**The Role of Bystanders in the Prevention of Railway Suicides in New South Wales, Australia**

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**Electronic Supplementary Material 1**

## Appendix 1: Coding Guide

Cases of attempted suicide are considered in the current study and are defined as "a situation where information was presented to show an apparent deliberate act by an individual who was intent on harming themselves but this act did not result in their death" (Beavan, 2016). Incidents were included in analysis as "train suicide attempts" if an individual attempted suicide by coming into contact with a train. Incidents were excluded from this category if they related to other means of self-harm, such as drugs. It should be noted that some individuals classed as attempted train suicide may also have been focussed on self-harm: for example, some cases 'prevented' from completing suicide by emergency services could be more likely to have been self-harmers than people attempting suicide, otherwise they would not have waited for the arrival of emergency services to make the attempt.

Our primary focus is on incidents classed as "active preventions". These incidents are ones in which there is clear evidence that an individual was attempting to come into contact with a train for the purpose of self-harm, but was prevented by the actions of others. Table 2 in the results section shows excerpts from cases of active prevention and illustrates how coding occurred. Responses that enabled preventions were categorised in terms of who responded and the form their response took. The individuals reporting or responding were classified as bystanders (members of the public with no relationship to the attempter), rail personnel at stations, other rail personnel (including those on trains and security personnel), emergency services (ambulance, law enforcement, and fire and rescue), other (self-report, multiple parties, kin), and unknown. The type of actions that individuals took was classified as "first response", where the individual(s) were the first to take action, or "reporters", where the individual(s) notified others of the incident to enlist further assistance. In some cases, a reporter was also a first responder. Actions were further distinguished as to the nature of the interaction. A "light" physical interaction was one in which the intervener engaged in guiding, blocking, helping, or use of minimal force to assist the person at risk. A "heavy" physical interaction was one in which the intervener engaged in tackling, pulling, holding, grabbing or restraining actions to assist the person at risk. Cases were also distinguished as to whether a single bystander, or more than one, engaged in the action.

Table E1 shows further details of coding for reporters and responders.

**Table E1. Coding of First Reporters/First Responders**

| Reporting party | |
|---|---|
| **Railway Personnel** | The person-of-interest (POI) was first reported or responded to by people who were employed by Sydney Trains/NSW TrainLink/CityRail at the time of the incident, either as employees or as contractors, even if off-duty. |

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| | |
|---|---|
| **– in station** | Personnel were present either in the train station or at the site of the incident. Examples include platform staff, guards, transit officers, maintenance staff, track workers and other staff present in station areas at the time of the incident. |
| **– on train** | Personnel were present on a train at the time of the incident. Examples include train drivers, guards, transit officers, and other staff travelling on the train at the time of the incident. |
| **– off-site** | Personnel were off-site, and made the detection via the surveillance network. An example is the GRML/SMF (Group Resource Monitoring Location/Security Monitoring Facility) |
| **Emergency services** | The POI was initially reported/responded to by people who were established to be employed by the emergency services (ambulance, law enforcement, fire and rescue services) at the time of the incident. This also applies even if the person is off-duty. |
| **Bystanders (Members of the public – no relation to the POI)** | The POI was initially detected/responded to by people who were neither employed by Sydney Trains/NSW TrainLink nor the emergency services at the time of the incident. The person has no evident past relationship with the POI. |
| **Kin of the POI** | The POI was initially reported/responded to by people who were neither employed by Sydney Trains/NSW TrainLink nor the emergency services at the time of the incident. The person displayed evidence of an ongoing relationship with the POI. |
| **Multiple parties** | The POI was initially reported/responded to by multiple different entities, as described above. |
| **Self-reported** | The alarm, and thus the report, was raised by the POI themselves.<br>Not applicable for first responders. |
| **Unknown** | The evidence is insufficient to identify who was the party responsible for the reporting of the POI. |

The "location" of the incidents studied was taken from a field in the database termed "location on asset". Table S2 below shows the meaning of the coding applied for the Results section in the body of the paper (Table 2).

**Table E2. Coding of Location**

| Location | |
|---|---|
| **Platform** | On the platform, including sitting on the edge, extending a limb out. |
| **Track near platform** | Also termed "track/between platforms". This code is for incidents that occurred within the rail corridor. It includes incidents where the POI accessed the rail corridor from the train station. In most cases, the POI accessed the rail corridor from the platform. |
| **Track not at platform** | Also termed "perway track/civil". This code is for incidents that occurred in the rail corridor, but outside of a train station. |
| **Other (e.g. level crossing)** | This code is for "Level crossing - signal", "rolling stock related", "footbridge", "bridges/tunnels – civil", "concourse" and "other". |

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**Appendix 2: Results Details**

**Table E3** Detailed **c**omparison of bystander active preventions, other active preventions and deaths by suicide

| | Bystander Preventions n(%) (N = 69) | Other Preventions n(%) (N = 566) | $X^2$ p-value | | Deaths by Suicide n(%) (N = 191) |
|---|---|---|---|---|---|
| Pre-crash behaviour | | | | | |
| Jumping | 19 (35.8%) | 48 (14.5%) | < .001 | | 77 (57.0%) |
| Non-jumping | 34 (64.2%) | 283 (85.5%) | | | 58 (43.0%) |
| Total known values | 53 (100%) | 331 (100%) | | | 135 (100%) |
| Location (Sydney metro region) | | | | | |
| Platform | 15 (29.4%) | 45 (12.1%) | < .001 | | 14 (9.5%) |
| Track near platform | 26 (51.0%) | 191 (51.3%) | | | 85 (57.4%) |
| Track not at platform | 4 (7.8%) | 108 (29.0%) | | | 37 (25.0%) |
| Other (e.g. level crossing) | 6 (11.8%) | 28 (7.5%) | | | 12 (8.1%) |
| Total known values | 51 (100%) | 372(100.0%) | | | 148 (100%) |
| Location (regional area NSW) | | | | | |
| Platform | 1 (5.6%) | 7 (3.6%) | 0.17 | | 1 (2.3%) |
| Track near platform | 11 (61.1%) | 91 (46.9%) | | | 12 (27.9%) |
| Track not at platform | 2 (11.1%) | 71 (36.6%) | | | 13 (30.2%) |
| Other (e.g. level crossing) | 4 (22.2%) | 25 (12.9%) | | | 17 (39.5%) |
| Total known values | 18 (100%) | 194 (100%) | | | 43 (100%) |
| Gender | | | | | |
| Male | 31 (44.9%) | 297 (53.3%) | 0.19 | | 124 (73.8%) |
| Female | 38 (55.0%) | 260 (46.7%) | | | 44 (26.2%) |
| Total known values | 69 (100%) | 557 (100 %) | | | 168 (100%) |
| Time of day | | | | | |
| Midnight – 3am | 7 (10.1%) | 45 (9.9%) | 0.41 | | 14 (7.3%) |
| 3am – 6am | 6 (8.7%) | 27 (5.9%) | | | 9 (4.7%) |
| 6am – 9am | 2 (2.9%) | 13 (2.9%) | | | 21 (11.0%) |
| 9am – midday | 6 (8.7%) | 39 (8.6%) | | | 30 (15.7%) |
| Midday – 3pm | 4 (5.8%) | 72 (15.9%) | | | 35 (18.3%) |
| 3pm – 6pm | 11 (15.9%) | 87 (19.2%) | | | 20 (10.5%) |
| 6pm – 9pm | 15 (21.7%) | 87 (19.2%) | | | 29 (15.2%) |
| 9pm – midnight | 18 (26.1%) | 84 (18.5%) | | | 33 (17.3%) |
| Total | 69 (100%) | 454 (100%) | | | 191 (100%) |