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DETERMINING A SUICIDE UNDER AUSTRALIAN LAW

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This article examines the role of coroners in making legal determinations of suicide in Australia. Research indicates that the requirement to make findings of intent and capacity in unexpected, violent deaths can be difficult for coroners and recent government inquiries have suggested that the law contributes to the problem. A review of laws and commentary that guide coroners in Australian states and territories reveals not only that coroners are the only persons tasked with making routine legal determinations of suicide, but that such legal guidance lacks clarity. This article concludes that law reform would aid coroners by clarifying definitional issues, removing inconsistency between state jurisdictions and increasing the transparency of case law. Along with requirements for a determination of intent, which is a practical matter previously raised by the Victorian Coronial Council, such changes would go some way to ensuring that Australian suicide statistics are more reliably created.

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I INTRODUCTION

Coroners' findings contribute to national suicide statistics in Australia.[1] Indeed, coroners are presently the only legal persons who make routine determinations of suicide so that it may be coded as such.[2] As a result, the process by which coroners make determinations of suicide is critically linked with policymaking in public health and mental health, as well as planning and funding of suicide prevention strategies.[3] Issues surrounding coronial determinations of suicide have been the subject of increased scrutiny and commentary in Australia since the Australian Senate's report, *The Hidden Toll: Suicide in Australia* ('*The Hidden Toll*'), revealed the extent of underreporting of suicides.[4] As recently as 2014, a report by the Coronial Council of Victoria expanded on the ways in which the law relating to suicide contributes to that problem.[5] It has been suggested that key reasons for underreporting are inconsistencies in coronial practices and a reluctance by coroners to make explicit findings of intent.[6]

Given that coroners are the only persons tasked with making routine legal determinations of suicide in Australia, the process by which coroners come to such a finding is an important yet relatively under-researched and under-analysed element of this process. To date, most research to investigate the process of suicide determination by coroners has focused on the output of coronial decision-making in the form of secondary analysis of coronial data.[7] In contrast, this article examines the legislation, case law and secondary literature relating to suicide determinations in all Australian jurisdictions to determine precisely what law informs coroners in their suicide deliberations.

As the first comprehensive review and analysis of the Australian law in this area, this article builds on recommendations made by the Coronial Council of Victoria and the Senate Community Affairs References Committee in their

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1 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia, 2014: Method of Intentional Self-Harm* (8 March 2016) <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2014~Main%20Features~Method%20of%20Intentional%20self-harm~10053>.

2 Joan Ozanne-Smith and Jessica Pearse, National Coronors Information System, Submission No 84 to Senate Community Affairs Reference Committee, *Inquiry into Suicide in Australia*, 20 November 2009, 5; Sue Walker, Linping Chen and Richard Madden, 'Deaths Due to Suicide: The Effects of Certification and Coding Practices in Australia' (2008) 32 *Australian and New Zealand Journal of Public Health* 126, 126; Diego De Leo et al, 'Achieving Standardised Reporting of Suicide in Australia: Rationale and Program for Change' (2010) 192 *Medical Journal of Australia* 452, 452.

3 Diego De Leo, 'Can We Rely on Suicide Mortality Data?' (2015) 36 *Crisis* 1; Senate Community Affairs References Committee, Parliament of Australia, *The Hidden Toll: Suicide in Australia* (2010) 26.

4 Senate Community Affairs References Committee, above n 3.

5 Coronial Council of Victoria, 'Suicide Reporting in the Coronial Jurisdiction' (Report, 17 June 2014).

6 Senate Community Affairs References Committee, above n 3.

7 See, eg, David M Studdert and Stephen M Cordner, 'Impact of Coronial Investigations on Manner and Cause of Death Determinations in Australia, 2000–2007' (2010) 192 *Medical Journal of Australia* 444. There is considerable research in England that follows this approach, such as: Bret S Palmer et al, 'Factors Influencing Coroners' Verdicts: An Analysis of Verdicts Given in 12 Coroners' Districts to Researcher-Defined Suicides in England in 2005' (2015) 37 *Journal of Public Health* 157; Debbi Stanistreet et al, 'Accident or Suicide? Predictors of Coroners' Decisions in Suicide and Accident Verdicts' (2001) 41 *Medicine, Science and the Law* 111.

report, *The Hidden Toll.* It suggests that a major barrier to consistent and accurate suicide reporting is the lack of clarity in the law guiding coroners in their practice. Specifically, that the impediments to uniform approaches to determinations of suicide may be caused by practical barriers, including requirements to hold an inquest or make a definitive finding within the binary of suicide/not suicide, and interpretational barriers, including what constitutes a suicide and the applicable standard of proof. It concludes that a severely underdeveloped legal framework for the identification of suicide in Coroners Acts is compounded by a lack of definitional clarity, and a subsequent over-reliance on English coronial law and Australian criminal law, both of which rely on a standard of proof beyond that required within the coronial jurisdiction. It is recommended that clarification of the law as well as the publication of inquest findings would be a minimum required for Australian coronial law to develop in this area.

To determine the law applicable in this area, the approach taken in this review is multifaceted. First, the Coroners Acts in each jurisdiction have been searched for any mention of suicide or intent as well as any sections relevant to when findings can be made and what they may contain. The websites of Coroners Courts have also been searched for any other sources of official guidance. Second, legal databases have been searched for case law relating to determinations of suicide under Australian law. Third, secondary literature has been reviewed in the form of scholarly academic literature as well as key coronial texts. Due to the difficulty of accessing inquests online, details from inquests have generally been included only where the case was raised in the literature. For this reason, emphasis is given to discussion of the law in selected inquests, such as *Tyler Cassidy* and *Rebekah Lawrence*.[8] It is important to note that within Australia, inquests are notoriously difficult to access and search.[9] As a

8 *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria (Judge Coate) (‘*Tyler Cassidy*’); *Inquest into the Death of Rebekah Anne Lawrence* [2009] Coroner’s Court of New South Wales (Malcolm MacPherson) (‘*Rebekah Lawrence*’).

9 For example, s 73(1) of the *Coroners Act 2008* (Vic) requires that all inquest findings with recommendations be published on the internet, unless otherwise ordered by a coroner. Inquest findings are available from 1 November 2009: Coroners Court of Victoria, *Coroners’ Written Findings* <http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/>. Some earlier findings have been included at the request of the coroner. How the ‘search’ function works is neither transparent nor readily understandable. Indeed, a search for ‘suicide’ revealed no results; a search for ‘intent’ or ‘intention’ revealed four cases, none of which were the key *Tyler Cassidy* case, for instance. Prior to 2012, in New South Wales, only findings deemed to be ‘key’ findings were published online. That did not include the *Rebekah Lawrence* inquest which contained important discussions of law; no ‘search’ function is available. Individual inquests can only be clicked on for a PDF and searched within: see NSW Coroner’s Court, *Coronial Findings* <http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx>. In Queensland, all findings are online with a ‘search’ function by ‘key terms’ available from 2004 onwards: Queensland Courts, *Findings – Coroners Court* <http://www.courts.qld.gov.au/courts/coroners-court/findings>. In the Australian Capital Territory, only ‘selected findings’ are available from 2002 onwards, though there are advanced search options: Magistrates Court of the Australian Capital Territory, *Selected Findings* <https://www.courts.act.gov.au/magistrates/courts/coroners_court/selected-findings>. In Tasmania, findings are available from 2001 onward: Magistrates Court of Tasmania, *Coronial Findings – 2014 and Earlier* <http://www.magistratescourt.tas.gov.au/about_us/coroners/findings_pre-2015>; Magistrates Court of Tasmania, *Coronial Findings (Decisions) 2015–2017* <http://www.magistrates

consequence of this, there exists no readily available pool of relevant case law, experience, and precedent related to findings of suicide for the coroners to access and apply within their own decision-making processes.

II A BRIEF HISTORY OF SUICIDE UNDER AUSTRALIAN LAW

A brief history of suicide under Australian law is necessary to contextualise how suicide is dealt with in the contemporary coronial system. Under the common law, a deceased who suicided was once considered a felon unto himself or *felo de se*.[10] The offence, framed in the 1800 edition of Sir Matthew Hale's *History of the Pleas of the Crown*, occurs where 'a man of the age of discretion, and *compos mentis*, voluntarily kills himself by stabbing, poison, or any other way'.[11] The act of killing oneself was considered a crime against God and the King, who had an interest in preserving his subjects.[12] The consequences of committing the offence included the legal forfeiture of property and the ecclesiastical forfeiture of burial.[13] Verdicts of *felo de se* were included in coroners' findings.[14]

Changing attitudes towards suicide in recent times saw the coronial verdict of *felo de se* abolished in the colony of New South Wales in 1876.[15] Though no longer a coronial verdict, it remained a crime. In England, the act of suicide was decriminalised in 1961,[16] however it took considerably longer to be decriminalised across Australia. Suicide has never been a criminal offence in the

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court.tas.gov.au/about_us/coroners/coronial_findings>. The 'search' function is limited to keywords, coroner, date, TASCD number and title of inquest. In Western Australia, inquests are only available online from 2012 onwards. There is no ability to search except inside individual PDFs. In South Australia, inquest findings are available from 2000 onwards: Courts Administration Authority of South Australia, *All Findings* <http://www.courts.sa.gov.au/CoronersFindings/Pages/All-Findings.aspx>. Also, how the 'search' function works is not transparent or readily understandable; a search for 'suicide', 'intent' or 'intention' revealed no results. It is possible to click on individual findings and search within each. It is assumed that the difficulty we had in searching inquests is also likely a difficulty presented for coroners and other key stakeholders.

10 Conway W Lovesy, *Sir John Jervis on the Office and Duties of Coroners: With Forms and Precedents by William N Welsby* (J Sweet, W Maxwell and Stevens & Sons, 3rd ed, 1866) 141.

11 Matthew Hale, *Hale's History of the Pleas of the Crown* (E Rider, 1800) vol 1, 411 (emphasis in original).

12 Lovesy, above n 10, 141.

13 It was commonplace for the coroner to grant a warrant directing that the body of the deceased be buried in a public street or highway and normally resulted in burial at a public crossroad with a stake driven through the body: ibid 144–9; John Vincent Barry, 'Suicide and the Law' (1965) 5 *Melbourne University Law Review* 1, 5–6. See also Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber, 1958) 234.

14 Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) 633–4.

15 *Verdicts of Felo-de-se Abolition Act 1876* (NSW) s 1 provided: 'From and after the passing of this Act the verdict of *Felo-de-se* shall be and the same is hereby abolished. Provided that nothing in this Act contained shall affect the law with respect to attempts to commit suicide' (emphasis in original).

16 *Suicide Act 1961* (UK) c 60, s 1.

code states of Queensland, Western Australia and Tasmania.[17] However, for common law states, suicide remained a crime until legislatively abolished.[18] In 1967, Victoria decriminalised the act of committing or attempting to commit suicide and in 1983, New South Wales and South Australia followed suit.[19] It was not decriminalised until 1990 in the Australian Capital Territory and as late as 1996 in the Northern Territory.[20]

Aside from the consequences to property and burial, under the common law it was once considered to be against public policy for insurers to make payment in the event of suicide of the insured.[21] However, in 1945, the blanket rule against payments in those circumstances was overruled by Commonwealth legislation.[22] Currently, the financial implications of suicide are limited to where an individual dies by suicide within an exclusion period, normally 13 months of the policy commencing, during which the insured sum will not be paid.[23] A broader view of the consequences arising from suicide encompasses possible embarrassment and stigma,[24] the implications of which will be discussed later in this article. In summary, the contemporary relationship between suicide and Australian law is aptly described by the Supreme Court of Victoria: 'Suicide is a tragedy but not a crime'.[25]

III LEGAL FRAMEWORK FOR CORONERS IN AUSTRALIA

The coronial system in Australia is governed by state and territory legislation ('the Coroners Acts').[26] There are minor variances between jurisdictions however; broadly, suicide is brought into the coronial jurisdiction by virtue of

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17 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 245 [77] (Gummow, Hayne and Heydon JJ). Though the act of suicide itself was not a crime in code states, attempting suicide was until recently, see: *Criminal Code Act 1889* (Qld) sch 1 s 312, as repealed by the *Criminal Law Amendment Act 1979* (Qld) s 4. Despite not being decriminalised until 1979, it was reported, by a Queensland judge, that it was practice not to prosecute for the offence in 1965: Barry, above n 13, 8, citing Sir Roslyn Philp, Justice of the Supreme Court of Queensland; *Criminal Code Act 1924* (Tas) sch 1 s 164, as repealed by *Criminal Code Act 1957* (Tas) s 3; *Criminal Code Act Compilation Act 1913* (WA) sch 1 s 289, as repealed by *Criminal Code Amendment Act 1972* (WA) s 10.

18 Ian Freckelton, 'Psychotherapy, Suicide and Foreseeable Risks of Decompensation by the Vulnerable' (2011) 18 *Journal of Law and Medicine* 467, 469.

19 *Crimes Act 1967* (Vic) s 2, inserting *Crimes Act 1958* (Vic) s 6A; *Crimes (Mental Disorder) Amendment Act 1983* (NSW) sch 1 item 2, inserting *Crimes Act 1900* (NSW) s 31A; *Criminal Law Consolidation Act Amendment Act 1983* (SA) s 2, inserting *Criminal Law Consolidation Act 1935* (SA) s 13A.

20 *Crimes (Amendment) Ordinance (No 2) 1990* (ACT) s 5, inserting *Crimes Act 1900* (NSW) s 16; *Criminal Code Amendment Act 1996* (NT).

21 *Clark v NZI Life Ltd* [1991] 2 Qd R 11, 16 (Thomas J).

22 Ibid referring to the *Life Insurance Act 1945* (Cth) s 120 (now repealed) and the 'public policy' defence in *Beresford v Royal Insurance Co Ltd* [1938] AC 586 ('*Beresford's Case*').

23 Paul Yip et al, 'Assessing the Impact of Suicide Exclusion Periods on Life Insurance' (2010) 31 *Crisis* 217, 217.

24 Freckelton, above n 18, 471.

25 *DPP (Vic) v Rolfe* (2008) 191 A Crim RJ 213, 216 [20] (Cummins J).

26 *Coroners Act 1997* (ACT); *Coroners Act 2009* (NSW); *Coroners Act 1993* (NT); *Coroners Act 2003* (Qld); *Coroners Act 2003* (SA); *Coroners Act 1995* (Tas); *Coroners Act 2008* (Vic); *Coroners Act 1996* (WA).

being an unexpected, unnatural or unusual death and therefore reportable to the coroner.[27] Interestingly, and despite the key role that coroners play in the detection of suicides, none of the Coroners Acts require coroners to make an explicit determination of suicide or of a deceased's intent; making a ruling on intent is generally at a coroner's discretion.[28] Mentions of the word 'suicide' in the Acts are scarce and generally in relation to non-publication orders.[29]

Once a suicide has been reported to the coroner, it will be suggested here that five aspects of the law come into play which critically impact whether the death will be deemed a suicide. First, a suicide finding is impacted by whether the Coroners Acts require or permit the coroner to hold an inquest, or make a finding in relation to a suspected suicide. Second, if the coroner is permitted to make a finding, the outcome critically turns on what circumstances constitute a suicide under the law, and third, the applicable standard of proof for a finding thereof. Alongside the Coroners Acts are also other key sources of law. There is the case law that predominantly emanated in the context of either insurance claims and/or criminal law, both of which speak to the fourth issue: the question of whether there is a legal presumption against suicide. Then finally, there are other, more informal, sources of guidance available to coroners within different jurisdictions. Exploration of these issues will reveal that there are significant inconsistencies between states and a lack of clarity on the key legal issues. These five aspects of the law are examined in turn.

A The Coroners Acts

As mentioned above, none of the Coroners Acts require coroners to make an explicit determination of suicide or of a deceased's intent.[30] Where a coroner does opt to make a ruling on intent, it is generally contained within the findings as to 'how' the person died. According to the Queensland Court of Appeal, 'how' a deceased person died has been ascribed to mean 'by what means and in what circumstances'.[31] However, where the Coroners Acts require findings as to 'cause' of death, this has been interpreted narrowly to mean medical cause.[32] Under these statutory schemes, whether an explicit finding of intent is made depends on the extent to which the individual coroner considers it relevant to reference 'how' the person died.[33] In Queensland, the position is slightly different as their guidelines[34] – which they are legally obliged to implement if possible – note that they should 'strive to indicate [in manner of death] whether the death

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27 *Coroners Act 1997* (ACT) ss 13, 17; *Coroners Act 2009* (NSW) ss 6, 35; *Coroners Act 1993* (NT) s 12; *Coroners Act 2003* (Qld) ss 7, 8; *Coroners Act 2003* (SA) ss 3, 28; *Coroners Act 1995* (Tas) ss 3, 19; *Coroners Act 2008* (Vic) ss 4, 15; *Coroners Act 1996* (WA) ss 3, 17.

28 Ibid; De Leo et al, above n 2, 454.

29 In relation to non-publication orders see, eg, *Coroners Act 2009* (NSW) s 75.

30 De Leo et al, above n 2, 454; Ozanne-Smith and Pearse, above n 2, 5.

31 *Atkinson v Morrow* [2005] 1 Qd R 397, 402 [13] (McPherson JA). This is consistent with guidance in the *State Coroner's Guidelines 2013* (Qld) [8.3].

32 'Form 20A: Version 2: *Coroners Act 2003* (*Sections 45, 51 and 97(2)*): Coroner's Findings and Notice of Completion of Coronial Investigation' (Coroners Court of Queensland, 2 November 2009).

33 Ozanne-Smith and Pearse, above n 2, 5.

34 *State Coroner's Guidelines 2013* (Qld).

was accidental or intentional. If intent is unable to be determined, that should also be explained'.[35]

Intent is indicated by coroners in a range of ways. In the 2016 *Inquest into the Death of Russell Peter McBride*,[36] it is stated that 'Mr McBride intentionally hanged himself from a towel rail in his cell at Arthur Gorrie Correctional Centre while on remand for serious sexual offences'.[37] In the 2016 *Inquest into the Death of Leslie Geoffrey Winbank*,[38] intent is captured in the following manner: 'Mr Winbank shot himself with a modified bolt action rifle while in his home during the course of a stand-off with police. … Earlier that day Mr Winbank had called 000 and expressed an intention to end his life'.[39] In the 2016 *Inquest into the Death of John Edward Drane*,[40] it is stated that 'John Drane took his own life when he set his clothing alight in such a manner to ensure a rapid spread of fire across his clothing'.[41] Though uncommon, suicide can be explicitly noted by a coroner in their findings as is the case of the 2017 *Inquest into the Death of Donna Cowley-Persch*: 'She died by suicide at her work premises on 19 September 2013 by injecting herself with an animal euthanasia drug named "Lethabarb"'.[42] Explicit findings of intent are important as coders from the Australian Bureau of Statistics ('ABS') are required to have evidence from a medical or legal authority that the injury causing death was self-inflicted and there was an intent to suicide before it can be coded as such.[43] Without a definitive statement from the coroner, the default is that the death will be coded an accident.[44]

Even though a coroner may consider suicidal intent relevant to how a person died, they may be limited in their ability to make a finding depending on the jurisdiction. This is because, in several jurisdictions, the content of the findings open to the coroner will turn on whether an inquest can or must be held into the death. For example, in South Australia, inquests are only held where the death occurred in custody, or where the State Coroner considers it either necessary or desirable, or where the Attorney-General directs.[45] Where an inquest is held, the Coroner must determine the cause and circumstances of death (which could encompass a finding of suicide).[46] However, where an inquest is not held, the South Australian Coroners Act *only* permits a finding in relation to cause, not to circumstances of death.[47] As a result of this wording, the State and Deputy Coroners in South Australia consider themselves forbidden from making a

35 Ibid 5 [8.3].
36 *Inquest into the Death of Russell Peter McBride* [2016] Coroners Court of Queensland (5 August 2016) (Terry Ryan).
37 Ibid 9–10 [60].
38 [2016] Coroners Court of Queensland (Terry Ryan).
39 Ibid 8 [59].
40 [2016] Coroners Court of Queensland (John Lock).
41 Ibid 22 [138].
42 [2017] Coroners Court of Queensland 1 [1] (John Hutton).
43 Walker, Chen and Madden, above n 2, 127.
44 Ibid 128.
45 *Coroners Act 2003* (SA) s 21(1).
46 *Coroners Act 2003* (SA) s 25(1).
47 *Coroners Act 2003* (SA) s 29.

finding of intent where an inquest is not held.[48] Conversely, in the Australian Capital Territory, inquests must be held into all reportable deaths and the manner of death must be determined in the findings.[49] The practical effect of these differences is that a particular death could be determined by the coroner to be a suicide in the Australian Capital Territory, but a coroner in South Australia could be prohibited from making the same finding. The varying findings that may be made by Australian coroners are set out in Table 1 below for each jurisdiction.

Table 1: Findings That May Be Made by Australian Coroners (by Jurisdiction)*

Jurisdiction	**Findings If Inquest Is Held**	**Findings If Inquest Is Not Held**
Australian Capital Territory	Manner and cause of death.[50]	Coroners must hold an inquest into all reportable deaths.[51] Coroners may only dispense with a hearing where manner and cause of death are already sufficiently disclosed.[52]
New South Wales	Manner and cause of death.[53]	Cause of death. Reasons for dispensing with an inquest must sufficiently disclose manner of death.[54]
Northern Territory	Cause of death and any relevant circumstances concerning death.[55]	Cause of death and any relevant circumstances concerning death.[56]
Queensland	How and what caused death.[57]	How and what caused death.[58]
South Australia	Cause and circumstances of death.[59]	Cause of death.[60] State and Deputy State Coroners consider they are forbidden from finding on intent.[61]
Tasmania	How the death occurred and the cause of death.[62]	How the death occurred and the cause of death.[63]

48 De Leo et al, above n 2, 454.
49 *Coroners Act 1997* (ACT) ss 13(1), 52(1). However, the coroner may dispense with the requirement to hold a hearing where 'the manner and cause of death are already sufficiently disclosed' under s 34A(1)(a).
50 *Coroners Act 1997* (ACT) ss 13(1), 52(1)(c).
51 *Coroners Act 1997* (ACT) s 13(1).
52 *Coroners Act 1997* (ACT) s 34A(1)(a).
53 *Coroners Act 2009* (NSW) ss 81(1)(c), 27(1)(d).
54 *Coroners Act 2009* (NSW) ss 25(1), 27(1)(c)(i).
55 *Coroners Act 1993* (NT) ss 34(1)(iii), (v).
56 *Coroners Act 1993* (NT) ss 34(1)(iii), (v).
57 *Coroners Act 2003* (Qld) ss 45(2)(b), (e).
58 *Coroners Act 2003* (Qld) ss 45(2)(b), (e), (6).
59 *Coroners Act 2003* (SA) s 25(1).
60 *Coroners Act 2003* (SA) s 29.
61 De Leo et al, above n 2, 454.
62 *Coroners Act 1995* (Tas) ss 28(1)(b), (c).
63 *Coroners Act 1995* (Tas) ss 28(1)(b), (c).

Jurisdiction	Findings If Inquest Is Held	Findings If Inquest Is Not Held
Victoria	Cause and circumstances of death.[64]	Cause of death.[65] No requirement to make a finding with respect to circumstances if the Coroner finds it would not serve the public interest to do so.[66]
Western Australia	How the death occurred and the cause of death.[67]	How the death occurred and the cause of death.[68]

* The requirements listed in this table are not exhaustive and are in addition to other requirements such as those relating to time and place of death as well as the identity of the deceased.

B What Constitutes a Suicide under Australian Law?

In addition to the Coroners Acts, the common law may guide coroners on some aspects of suicide. The first of these is what constitutes a suicide under Australian law. This is not a straightforward enquiry. To exemplify the difficulty inherent in this area, it can be noted that from a sociologist's perspective, there is no internationally agreed definition of what constitutes a suicide.[69] According to Silverman, there are currently at least 15 commonly referenced definitions, beginning with Durkheim's seminal description, which is: '[a]ll cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result'.[70] In addition to these 15, suicide is also defined differently by the ABS,[71] by the World Health Organization,[72] and within the Operational Criteria for the Determination of Suicide.[73] From a judicial perspective, it has been defined as 'voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing'.[74] In the *Inquest into the Death of Tyler Jordan Cassidy*,[75] after receiving no submissions indicating a definitive Victorian or Australian authority on the test a coroner should apply when making a finding of suicide, Coroner Coate proposed a formulation:

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64 *Coroners Act 2008* (Vic) ss 67(1)(b), (c).
65 *Coroners Act 2008* (Vic) s 67(1)(b).
66 *Coroners Act 2008* (Vic) s 67(2)(b)(ii).
67 *Coroners Act 1996* (WA) ss 25(1)(b), (c).
68 *Coroners Act 1996* (WA) ss 25(1)(b), (c).
69 Morton M Silverman and Diego De Leo, 'Why There Is a Need for an International Nomenclature and Classification System for Suicide' (2016) 37 *Crisis* 83.
70 Morton M Silverman, 'The Language of Suicidology' (2006) 36 *Suicide and Life-Threatening Behavior* 519, 522, quoting Emile Durkheim, *Suicide: A Study in Sociology* (John A Spaulding and George Simpson trans, Free Press, 1951) 44 [trans of: *Le Suicide* (first published 1897)].
71 Australian Bureau of Statistics, above n 1.
72 World Health Organization, *Suicide* (August 2017) <http://www.who.int/mediacentre/factsheets/fs398/en/>.
73 Mark L Rosenberg et al, 'Operational Criteria for the Determination of Suicide' (1988) 33 *Journal of Forensic Sciences* 1445.
74 *R v Cardiff City Coroner; Ex parte Thomas* [1970] 1 WLR 1475, 1478.
75 [2011] Coroners Court of Victoria.

> In my view, the appropriate question is properly framed as one in which I must consider whether or not, in doing what he did on that night, Tyler was engaged in a voluntary or deliberate course of conduct or act or acts in which he consciously intended at the moment of engagement in the acts, by those acts, to end his own life.[76]

Accepting that formulation as appropriate for the coronial jurisdiction, the elements for a suicide to be established are: (1) a voluntary or deliberate act of the deceased; of which (2) the intent behind the act was to end their own life; with (3) a conscious understanding, at the moment of engagement in the act that such an act would necessarily result in death. While these elements are clearly present in many suicide cases, there are significant grey areas. These elements are discussed in turn.

1 Voluntary or Deliberate Act of the Deceased

The first element is that the suicidal act must be voluntarily and deliberately carried out by the deceased.[77] This element will ordinarily mark out the suicidal act from a homicidal act of which another person will be culpable. The suicidal act must be perpetrated by persons onto themselves.[78] However, Freckelton notes that there is room for movement with regard to how direct that action must be.[79] Suicides have been found which include indirect actions by the deceased. In the United States, for example, a 'suicide by cop' was found where the deceased fired at armed police officers with the virtual inevitability that they would fire back.[80] A similar situation was recently identified in Australia, however the actions of the deceased young boy to induce police to shoot him were found to not be a suicide.[81] The particular circumstances of that case will be discussed later in this article.

2 The Intent behind the Act Was to End Their Own Life

The second element is that the intent behind the act perpetrated by the deceased was to end their own life. This distinguishes the act from homicide, where the intent is to end the life of another. The law does not clearly delineate which acts constitute an act with an intention to end life. There are many circumstances where determining the intent of a person at the time that they commit the supposed suicidal act may be inherently difficult based on the nature of the act. *The Hidden Toll* report lists examples of such circumstances:

- drug overdoses which may be accidental or a suicide;[82]
- single vehicle accidents where the driver has crashed into a fixed object;

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76 Ibid 52 [244] (Judge Coate).

77 Freckelton, above n 18, 468.

78 Ibid.

79 Ibid.

80 Ibid, citing the United States case of *Krulls v Hartford Accident & Indemnity Co*, 535 NYS 2d 157, 158 (Mercure J) (NY, 1988).

81 *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria 59 [282] (Judge Coate). See discussion below in Part III(B)(3)(ii) on emotional distress.

82 See, eg, *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181 (26 March 2013) [70]–[71] (Hallett LJ).

- falls or drowning which could also be accidental;
- incidents of murder/suicide which could also be a double suicide; and
- hanging where there is the possibility of autoeroticism or there may be questions about the capacity of the person to understand the seriousness of their actions (for example young children).[83]

On the other hand, there are clearly some acts which, though they involve an action by the deceased which results in their own death, would not involve intention to die, so as to constitute a suicide. An example of such an act would include recklessly playing with a rifle without a clear intention to harm oneself.[84]

There are, however, some cases which lie on the border of suicide and accident. These cases constitute a grey area between recklessness and intent.[85] An example of such a case would be where a person loses the will to live and takes a risk without caring whether they live or die.[86] Mr Alastair Hope, the former State Coroner of Western Australia, noted that this might occur where there is a person driving a 'vehicle in a manner which was so reckless that it would be very difficult to decide whether she wanted to die or just did not care'.[87] Similarly, a grey area would be presented when playing with a rifle moved beyond mere recklessness to playing Russian roulette where it is almost certain that death would occur in a percentage of cases.

3 Conscious Understanding, at the Moment of Engagement in the Act, That the Act Would Necessarily Result in Death

The third element is that, at the time of engagement in the life-ending act, the deceased had the ability to form the aforementioned intent to suicide. Accordingly, law relating to capacity to form that intention becomes relevant. The requirement for capacity in suicide relates to its criminal history when the requirements for criminal responsibility for the act 'assumed a mind capable of choosing to do or not to do the prohibited act'.[88] As Sir Matthew Hale's definition emphasises, suicide occurs where the person is 'of the age of discretion, and *compos mentis*'.[89] It is clear that capacity has always been considered a threshold requirement for a finding of suicide. This opinion is explicitly echoed in the coronial context in the 1886 edition of *Jervis on Coroners* where the author wrote that 'if an infant under the age of discretion, or a lunatic during his frenzy, destroy himself, he cannot be *felo de se*'.[90] In the sphere of coronial law, the primary circumstances that may impact capacity are where the deceased is a child, is mentally ill (suffering from depression,

83 Senate Community Affairs References Committee, above n 3, 20 [3.16].
84 *Clark v NZI Life Ltd* [1991] 2 Qd R 11, 15 [25] (Thomas J).
85 Senate Community Affairs References Committee, above n 3, 20 [3.17].
86 *Clark v NZI Life Ltd* [1991] 2 Qd R 11, 15 [25] (Thomas J).
87 Senate Community Affairs References Committee, above n 3, 20 [3.17].
88 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 236 [44] (French CJ).
89 Hale, above n 11.
90 Lovesy, above n 10, 143.

psychosis, or is extremely emotionally distressed), or is under the influence of alcohol or drugs.[91]

(a) Children

Capacity to form an intent can be a serious question where the deceased is a child. This is due to controversy over '[w]hether or not children can formulate concepts of the finality of death'.[92] Prior to 2011, Australian statistics on suicides of children under 15 years were not published due to the small number and sensitivities around suicide.[93] However, as the Senate's report identified child suicides to be a significant issue, the ABS has begun to release data for children aged 5–14 years.[94] The ABS is not aware of any suicides of children under the age of five in Australia.[95]

From a legal perspective, the capacity for children to form an intention to suicide is similar to the debates surrounding children's ability to form an intention to commit a criminal act. Under the criminal law in Australia, children cannot be found criminally responsible for any act if they are under a certain age.[96] The age varies in Australian jurisdictions, set at seven in Tasmania, eight in the Australian Capital Territory and 10 in other jurisdictions.[97] Under these ages, they are 'irrebuttably presumed incapable of possessing criminal intention' and the defence of infancy, or *doli incapax*, applies.[98] Between the minimum age and 14 years of age the presumption of *doli incapax* exists, but it becomes rebuttable by evidence to the contrary. On reaching the age of 14, the law deems children to be capable of forming criminal intention in the same way as adults.[99] Though this concept resides in the criminal law, it is possible that it affects coroners' considerations of children's ability to form suicidal intent in the absence of other guidance.[100]

(b) The Mentally Ill

Generally, attempted suicide, or suicide, will not give rise to a presumption of mental illness at common law.[101] That is, a finding of suicide will not necessarily mean a finding that a deceased was mentally ill. The resistance of the

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91 Coronial Council of Victoria, above n 5, 10 [2.12].

92 Ibid 10 [2.13].

93 Senate Community Affairs References Committee, above n 3, 93 [6.50].

94 Ibid 81, 93; Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia, 2011: Appendix 1: Suicide Deaths of Children and Young People under the Age of 15* <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0Appendix12011>.

95 Australian Bureau of Statistics, *Causes of Death, Australia, 2011,* above n 94.

96 Ben Mathews, 'Children's Criminal Responsibility in Australia: Some Legal, Psychological and Human Rights Issues' (2000) 5(2) *Australia & New Zealand Journal of Law & Education* 27, 28; Gregor Urbas, 'The Age of Criminal Responsibility' (Paper No 181, Australian Institute of Criminology, November 2000).

97 Mathews, above n 96, 28.

98 Ibid.

99 Ibid.

100 This association was borne out in interviews with Australian coroners conducted during 2016 and 2017, the data from which will be included in a forthcoming publication by the authors.

101 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 237 (French CJ).

common law to assume a link between mental illness and suicide harks back to the requirements under the criminal law, that a person should have a mind capable of choosing to commit a criminal act; that of *felo de se*.[102] Nevertheless, the connection between suicide and mental illness is well documented,[103] so in many cases a deceased will be deemed mentally ill. It is not clear whether a finding of mental illness leads to a resistance to make a finding of suicide due to lack of capacity. Historically, coroners used language such as 'whilst temporarily insane' or 'while the balance of his mind was disturbed' to avoid the prohibition that someone had committed the crime of suicide, rather than to indicate the deceased suffered from mental illness.[104] In any case, Waller notes that those phrases have not been used for many years in New South Wales at least.[105]

There is some suggestion from the brief review of cases undertaken on behalf of the Coronial Council of Victoria, that while mental health issues are discussed in most coronial suicide cases, it is rare to be accompanied with concerns about the deceased's capacity.[106] However, it was noted by the Coronial Council that there is a need for systematic research in order to reach firm conclusions.[107]

Evidence that a person suffered from depression will not generally be seen as depriving a person of their ability to appreciate the consequences of their actions so that such a condition precludes a finding of suicide.[108] Waller notes that the finding of a suicide containing the phrase 'whilst mentally depressed' was once commonplace but has since fallen into disuse.[109]

In contrast to depression, psychosis is generally deemed to preclude a finding of suicide, on the basis that the deceased's state of mind meant that they did not intend to kill themselves by their action even if death was the result. The recent inquest of *Rebekah Lawrence* in New South Wales grappled with the issue of a woman displaying symptoms of psychosis at the time she jumped out of a window to her death.[110] Coroner MacPherson considered the essential issue for the inquest to be whether Rebekah intended to take her own life.[111] Thus the question was posed 'did Rebekah Lawrence have a sufficient state of mind to form the intention to take her own life'?[112] The Coroner considered the evidence to show, overwhelmingly, that the act of stepping out of the window was 'the tragic culmination of a developing psychosis' and impliedly not an intention to take her own life.[113] The finding was not of suicide, but rather that the deceased

102 Ibid 236.

103 John Mendoza and Sebastian Rosenberg, 'Suicide and Suicide Prevention in Australia: Breaking the Silence' (Report, ConNetica Consulting, 2000) 63–71.

104 Paul Matthews, *Jervis on the Office and Duties of Coroners: With Forms and Precedents* (Sweet & Maxwell, 12th ed, 2002) 310 [13–25].

105 Kevin M Waller, *Coronial Law and Practice in New South Wales* (Law Book, 2nd ed, 1982) 60, 103.

106 Coronial Council of Victoria, above n 5, 11 [2.16].

107 Ibid.

108 Waller, above n 105, 62.

109 Ibid.

110 *Inquest into the Death of Rebekah Anne Lawrence* [2009] Coroner's Court of New South Wales 7 [43]; 8 [45]–[46] (M MacPherson).

111 Ibid.

112 Ibid.

113 Ibid 13 [69] (M MacPherson).

died 'from multiple injuries sustained when she stepped off the ledge' of the window and fell to the pavement below whilst in a psychotic state.[114] Freckelton considers this case to be illustrative of the principle that where a deceased is 'seriously psychiatrically unwell' at the time of death, 'they should be regarded as incapable of forming the necessary intent' and that 'a finding of suicide should not be made'.[115] This reasoning aligns with the recent 2015 Queensland *Inquest into the Death of Connon Kenneth Press* where Coroner Ryan stated that '[i]n order to make a finding of suicide I am required to be satisfied that Mr Press acted intentionally, knowing the probable consequences'.[116] The deceased was a paranoid schizophrenic and, with regard to the circumstances of his death, Coroner Ryan was of the view that it was more likely that 'Mr Press was affected by symptoms of his mental illness and drug use to such an extent that he was not capable of acting intentionally with sufficient awareness of the probable consequences of his actions'.[117]

Coroners are entitled to investigate a deceased's mental condition and to use that evidence to decide between findings.[118] Where there is clear evidence that a person was in a psychotic state, despite their own actions leading to their death, their mental state has precluded a finding of suicide.[119] The resistance to find a suicide where a person is suffering from psychosis is analogous to criminal law where 'insanity' or 'disease of the mind' has long been used as grounds for exemption from criminal responsibility.[120] The question posed is whether the defendant is suffering from a disease or disorder of the mind such that they are 'prevented by mental disorder from knowing the physical nature of the act [or] … from knowing that what he was doing was wrong';[121] '[d]isease of the mind' being the opposite to '[m]ere excitability of a normal man, passion, even stupidity, obtuseness, lack of self-control, and impulsiveness'.[122] Such a defence is appropriate in the criminal law as Dixon J noted that the purpose of such laws is to deter and punish, and that there is no utility in finding a person guilty of an offence 'if their mental condition is such that they cannot be in the least influenced by the possibility or probability of subsequent punishment; if they cannot understand what they are doing or cannot understand the ground upon which the law proceeds'.[123] Modern legislative defences replace 'insanity' or 'disturbance of the mind' with the words 'mental illness' or 'mental impairment'

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114 Ibid 13 (M MacPherson).

115 Freckelton, above n 18, 472.

116 [2015] Coroners Court of Queensland 14.

117 Ibid 3, 14.

118 Waller, above n 105, 61.

119 *Inquest into the Death of Rebekah Anne Lawrence* [2009] Coroner's Court of New South Wales. For further discussion of that inquest, see Freckelton, above n 18.

120 See discussion in C R Williams, 'Development and Change in Insanity and Related Defences' (2000) 24 *Melbourne University Law Review* 711; Stephen Allnutt, Anthony Samuels and Colman O'Driscoll, 'The Insanity Defence: From Wild Beasts to M'Naghten' (2007) 15 *Australasian Psychiatry* 292; Jan Wilson, 'An Irresistible Impulse of Mind: Crime and the Legal Defense of Moral Insanity in Nineteenth Century Australia' (1995) 11 *Australian Journal of Law and Society* 137.

121 *R v Porter* (1933) 55 CLR 182, 188 (Dixon J).

122 Ibid.

123 Ibid.

as derived from psychiatric manuals.[124] However, despite the use of such terms in determining whether such a defence is applicable, the High Court has emphasised that it is not strictly a medical determination, but a legal one.[125]

However, where a deceased is deemed to have suffered from some form of psychosis in their lifetime, the question of whether their psychosis prohibited them from having capacity at the time of the life-ending act is not easily answered. As Waller comments, people with mental illness do have periods of time where they are lucid and it is near impossible to say what state they were in at the time of their death.[126] In such cases, he says, an open verdict is apt.[127] An example of this can be seen in the 2011 *Inquest into the Death of Frances May Cooper*, where the deceased – suffering from chronic paranoid schizophrenia – was found dead next to the train tracks adjoining the mental health facility to which she had been admitted.[128] Though the deceased had a history of auditory hallucinations and grandiose delusions, Coroner King made an open finding as it was unclear whether, at the time of her death, she had made an impulsive decision to kill herself or she had simply slipped or was trying to board the moving train.[129]

Within the realm of 'mental incapacity', the final condition in which a deceased has been found not to be able to form the intent to die is that of 'emotional distress'. This was the finding of Coroner Coate in the *Inquest into the Death of Tyler Jordan Cassidy*.[130] The deceased young boy acted so as to induce police to shoot him. However, the finding was that the deceased did not commit suicide as, though his actions were conscious and deliberate, he was unable to act voluntarily due to his state of overwhelming emotional distress.[131]

(c) Intoxication

In a review of coroners' cases in England, intoxication was used as grounds for coroners not returning verdicts of suicide in some cases where a suicide note was present.[132] Concern about intoxication formed part of the *Tyler Cassidy* case mentioned above[133] and acts performed whilst intoxicated have also been found to fall into the grey area of potential accidents. For instance, in the United Kingdom, suicide could not be found where, in one case, the deceased was drunk and potentially asleep on train tracks when the train hit and, in another, where the

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124 See discussion of various legislative defences in Thomson Reuters, *The Laws of Australia* (at 1 January 2017) 9 Criminal Law Principles, '9.3 Defences and Responsibility' [9.3.1640].

125 *R v Falconer* (1990) 171 CLR 30, 48–9 (Mason CJ, Brennan and McHugh JJ).

126 Waller, above n 105.

127 Ibid 60.

128 [2015] Coroner's Court of Western Australia.

129 Ibid 30–1 [129]–[135].

130 [2011] Coroners Court of Victoria.

131 Ibid 59 [282] (Judge Coate).

132 K R Linsley, Kurt Schapira and T P Kelly, 'Open Verdict v. Suicide: Importance to Research' (2001) 178 *British Journal of Psychiatry* 465, 467.

133 *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria.

deceased was on drugs and the overdose could have been accidental.[134] Similarly, in the 2013 *Inquest into the Death of Charles Ross Maxwell Morgan*,[135] Queensland Coroner Lock could not conclude whether the deceased, who was moderately intoxicated with alcohol and cannabis, was intentionally taking his own life or had simply fallen asleep on the railway tracks.[136]

C Standard of Proof

Alongside requirements under the Coroners Acts, and guidance as to what circumstances constitute a suicide, coroners ultimately must find that the evidence supports a finding of suicide to the appropriate standard of proof. In making their findings, coroners apply the civil standard of proof: the balance of probabilities but with the application of the *Briginshaw* principle.[137] That principle denotes that the standard is one of 'reasonable satisfaction' taking into consideration the 'seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding'.[138] The standard of proof in Australia differs from that in the English system which employs a criminal standard for suicide findings.[139] The standard of proof applicable to findings of suicide, and coroners' interpretation of the standard in practice, is vitally important as in England their high standard of proof has led to very low estimations of suicide.[140]

The application of standard of proof in suicidal determinations is inextricably bound up with the historical consequences of a finding of suicide. Historically, there were clear factors guiding the application of the *Briginshaw* principle to a finding of suicide. As detailed in Part II of this article, until recent decades, suicide was a serious allegation due to its criminalisation in the common law and state and territory legislation.[141] Significant consequences flowed from a finding of suicide for religious burial and life insurance policies.[142] In those circumstances, the *Briginshaw* principle would require a relatively high standard of proof. Indeed, coroners have been identified as employing a high standard of proof in suicide determinations, in particular requiring a very high degree of certainty regarding the intent of the deceased.[143]

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134 *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin) (10 October 2012) [27] (Pitchford LJ); *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ (26 March 2013) 181 [71] (Hallett LJ).

135 [2013] Coroners Court of Queensland.

136 *Inquest into the Death of Charles Ross Maxwell Morgan* [2013] Coroners Court of Queensland 15.

137 *Briginshaw v Briginshaw* (1938) 60 CLR 336; *Anderson v Blashki* [1993] 2 VR 89, 96 (Gobbo J); *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria 53 [249] (Judge Coate); *State Coroner's Guidelines 2013* (Qld) 2 [8.1].

138 *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361–2 (Dixon J); *State Coroners Guidelines 2013* (Qld) 8 [8.9].

139 *R (Lagos) v HM Coroner for the City of London* [2013] EWHC 423 (Admin) (14 March 2013) 6 [35].

140 Gordon Tait and Belinda Carpenter, 'Suicide, Statistics and the Coroner: A Comparative Study of Death Investigations' (2015) 51 *Journal of Sociology* 553, 559 ('Suicide, Statistics and the Coroner').

141 Freckelton, above n 18, 469. See further discussion in Part II of this article.

142 See discussion in Part II of this article.

143 Senate Community Affairs References Committee, above n 3, 22 [3.27].

In light of changing laws and social values, it is questionable whether this high standard of proof is still warranted.[144] In terms of the 'seriousness of the allegation', it is arguably less serious in contemporary Australia to allege that a deceased has committed suicide. Suicide, once a common law felony, is now decriminalised across Australia.[145] No legal consequences flow to the deceased and their property,[146] only to persons who have assisted or encouraged the suicide.[147] The financial and insurance consequences flowing from a suicide finding are lessened. In the context of an insurance claim before the Supreme Court of Queensland in 1991, Thomas J noted that a finding of suicide is 'not one to be made lightly, but neither is it one of such inherent unlikelihood or gravity as to bring it toward the top of the range of what it is sometimes called the Briginshaw test'.[148] In coming to that conclusion, his Honour noted the inherent difficulty in determining the gravity of a finding of suicide given that it 'carries nothing like the odium that it formerly did, although it remains an unpleasant allegation not entirely free from stigma relating to the deceased and his family'.[149] His Honour's statement suggests that he perceived the seriousness of suicide, without the clarity of criminal law, to be a reflection of the social stigma relating to suicide and its perceived impact upon the reputation of the deceased and their families. Even in light of this, he felt it did not warrant sitting towards the top of the *Briginshaw* range. This interpretation contrasts with the evidence, borne out in the Australian Senate's report, that Australian coroners employ a high standard of proof in suicide determinations. Similarly, Coroner Hand in New South Wales remarked that he had to be certain 'that Nugan [the deceased] had committed suicide because [he] had to be more certain than on the balance of probabilities'.[150] It is clear that there are divergent views in the applicable standard proof in suicide findings. There currently exists very little guidance on how coroners should apply the *Briginshaw* sliding scale to suicide findings in the Australian coronial system.

D Presumption against Suicide

Muddying the water of standard of proof is the debate over whether there is a legal presumption against suicide. The presumption has been employed most clearly in the adversarial context where it resulted in the burden of proof reversing. This was seen in life insurance disputes where, in seeking to deny a

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144 As the Western Australian State Coroner notes in their guide to administrative findings, 'the law, and community views about suicide, have changed': Office of the State Coroner for Western Australia, 'An Introductory Guide to Writing Administrative Findings' (Version 4, 2014) 15.

145 Freckelton, above n 18, 469.

146 Coronial Council of Victoria, above n 5, 3 [1.6].

147 See provisions criminalising assisted suicide and encouraging a suicide: *Crimes Act 1900* (ACT) s 17; *Crimes Act 1900* (NSW) s 31C; *Criminal Code Act 1983* (NT) sch 1 s 162; *Criminal Code Act 1899* (Qld) sch 1 s 311; *Criminal Law Consolidation Act 1932* (SA) s 13A; *Criminal Code Act 1924* (Tas) sch 1 s 163; *Crimes Act 1958* (Vic) s 6B; *Criminal Code Act Compilation Act 1913* (WA) sch s 288.

148 *Clark v NZI Life Ltd* [1991] 2 Qd R 11, 16 [15].

149 Ibid.

150 Derrick Hand and Janet Fife-Yeomans, *The Coroner: Investigating Sudden Death* (ABC Books, 2008) 21.

claim, the deceased's estate would shoulder the burden of proving the death occurred but the insurer would hold the burden of proving it was a suicide.[151] Historically, the presumption arose from the serious implications of a suicide finding as outlined above.[152] Additionally, it was held to be founded on the 'inference drawn from the experience of mankind that self-destruction, being contrary to human instincts, is unlikely to have occurred'.[153] As such, it has formed part of the common law and, in England, has been applied in the context of coronial findings.[154] In Australia, the High Court has endorsed the presumption in litigation contexts.[155] However, recent cases before State courts have shifted away from endorsing the presumption, proposing that 'the language of presumption and counter-presumption has been largely supplanted by the language of proper inference upon the whole of the evidence'.[156] Further, the effect of the presumption on the burden of proof is largely irrelevant for coronial courts which employ inquisitorial rather than adversarial processes.[157]

In the coronial jurisdiction, Coroner Coate was of the view in a 2011 inquest that the current state of the law is that 'a finding [of suicide] must not be presumed, based on what appears to be "a likely explanation" but rather by finding proof to the proper evidentiary standard'.[158] On that basis, it is likely that the contemporary operation of the presumption against suicide in the coronial jurisdiction functions merely to confirm the place of suicide on the *Briginshaw* sliding scale. However, the lack of legal clarity in this area has led the Western Australia State Coroner to posit that a legal presumption against suicide still operates, yet to be mindful that 'the law, and community views about suicide, have changed';[159] such that, 'notwithstanding the presumption, a coroner ought not be reluctant to find suicide where the evidence satisfies the standard of proof'.[160] Similarly, in a 2014 inquest, a Queensland Coroner implied that the presumption exists.[161] Freckelton considers that the 'contemporary operation and effect in the coronial context of the presumption against a finding of suicide is somewhat unclear but serves to emphasise that a finding of suicide can only be arrived at where there is clear evidence; in its absence, a finding of accident or an open verdict is the proper outcome'.[162] Despite the legal position shifting away

151 Coronial Council of Victoria, above n 5, 26 [10.2].
152 Ibid 26 [10.1].
153 *Dominion Trust Co v New York Life Insurance Co* [1919] AC 254, 259 (Lord Dunedin).
154 *R v City of London Coroner; Ex parte Barber* [1975] 1 WLR 1310, 1313 (Lord Widgery CJ).
155 *Mutual Life Insurance Co of New York v Moss* (1906) 4 CLR 311; *Spiratos v Australasian United Steam Navigation Co Ltd* (1955) 93 CLR 317, 320 (Dixon CJ, Webb and Fullagar JJ).
156 *Clark v NZI Life Limited* [1991] 2 Qd R 11, 16 (Thomas J); *American Home Assurance Company v King* [2001] NSWCA 201, [12] (Stein JA); *SA Health Commission v McArdle* (Unreported, Supreme Court of South Australia, Doyle CJ, Millhouse and Nyland JJ, 26 May 1998).
157 Coronial Council of Victoria, above n 5, 26 [10.4]; *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria 53 [247]–[248] (Judge Coate); Studdert and Cordner, above n 7, 444.
158 *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria 52 [245].
159 See, eg, Office of the State Coroner of Western Australia, above n 144.
160 Ibid 15.
161 *Inquest into the Death of Michael Patrick Molloy* [2014] Coroners Court of Queensland 10 (Jane Bentley).
162 Freckelton, above n 18, 472.

from the presumption against suicide, this interpretation is not universal, and it is likely that it still affects the determination of the standard of proof required by a coroner to make a finding.[163]

E Other Sources of Guidance to Coroners on the Law

As demonstrated above, primary sources of law that guide coroners in their practice contribute minimally towards coherent and consistent approaches to suicide determinations. It is likely that in the absence of direct legal guidance, coroners' practice in this area is influenced by some key sources of commentary on coronial practice.

Some state coroners have attempted to provide direction for their jurisdiction in the absence of direct guidance from legislative authority and the common law. For instance, Queensland coroners are aided by official guidelines.[164] The Queensland State Coroner is required under the *Coroners Act 2003* (Qld) to issue guidelines to all coroners regarding performance of coronial functions and investigations generally.[165] The force of the guidelines is such that, when investigating a death, a coroner must comply with the guidelines and any directions to the coroner to the greatest practicable extent.[166] Chapter 8 of the guidelines deals with coronial findings and offers guidance to coroners on findings of suicide.[167] Notably, the guidelines state that coroners in that jurisdiction should, when recording manner of death, 'strive to indicate whether the death was accidental or intentional. If intent is unable to be determined, that should also be explained'.[168] The Western Australian State Coroner has attempted to translate the legal position on suicide in the guide for coroners in that jurisdiction on administrative findings which provides some direction on balancing the existence of the legal presumption against suicide with the requirements of the *Briginshaw* scale.[169] In New South Wales, the State Coroner has also issued a bulletin to coroners on suicide findings.[170] That bulletin reminds coroners to be cognisant of the role their suicide findings play in assessing the efficacy of mental health services and suicide prevention strategies.[171] Similar to the Queensland guidelines, such a statement can be interpreted as urging coroners to record intent where it is possible to do so.

While not having the force of law, coroners in New South Wales and Tasmania are aided by the Local Court Bench Book in New South Wales and the Coronial Practice Handbook in Tasmania.[172] Those texts, along with the coroner-issued guidance mentioned in the previous paragraph, are useful interpretative

163 Coronial Council of Victoria, above n 5, 26 [10.5].
164 *State Coroners Guidelines 2013* (Qld).
165 *Coroners Act 2003* (Qld) s 14(1)(b).
166 *Coroners Act 2003* (Qld) s 14(5).
167 *State Coroners Guidelines 2013* (Qld) ch 8.
168 Ibid 5 [8.3].
169 Office of the State Coroner of Western Australia, above n 144, 15.
170 Office of the NSW State Coroner, 'State Coroner's Bulletin No 1/2015' (2015).
171 Ibid 5.
172 Judicial Commission of New South Wales, *Local Court Bench Book* (2017); Magistrates Court of Tasmania: Coronial Division, *Tasmanian Coronial Practice Handbook* (2016).

aids for legislative language such as 'cause of death' or 'how a person died'. However, they do not add significant clarity to the common law principles or to the interpretation of standard of proof in practice.

Seminal texts by Jervis,[173] Waller,[174] and Freckelton and Ranson,[175] contain some guidance to coroners in their practice as it pertains to interpreting the common law principles and standard of proof. However, the extent to which they address the practical problems in interpreting the law on suicide findings is minimal. It is notable that *Jervis on Coroners* is written in the context of the English system which decides suicides according to the criminal standard of proof.[176] That standard of proof has been found to lead to low estimations of suicide findings in the United Kingdom.[177] The texts set in the Australian context tend to restate the historical context of suicide verdicts without providing much commentary on the currency of English common law principles in the Australian coronial system.[178] It is possible that over-emphasis on the treatment of suicide historically, and the current treatment in the English system, may contribute to confusion amongst coroners, or at the very least adds weight to the view that suicide is a serious finding requiring a very high standard of proof.

IV LEGAL BARRIERS TO A FINDING OF SUICIDE

The evidence suggests that there are a number of factors that have a significant role to play in reducing the likelihood of a coronial finding of suicide. The barriers are both: (a) practical, in terms of problematic elements of the governance of the decision-making process; and (b) interpretative, in terms of the relative lack of clarity and consistency of the operative legal principles. This requires further analysis.

A Practical Barriers Presented by the Coroners Acts

1 Requirements to Hold Inquests or Make Findings

Whether or not a coroner is required to hold an inquest, or to make a finding in relation to a suspected suicide, acts as a threshold barrier to suicide findings. As these thresholds vary between jurisdictions, they present significant obstacles to consistency across Australia. Without having the same requirements for when inquests can or must be held, or for the findings the coroner may make, it is impossible for there to be a uniform approach to suicide cases. Revising the legislation in each state to reflect the need to make a finding as to 'how a person died' or 'circumstances of death', where the death was caused by an action of the deceased, would allow for this.

173 Matthews, above n 104.
174 Waller, above n 105.
175 Freckelton and Ranson, above n 14, 633–4.
176 See, eg, a recent discussion of the standard of proof in the United Kingdom: *R (Lagos) v HM Coroner for the City of London* [2013] EWHC 423 (Admin) (14 March 2013) [35] (Lang J).
177 Tait and Carpenter, above n 140, 559.
178 See, eg, Freckelton and Ranson, above n 14, 633–4.

This problem is particularly evident with regard to the production of defensible suicide statistics. Coroners are largely required to reach findings within the governmental binary of suicide/not suicide. Unfortunately, these two choices are often unable to encompass the full complexity of the circumstances surrounding self-inflicted death. An example of this is in cases where high-risk conduct is engaged in by individuals who do not actually care whether they live or die. It has been argued elsewhere that a greater range of suicide-related findings may need to be made available to coroners to cover this behaviour, such as 'possible suicide/probable suicide/suicide, beyond a reasonable doubt', or to include the category of 'indirect suicide'.[179]

2 *Findings of Intent*

Without an explicit requirement to rule on intent, coroners can opt not to make such a ruling due to the inherent difficulty in its determination. This is supported by evidence that 29 per cent of coroners, nationally, do not make explicit findings of intent.[180] The difficulty in practice was outlined by Coroner Coate:

> If the Coroner can find a voluntary, conscious and deliberate act or acts, then discerning the intention of a person engaged in those acts can be a very complex task for a Coroner. The Coroner must endeavour to discern on the evidence (to the *Briginshaw* standard): did the person have the capacity to form the intent and what was that intent at the time at which those voluntary, conscious and deliberate acts were engaged in? Did the intention remain fixed or did it change part way through the voluntary, conscious and deliberate acts?[181]

A direction to coroners to include the intent of the deceased, or even explicitly whether or not it was a suicide, would allow for consistent approaches between both individual coroners and jurisdictions.

B Interpretation Barriers Presented by Inconsistent or Unclear Legal Principles

Arguably, Australian law, as it pertains to suicide, is characterised by a lack of clarity on some of the most important, defining elements of this category of death. That is, in addition to the widespread uncertainty in relation to an acceptable, functional definition of suicide – as discussed in Part III(A) of this article – there exists ambiguity and inconsistency in terms of pivotal issues such as intent and capacity, as well as a lack of agreement over the seemingly settled matter of standard of proof.

179 Gordon Tait et al, 'Problems with the Coronial Determination of "Suicide"' (2015) 20 *Mortality* 233, 235.

180 Personal correspondence from Jessica Pearse, National Coronial Information System to the authors, cited in De Leo et al, above n 2, 453.

181 *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria 54 [252].

1 What Constitutes a Suicide under Australian Law?

(a) The Intent behind the Act Was to End Their Own Life

The law in Australia that defines a suicide is complex and difficult to translate in practice. One particularly challenging area is the nature of a life-ending act that may be seen to fall into the grey area between accident and suicide. Tait et al write that there are very clear-cut scripts of suicides which may involve, for example, a history of mental illness or the leaving of a suicide note.[182] Alternatively, they may involve acts which are nearly incontrovertibly suicidal such as death by hanging.[183] However helpful these traditional markers are to a coroner tasked with investigating a suspected suicide, they become problematic if, due to employing a very high standard of proof, a coroner will not make a finding of suicide in the absence of such markers.[184] For example, if a coroner does not find a suicide without evidence of a suicide note, that approach would discount the majority of suicides as there is evidence that suicide notes are only left in approximately 25–30 per cent of researcher-defined suicides.[185] Additionally, certain groups of people, such as Indigenous Australians, may be even less likely to leave a suicide note so such an approach would incorrectly skew demographic data on suicide rates.[186] Legal guidance on the applicable standard of proof in suicide determinations would go some way towards consistency in approaching these difficult cases.

(b) Children

There may be a reluctance of coroners to rule that a child committed suicide due to legal concepts about capacity and, relatedly, the concept of *doli incapax*, from the criminal law. Imparting this concept from the criminal law into the coronial space is problematic as research literature indicates that children do understand concepts of death and suicide.[187] This concern was raised by the Queensland Commission for Children and Young People and Child Guardian ('the Queensland Commission') at the Senate Inquiry.[188] A 1999 study of children aged 6–12 showed that children generally know enough to commit suicide with the knowledge that this will result in permanent death.[189] Children acquire an understanding of suicide from a young age, even if they may not use the term

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182 Tait et al, above n 179, 235.

183 Belinda Carpenter et al, 'Who Leaves Suicide Notes? An Exploration of Victim Characteristics and Suicide Method of Completed Suicides in Queensland' (2016) 20 *Archives of Suicide Research* 176, 179.

184 Tait et al, above n 179, 236.

185 Carpenter et al, 'Who Leaves Suicide Notes?', above n 183, 177.

186 Belinda Carpenter and Gordon Tait, 'Health, Death and Indigenous Australians in the Coronial System' (2009) 1 *Australian Aboriginal Studies* 29, 35.

187 See, eg, Claude L Normand and Brian L Mishara, 'The Development of the Concept of Suicide in Children' (1992) 25 *Omega Journal of Death and Dying* 183.

188 Senate Community Affairs References Committee, above n 3, 93 [6.51], quoting Senate Community Affairs References Committee, Parliamentary Debates, Senate, 2 March 2010, 54–60 (Angela Ritchie, Commission for Children and Young People and Child Guardian).

189 Brian L Mishara, 'Conceptions of Death and Suicide in Children Ages 6–12 and Their Implications for Suicide Prevention' (1999) 29 *Suicide and Life-Threatening Behavior* 105, 117.

'suicide'.[190] It was found that many children aged 6–7, and almost all older children, understood the finality of death.[191] Children are likely to learn of suicide from media reports as well as conversations with adults and older children.[192]

The view that young children can understand and perform suicidal acts is reflected in statistics kept by the Commission that were reported to the Senate Committee.[193] In 2004, the Queensland Commission's register of child deaths recorded 12 deaths where the ABS had only recorded seven.[194] That discrepancy represents a 40 per cent rate, in the Commission's view, of underreporting of child suicides in Queensland for 2004.[195] Statistics kept by the Commission show a 'disturbing rate of suicide' in children aged 10–14 years old which was not revealed in other data sets prior to the Commission commencing death review functions in 2004.[196] The Commission does not set any minimum age, however at the time of the Senate hearing the youngest death they had recorded was for a child of 10 years old.[197]

Though the ABS has begun to track child suicides, there may still be a reluctance by some coroners to determine child suicides where they impart the concept of *doli incapax* from the criminal law. Clarification of the law relating to the capacity of children to form suicidal intent would be of assistance to coroners in dealing with that difficult task.

2 Standard of Proof

The application of the *Briginshaw* standard to suicide determinations is divergent. One possible interpretation of this is that the 'seriousness' of a finding of suicide rests, not on any objectively ascertainable statement of law, but on a more subjective interpretation of the individual making the finding. That is, coroners may be guided by two factors affecting their application of the *Briginshaw* standard: (1) how serious they themselves consider a finding of suicide to be, and (2) how serious they perceive a finding of suicide to be to the deceased or the deceased's family. The first criterion may reflect the coroner's personal experience and set of beliefs around society's stigmatisation of suicide. To what degree the second of these two criteria influences their judgment, if at all, may depend on their view of their role as a coroner. That is, whether they view their role as strictly legalistic or, to some degree, therapeutic in nature.[198] Whether they view their role as therapeutic may depend on a combination of their personal professional identity and the degree of their involvement with a

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190 Ibid 116–17.
191 Ibid 117.
192 Ibid; Brian L Mishara, 'How the Media Influences Children's Conceptions of Suicide' (2003) 24 *Crisis* 128, 128.
193 Senate Community Affairs References Committee, Parliamentary Debates, Senate, 2 March 2010, 54–60 (Angela Ritchie, Commission for Children and Young People and Child Guardian).
194 Ibid 53.
195 Ibid.
196 Ibid.
197 Ibid 56.
198 Tait et al, above n 179, 236–7. See generally Belinda Carpenter et al, 'When Coroners Care Too Much: Therapeutic Jurisprudence and Suicide Findings' (2015) 24 *Journal of Judicial Administration* 172.

deceased's family mandated by their Coroners Act or as a matter of practice in their jurisdiction. It may also depend on the characteristics of the deceased. That is, for example, coroners may be more reluctant to find the death of a young child to be a suicide. In that way, coroners may be seen to function as an 'informal therapeutic filter, through which the factual circumstances of a death are directed'.[199] However, if, in applying a therapeutic approach, coroners intentionally make an inaccurate or vague finding as to intent and do not expressly state their reasons for doing so, their actions may dilute the normative or legal force of their ruling.[200] Therapeutic justice calls for transparency and not skewing of legal reasoning.[201] The law guiding the application of standard of proof in suicide findings needs to be clear.

V CONCLUSION

Given that suicide is rarely mentioned in Coroners Acts, it can be concluded that coroners are minimally aided by their Coroners Act on the specifics of a suicide determination. They are impacted by practical barriers to reaching verdicts of suicide where they are discouraged from making a finding of intent in certain jurisdictions, or in conflating medical cause with 'how' a person died. Further, the case law guiding them is inconsistent. Seminal texts in the area, such as the English texts of *Jervis on Coroners* and *Death Investigation and the Coroner's Inquest*, are likely influential. Guidelines exist in some states which are more specific on the issue, such as Queensland. Other unofficial guidance to coroners comes in the form of a bulletin issued by the current State Coroner of New South Wales, discussion at annual Coroners Conferences and other self-authored guidelines as currently exist in Western Australia. The approaches in these sources of varying authorities are disparate and this likely contributes to confusion and resulting inconsistent approaches to suicide determinations.

If coroners' findings are to remain integral to the production of our national data on suicide, the law on suicide must be clarified. In the absence of this clarification, jurisdictional barriers and inconsistent interpretations will continue to contribute to the problem of indefensible suicide statistics. Among many recommendations made by the Senate Committee in *The Hidden Toll* report, was one to standardise coronial legislation.[202] The Victorian Coronial Council supported this, recommending that the Attorney-General raise the issue of standardisation with the Victorian Standing Council on Law, Crime and Community Safety.[203] They also recommended that intent be clearly indicated where a death was caused by an action of the deceased to clarify whether:

(a) the deceased intended to take the action which caused his or her death (intentional self-harm);

199 Carpenter et al, 'When Coroners Care Too Much', above n 198, 173.
200 Ibid.
201 Ibid.
202 Senate Community Affairs References Committee, above n 3, xvii (Recommendation 3).
203 Coronial Council of Victoria, above n 5, 28 (Recommendation 4).

(b) the deceased intended his or her action to cause his or her death (suicide);
(c) the deceased lacked the capacity to recognise that his or her action would cause his or her death but death was a reasonably foreseeable consequence of the action;
(d) it is not clear from the evidence whether the deceased intended to cause his or her death.[204]

Our recommendations build on those made by the Senate Committee and the Victorian Coronial Council, as the review of the law above reveals that there are issues that would not necessarily be corrected by standardising jurisdictional requirements and requiring a determination of intent. Our recommendations are:

1. There is currently no clear legal definition of suicide in any of the Coroners Acts. This needs to be rectified.
2. The application of the *Briginshaw* standard, and/or whether there is in fact a legal presumption against suicide, needs to be clarified and communicated to coroners.
3. Suicide findings are neither transparent nor accessible in all jurisdictions, so clarity and direction from case law is difficult for coroners to utilise. For this reason, we recommend that all inquests be made available online and easily searchable.

204 Ibid 28 (Recommendation 1).