported if it is less than 4.



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