

DETERMINING A SUICIDE UNDER AUSTRALIAN LAW: A COMPARATIVE STUDY OF CORONIAL PRACTICE

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This article examines the approach taken by Australian coroners to interpreting the law relating to suicide, and to applying it in practice. A previous review of the laws and commentary guiding coroners in Australian states and territories revealed not only that coroners are the only persons tasked with making routine legal determinations of suicide, but that such legal guidance lacks clarity. This study involved semi-structured interviews with Australian coroners in five states and two territories. The key finding is that coroners vary considerably in their approach to what constitutes a suicide, the circumstances that may or may not vitiate capacity to suicide, and the applicable standard of proof. Central to these findings is the difficulty of determining intent, especially in cases where the method is less active and where a body of well documented risk factors, or expressions of intent, are lacking. Utilising a range of suicidology literature on both reported suicide and deliberate self-harm, this article identifies the areas of concern for coroners and offers suggestions for further training and law reform.

I INTRODUCTION

Australian coroners play a pivotal role in the creation of Australian suicide statistics. Their findings have significant implications for policymaking in public health and mental health and, ultimately, the planning and funding of suicide prevention strategies. However, coronial determinations of suicide are argued to significantly underestimate the incidence of self-inflicted deaths in Australia.

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This was a major finding in the Australian Senate's report, *The Hidden Toll: Suicide in Australia* ('*The Hidden Toll*'),¹ and was the impetus for a recent report by the Coronial Council of Victoria that expanded on the ways in which the law relating to suicide contributes to that problem.² It was suggested that key reasons for under-reporting were inconsistencies in coronial practices and a reluctance by coroners to make explicit findings of intent.³

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.⁴ However, such analysis does not elicit a great deal of insight into how coroners work to navigate this socio-legal landscape in practice. It is necessary to understand how this difficult area is navigated by coroners currently, in order for any law reform or legal training to meaningfully address the problem. This research addresses this issue directly by engaging coroners in their experiences with the law and in the practical and daily work of suicide determination.

The first stage of this research was a comprehensive review by the authors of this article of the laws and commentary that guide coroners in Australian states and territories.⁵ That review revealed that legal guidance in this area varies considerably between jurisdictions and is lacking in clarity.⁶ This article complements that review of the law by discussing the difficulties that coroners encounter with the law in practice. Based on interviews with coroners across Australia, this article explores the ways in which they understand and navigate their role in a suicide determination, the barriers to, and complexity of, the finding, as well as the ways in which other areas of the law are relied upon to offer guidance when coronial legislation in Australia is lacking.

The article is divided into three parts. First, the methodology is outlined, including the analytical approach. This project recognised the privilege associated with interviewing high-status individuals and the trust and confidence placed in the researchers by these 32 coroners. This is reflected in the methodological approach and the presentation of the data. Second, the results are discussed with reference to the three interrelated areas that caused the coroners most concern: definitions of suicide; clarity of intent; and the legal standard of proof. We have utilised a range of literature to contextualise the coroners'

1 Senate Community Affairs References Committee, Parliament of Australia, *The Hidden Toll: Suicide in Australia* (2010) 21–2.

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

3 Senate Community Affairs References Committee, above n 1, 24 [3.34], 25 [3.38].

4 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.

5 Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41 *University of New South Wales Law Journal* 355.

6 *Ibid* 378.

approach, further informing the coronial decision-making process but also challenging assumptions where applicable. At times it has been relevant to use the research literature on suicide, especially when discussing the well-established risk factors for suicide. However, at other times it is more appropriate to utilise the broader research on deliberate self-harm, especially when we seek to destabilise coronial assumptions about capacity, or linear views on intent.⁷ Finally, we make a number of recommendations about law reform and training in order to both guide further discussion and enable coroners to examine their practices and processes.

II METHODOLOGY

This study is informed by interviews with 32 coroners from all states and territories in Australia, except Tasmania.⁸ Selective sampling was the basis for coroner involvement in the research. Contact was made with each coronial office through the state coroner who then provided the contact details of coroners willing to participate in the project. As the cohort of sitting coroners is relatively small, past coroners were also interviewed in order to capture a range of experience, expand the sample size and enhance anonymity. Having the support of two state coroners in the initial stages of this research was crucial, and as the list of participants grew, the legitimacy and significance of the research increased. This in turn made it easier to recruit more coroners to interview. It is often suggested that judicial officers are reluctant to be interviewed, believing that the law rather than the officer is responsible for a legal outcome.⁹ This was the case in only one state of Australia, where access to coroners was denied by the Chief Magistrate.

The interviews were semi-structured and conducted in the coroners' offices. Most took one hour to complete. They were recorded and transcribed and then returned to the coroner for their review. Only one coroner withdrew from the process at this point and their interview was destroyed. Coroners ranged in their professional experience. The longest serving coroner had been in the job for nearly 20 years, while the shortest serving coroner had only been employed for six months. Both genders were well represented in the sample with 14 female coroners and 18 male coroners interviewed for the project. Coroners were also located in both rural and urban areas; capturing those adjudging deaths of individuals across a wide range of cultural and socio-economic backgrounds.

7 It should be noted that this project sits within larger funded research which has sought to engage with the relationship between the adjudgement of suicide by coroners, and the truth of reported suicide statistics, by suggesting that suicide is what coroners deem a death to be. This also means of course that any assumptions about capacity for example, will also be discovered in any research on suicide, hence the incorporation of research that also examines deliberate self-harm.

8 The methodology stated herein is derived, with minor amendments, from an earlier article by the authors that reported on findings of the same study: Gordon Tait, Belinda Carpenter and Stephanie Jowett, 'Coronial Practice, Indigeneity and Suicide' (2018) 15 *International Journal of Environmental Research and Public Health* 765.

9 Jason Pierce, 'Interviewing Australia's Senior Judiciary' (2002) 37 *Australian Journal of Political Science* 131, 132.

The interviews were treated as a social encounter. This means that the interview was understood as producing knowledge rather than simply recording it. The coroners were understood as constructors of knowledge rather than as simple repositories, and the interview itself was a process of meaning making between the coroner and the interviewer. Interviews were thus interpretative, active and collaborative.¹⁰ However, this process was only possible because we followed the rules of ‘elite interviewing’ offered by Manheim and Rich: ‘use a “reflective and conversational tone”, “plan initial questions carefully” and ask questions that could be subject to “multiple interpretations”’, and know the subject.¹¹

Knowing the subject matter and having legitimacy is crucial because coroners and other judicial officers are socialised to hide or ignore the decision-making processes that are often of most interest to researchers. Avoiding unproductive interviews thus relies upon the interviewer establishing credibility and the coroner accepting the interviewer’s status as ‘quasi-insider’.¹² This was achieved by our academic status, our previous published research and external grants on the topic, and our knowledge of the workings of the system.

In interviewing high-status individuals, who were willing to be very open in discussing a sensitive subject, anonymity was a serious consideration in this study. To protect the identity of the interviewees, the numbers assigned to participants is rotated across publications to avoid cross-referencing of quotes. Where not required to illustrate a particular point, the location and background of the coroners was deliberately omitted.

The interviews centred upon conceptualisations of suicide, data coding and entry procedures, the processes and problems of suicide adjudgement, alternative ways of managing coronial approaches to suicide determination, and the specific problems associated with high-risk groups, such as Indigenous Australians. Interviews continued until saturation was reached. In addition, the authors conducted an analysis of the documents that organise coronial practices and responsibilities, as they relate to reaching a finding of suicide: state legislation, policy documents, professional guidelines, training materials, and data coding and entry procedures.¹³

Thematic analysis was the key process utilised in this research and an inductive approach to the data was favoured.¹⁴ As a method for identifying and analysing patterns within data, thematic analysis of the interview transcripts began with a process of schematic coding, which required all transcripts to be read in their entirety by the research team. Themes were identified through a series of discussions between the research team where both dominant and

10 James A Holstein and Jaber F Gubrium, ‘Active Interviewing’ in Jaber F Gubrium and James A Holstein (eds), *Postmodern Interviewing* (Sage Publications, 2003).

11 Lee Epstein, ‘Interviewing US Supreme Court Justices and Interest Group Attorneys’ (1990) 73 *Judicature* 196, 197, quoting Jarol B Manheim and Richard C Rich, *Empirical Political Analysis: Research Methods in Political Science* (Longman, 2nd ed, 1986) 135–7.

12 Milton Heumann, ‘Interviewing Trial Judges’ (1990) 73 *Judicature* 200, 200.

13 Jowett, Carpenter and Tait, ‘Determining a Suicide’, above n 5.

14 Virginia Braun and Victoria Clarke, ‘Using Thematic Analysis in Psychology’ (2006) 3 *Qualitative Research in Psychology* 77.

emergent patterns were identified and then reviewed. Using previous research as a guide, we identified key themes. Importantly, a key theme does not necessarily depend on a 'quantifiable measure', but rather on whether it captures something important in relation to the overall research questions. In the context of this research, the key themes were as follows: lack of clarity around definitions of suicide; an over-reliance on certain risk factors and methods to indicate intent; and inconsistency around key determinants of capacity, especially concerning age, alcohol and mental illness.

III RESULTS AND DISCUSSION

Coroners discussed the role legislation played in making suicide findings, both in terms of the strict impacts of legislative requirements in their jurisdiction as well as the nuanced ways in which they interpreted and applied crucial aspects of coronial law. It was revealed that coroners are hindered by legal limitations on the content of findings and that a lack of clarity with how the law should be interpreted has led to varying understandings of the law and its application in practice. These are explored in turn.

A Defining Suicide

A previous review of the coronial law on suicide revealed considerable differences between states and territories as to the form and substance of findings that can be made by coroners.¹⁵ Coroners themselves are also aware of the considerable differences in legislation between states and territories, and the implications for consistent approaches to suicide findings.

There does appear to be a lot of parochialism in terms of the form and structure of coronial legislation and practice ... As with many things, it's arbitrary that the way your death is treated might depend on which leg you fall over on the state boundary. (Coroner 19)¹⁶

However, for the most part, coroners cited differences in interpreting and applying the law in practice as accounting for the greatest difficulties. For example, they differed on what constitutes a suicide, which may be viewed as a threshold inquiry before a death may be adjudged as such. This is somewhat unsurprising as, since the decriminalisation of suicide, no definition or guidance in this matter, for coronial purposes, is provided by coronial legislation in Australian states or territories.¹⁷ In lieu of this, coroners turn to the common law for guidance, which offers the following definition: 'voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is

15 Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 360–2.

16 One of the findings of the review of laws in Australian states and territories was that, in some jurisdictions, without an inquest, a coroner cannot comment on the circumstances of the death and therefore cannot find a suicide. It was assumed, therefore, that these deaths would not be deemed suicides: Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 361. However, the coroners in South Australia revealed in interviews that suicides are still found in that jurisdiction, it is just that '[t]here is no coronial imprimatur, it's coded by a clerical officer'.

17 Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 359.

doing'.¹⁸ In interviews, a number of coroners offered definitions which do closely resemble this definition from common law.

Well, they intentionally self-inflicted harm and it had caused their death and they intended to die. (Coroner 10)

Well there has to be the thought engaged in making a deliberate choice, a deliberate action, that has the consequence of causing that person's death. (Coroner 32)

You kill yourself, that is, you do an act or omission that ends in your death and you intended that you would die. (Coroner 22)

Diverging even further, some coroners discussed suicide in a way that is arguably at odds with a strict interpretation of the common law definition. The central point of contention pivots around the difference between a deceased who knowingly took action with the purpose of causing their own death, versus a deceased who consciously chose to engage in extremely dangerous behaviour that could end in death, irrespective of the intent or capacity at the precise moment of death. Some coroners, coroners 17 and 28 below, were of the opinion that the latter was sufficient for a legal determination of suicide.

There has to be evidence that the person intended to take their life [and this is] regardless of whether they fully understood the consequences of the fact of what death was. (Coroner 14)

I don't think you actually require an intent to kill yourself for suicide. All you have to intend is a dangerous act against yourself and the consequence is death. What your intent or what your motivation was I think is beside the point. (Coroner 17)

Changing mind, that's interesting. I've always taken the view you put yourself in a position of – in a position where it's very foreseeable that you're going to die, and even if it's – you've done so in a highly reckless way and then there may be some hint that perhaps they've changed their mind but it's too far, too late. I still find that suicide. (Coroner 28)

Some coroners did not reference a source definition, common law or otherwise, and were of the view that the concept of suicide was self-evident, while others sourced their definition from a combination of commentary and practice.¹⁹

I think it probably is determined as so self-evident that it has never required a definition. (Coroner 18)

18 *R v Cardiff City Coroner; Ex parte Thomas* [1970] 1 WLR 1475, 1478 (James J).

19 Importantly, most legal commentary on suicide is in the context of the English coronial system which, until recently, has operated under the criminal standard of proof, and this has led to significant underestimation of the suicide rates in that jurisdiction: Gordon Tait and Belinda Carpenter, 'Suicide, Statistics and the Coroner: A Comparative Study of Death Investigations' (2015) 51 *Journal of Sociology* 553, 559. A recent case in the High Court found the balance of probabilities to be the applicable standard of proof in England: *R (on the application of Thomas Maughan) v HM Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin). Following how other coroners have approached this issue in Australia would certainly enable a more consistent treatment of the determination of suicide, however, previous research has demonstrated suicide findings from inquests are not published online in a consistent and searchable manner. For instance, the potentially applicable definition of suicide under Australian law that was unpacked by Coroner Coate in some detail as part of an inquest finding in Victoria is not available on the website of the Victorian Coroners Court so that it might inform future consideration of this issue: Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 357, citing *Inquest into the Death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria (State Coroner Coate).

To tell you the truth, I haven't looked at the common law either. I just thought it was self-evident. (Coroner 21)

It's an individual judicial officer's determination, and it's really just on the basis of the reading that I've done, and ... looking at the situation in England and then looking at other findings that, say, other coroners have made and what they've looked for. (Coroner 25)

A clear finding from interviews with coroners across Australia is that there is significant variance as to the definition of suicide that they employ in order to reach their findings, if one is employed at all. Varying interpretations of the applicable definition of suicide by coroners have implications for suicide determination, since it is not beyond the realms of possibility to assume that deaths may be treated very differently depending upon the coroner who makes the finding. Herein lies the dilemma. Suicidology literature and peak public health bodies also struggle with a definition of suicide that is culturally neutral and conceptually consistent.²⁰ However, there is guidance to be had in the form of suicide nomenclature from the World Health Organisation, who suggest two clear elements: it must be self-initiated, and there must be intent.²¹ This does closely mirror the common law definition cited earlier, and upon which some coroners do rely for guidance. It also enables a differentiation between homicide (as it must be self-initiated) and accident (as there is a requirement of intent). For the purposes of our discussion here, these are the elements that we will explore with the goal of offering a more nuanced set of boundaries for conceptualising and operationalising the category of suicide in a legal context.

B Discerning Intent

Despite variance in defining suicide, most coroners agreed that an intent to suicide was crucial in a legal determination. Coroners also discussed at length their difficulties in trying to find and isolate clear suicidal intent. This may be a fruitless endeavour in many cases as the suicidology literature demonstrates that intent is often not clear cut and a range of intents, sometimes contradictory, can coexist simultaneously.²² Nevertheless, in order to try and map a way forward, it is clear that a number of different pieces of evidence are relied upon when arriving at a decision that a self-destructive behaviour was intentional in nature. Such evidence includes:

(1) intention to take the action; or (2) intention to harm himself or herself by the action; or (3) intention to die as a result of the action; and/or (4) at the time of

20 Morton M Silverman et al, 'Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors Part 2: Suicide-Related Ideations, Communications, and Behaviors' (2007) 37 *Suicide and Life-Threatening Behavior* 264.

21 Diego De Leo et al, 'Definitions of Suicidal Behavior: Lessons Learned from the WHO/EURO Multicentre Study' (2006) 27 *Crisis* 4, 4–15.

22 Jennifer White, 'Qualitative Evidence in Suicide Ideation, Attempts, and Suicide Prevention' in Karin Olson, Richard A Young and Izabela Z Schultz (eds), *Handbook of Qualitative Health Research for Evidence-Based Practice* (Springer, 2015) 335, 337.

acting, a capacity to understand the likely consequences of the act and form the desire to die.²³

A shared understanding of intent is important in the context of coronial decision-making for two reasons. First, it should influence the investigative techniques and methods required to form an opinion as to the existence or not of intent, and second, a shared understanding should also influence the depth of analysis required to determine its presence. This also means that information should be gathered from as many sources, and in as many formats as possible, keeping in mind that '[a]scertaining intention ... relies on human judgment, cultural context, and interpretation'.²⁴

1 Intention to Take the Harmful Action

Bryan and Rudd have suggested two types of suicidal intent that can help us in our exploration: (1) subjective or expressed intent; and (2) objective or observed intent.²⁵ The most obvious example of expressed intent is a suicide note, and such information is utilised by coroners as the most important indicator of intent. In fact, all coroners identified suicide notes to be the most integral evidence of intent.²⁶ Moreover, in the absence of a suicide note, coroners made it clear that the circumstances surrounding the suicide would need to be even more persuasive, given that the lack of a suicide note was discussed as a negative, rather than a neutral, indicator of intent.

Well easy ones obviously are when there are notes left. (Coroner 3)

I tend to treat the note as the cherry on the top that might make the difference between finding on the balance of probabilities that it is a suicide, and not being sure. (Coroner 1)

Well if there's a note, that's the best proof and the only – although sometimes it's not just a note, it's a video or a text or something. But that's the best evidence and all the rest of it is just someone's subjective opinion. (Coroner 16)

Have I found suicides when there hasn't been a note of some kind? Probably not. Oh, there has to be a declaration. (Coroner 15)

23 Morton M Silverman et al, 'Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors Part 1: Background, Rationale, and Methodology' (2007) 37 *Suicide and Life-Threatening Behavior* 248, 254, citing J Moller, 'Suicide and Self Harm: What Do We Mean and What Do We Measure?' (Paper presented at the International Association for Suicide Prevention Conference, Adelaide, Australia, 1997).

24 White, above n 22, 337.

25 Craig J Bryan and M David Rudd, 'Advances in the Assessment of Suicide Risk' (2006) 62 *Journal of Clinical Psychology: In Session* 185, 189–90.

26 Interestingly, coroners were not as committed to the need for a suicide note, when the deceased was Indigenous. This was generally due to a belief by coroners, supported by the literature: Belinda Carpenter and Gordon Tait, 'Health, Death and Indigenous Australians in the Coronial System' [2009] (1) *Australian Aboriginal Studies* 29. Coroners' approaches to Indigenous suicide are discussed further in Gordon Tait, Belinda Carpenter and Stephanie Jowett, 'Coronial Practice, Indigeneity and Suicide', above n 8: Indigenous persons were not as likely as non-Indigenous people to leave a note, and therefore its lack was not positioned as a negative indicator of intent. 'I wouldn't dream of looking for a suicide note in an Aboriginal person, that would be just craziness because they never do that so why would you look for that'. (Coroner 10).

However, while suicide notes are typically seen by coroners as an indication of the seriousness of the suicide attempt, research suggests that only a minority of completed suicides include suicide notes, with recent prior research identifying ranges of between 15 and 43 per cent,²⁷ and 15 and 38 per cent.²⁸ The generally agreed stable proportion of suicides with notes is between 25 and 35 per cent, despite fluctuations in the actual suicide rate.²⁹

Aside from the expression of intent indicated by notes, threats of suicidal behaviour to friends and family were also identified by some coroners as important expressions of intent. According to Silverman, a suicide threat is ‘any interpersonal action, verbal or nonverbal, without a direct self-injurious component, that a reasonable person would interpret as communicating or suggesting that suicidal behavior might occur in the near future’.³⁰

Such suicide related communications are positioned as the halfway point between private thoughts about suicide and actions directed at self-injury.

So a suicide note is maybe a very clear indication of intent, but I also think that conversations with friends, family associates – those type of indicators – and those types of conversations. (Coroner 20)

It might be – if it’s not as clear cut as this is what I’m doing – things like text messages shared between family members – and I’ve only just started receiving those. I think they’re really helpful to see, to always probably get that, because I think that shows you know? Even if it’s not automatically saying this is what I’m going to do, it might be that someone is suffering with mental health issues and they’re expressing that, or the tone of the conversations. (Coroner 3)

Coroners also relied upon observed intent, demonstrated through a range of behaviours such as preparations by the deceased for death, circumstantial evidence such as ‘triggers’ that might provide a ‘rationale’, and/or documented previous attempts of suicide. Preparations for suicide, such as making financial arrangements for dependants, distributing money and/or selling property, are considered by coroners as an implicit indicator of intent, and this is supported in the literature.³¹

Associated with closing bank accounts, and saying look after the kids, Jack, and all this sort of stuff. All of that is absolutely conclusive. (Coroner 24)

Previous attempts at self-harm were also viewed by coroners as a positive indicator of intent. According to Hawton and van Heeringen in the literature on suicide, a history of self-harm is the strongest risk factor for suicide, present in at least 40 per cent of cases.³² More specifically, it is a history of *multiple* attempts which indicates the highest risk, as compared with a history of one attempt or

27 Hideki Kuwabara et al, ‘Differences in Characteristics between Suicide Victims Who Left Notes or Not’ (2006) 94 *Journal of Affective Disorders* 145, 146.

28 Valerie J Callanan and Mark S Davis, ‘A Comparison of Suicide Note Writers with Suicides Who Did Not Leave Notes’ (2009) 39 *Suicide and Life-Threatening Behavior* 558, 560–1.

29 Richard Tewksbury, Geetha Suresh and Ronald M Holmes, ‘Factors Related to Suicide via Firearms and Hanging and Leaving of Suicide Notes’ (2010) 9 *International Journal of Men's Health* 40, 42.

30 Silverman et al, ‘Rebuilding the Tower of Babel (Part 2)’, above n 20, 268.

31 Mark L Rosenberg et al, ‘Operational Criteria for the Determination of Suicide’ (1988) 33 *Journal of Forensic Sciences* 1445, 1450; Carol Chu et al, ‘Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update’ (2015) 71 *Journal of Clinical Psychology* 1186.

32 Keith Hawton and Kees van Heeringen, ‘Suicide’ (2009) 373 *Lancet* 1372, 1372.

with those who think about suicide but have never attempted. Research also indicates that the risk decreases over time, with a suicide most likely in the six months to two years after a suicide attempt.³³

Previous attempts. That's another marker that I think is very, very important. Those sorts of things, I think, are pretty critical. (Coroner 1)

If there's no suicide note then you have to have pretty good evidence such as a significant, well-documented or well-known history of self-harm with intent to take their own life. (Coroner 15)

Coroners also discussed circumstantial evidence in the form of 'triggers' that would allow them to form the opinion that a rationale existed in the deceased's life that could plausibly have led them to suicide. These commonly included the breakdown of a close relationship, criminal proceedings against the deceased, unemployment or the collapse of a business. Again, research indicates that the majority of suicidal acts are precipitated by a stressful life event, with recent acute stressors – defined as occurring within the past year – identified as 'particularly pernicious'.³⁴

Ancillary evidence: everyone says, he's lost his job, he's lost his wife, lost everything, he's already very down, he has changed. That's always a good indicator ... the triggers. (Coroner 7)

I'd start with, had they had any recent relationship issues? Had they broken up with their boyfriend? (Coroner 16)

Coroners appear well versed in the evidence that needs to be gathered when considering suicide as a legal finding, with many of the issues raised by coroners in interviews supported in the literature on suicide risk factors. What is less clear is the emphasis that should be placed on certain factors over others, especially when suicide notes are considered. Requiring a note for intent is clearly not well aligned with the literature and an absent note should not be seen as a negative indicator of intent. Stressful life events in the past year, multiple previous attempts and preparations for death is also important evidence to consider, and should be gathered from interviews with family and friends. However, these elements of the suicide narrative can be undermined for coroners when they are faced with methods which carry a level of indeterminacy in their lethality.

2 *Intention for the Harmful Action to End in Death*

Silverman maintained that quantifying intent assumes a relation between intent, lethality and outcome, and concluded that the presence of intent required: 'knowledge (accurate or inaccurate) of risk associated with a behaviour; ... some perception that means or methods are available to achieve the desired outcome; and ... some knowledge about how to use the means or methods'.³⁵

According to Silverman, 'for most clinicians, high medical lethality suggests high intent, even though high intent [does not always translate to] high

33 Chu et al, above n 31, 1187.

34 Ibid 1190. See also C T Sudhir Kumar et al, 'Characteristics of High Intent Suicide Attempters Admitted to a General Hospital' (2006) 91 *Journal of Affective Disorders* 77, 80.

35 Silverman et al, 'Rebuilding the Tower of Babel (Part 1)', above n 23, 255.

lethality'.³⁶ Similarly, Kumar et al report that patients hospitalised for deliberate self-harm with high intent utilised methods of significant higher lethality than those with lower intent.³⁷ Coroners also appear to favour a relation between lethality and intent, and are more inclined to find intent when deliberate methods are employed. This is especially the case when expressed indicators of intent, such as notes, are missing.

The actual nature of the act, someone stepping in front of a train is fairly decisive, as opposed to someone taking an overdose of drugs. (Coroner 21)

Method is a very important one, and that's where you get those balcony cases ... there's not a lot of comeback from that action. (Coroner 13)

I think often the mechanism or the method they've taken is the deciding factor about whether it's intentional or not, because they've gone to elaborate lengths to either set up the hanging point, or put a hose in a car in their garage. (Coroner 26)

Hanging, in particular, was so strongly associated with intent that coroners discussed it as leading to a presumption of suicide in the absence of contrary evidence.

I mean it's a fairly obvious intent when you tie a noose or a ligature, put it somewhere, and then hang yourself. I don't think too many people would have difficulty in determining that the only reason the person could have done that was to end their own life. So that would be a very straightforward sort of case. (Coroner 18)

Sometimes you infer something about the cause – hanging. A person normally when they hang themselves, they don't think they're going to make it. (Coroner 22)

We usually say if someone's kind of hanging and the scene is secure and there's no suggestion anyone else was involved well, if it looks like a duck and it quacks like a duck, it's probably a duck. (Coroner 27)

So, the person who hangs themselves, now for the most part, you'd probably start with the proposition well did they intend by hanging themselves to end their life? There's almost an inference there. (Coroner 4)

In contrast, there were lethal methods that introduced a complication for coroners when determining intent. In particular, coroners discussed suspicions that a significant number of single vehicle motor crashes were suicidal in nature, but were unlikely to rule these as such. For many coroners this was due to the difficulty of discerning intent in an archetypal accidental death. However, research by Routley et al found the reported incidence of driver suicide in research studies ranged from 1.1 per cent to 7.4 per cent of all motor vehicle crashes.³⁸ Informed by such findings, Henderson and Joseph conclude that the failure of road safety strategies to reach their target reduction in the road fatality

36 Ibid 256.

37 Kumar et al, above n 34, 79–80.

38 Virginia Routley et al, 'Suicide and Natural Deaths in Road Traffic – Review' (Report No 216, Monash University Accident Research Centre, August 2003) 13 <<https://www.monash.edu/muarc/our-publications/muarc216>>.

rate is because at least one in 15 motor vehicle accidents are intentional but unrecognised by coroners.³⁹

I am convinced that there is a not insignificant number of single vehicle accidents that are suicides – intentional taking of life. We don't call them suicides, but I'm convinced they are. (Coroner 11)

I think I have a bit of a suspicion about a lot of single vehicle accidents ... I think that a lot of single vehicle accidents could well be [suicide], because when you get the reports they're troubled and they're this and they're that. You still don't have enough, in my opinion, to say how do I know that wasn't that he fell asleep or something? (Coroner 6)

The ones you'd miss in that population are probably single vehicle crashes because we hardly ever include those [as suicides] and it seems pretty clear that there is a significant number [which are]. (Coroner 29)

There's him driving at high speed and then the evidence of a big road train coming towards him, as the car has suddenly just swung straight in front of the road train. There's nothing else ... I had to make a finding of accident, although all my instincts drew me to, this looks like he has done this intentionally. (Coroner 20)

When considering motor vehicle crashes as a method of suicide, there are a range of risk factors in the literature that signal intent. Aside from demographic factors, and previous discussions of triggers, mental illness and previous attempts, these include: a single occupant, not wearing a seatbelt, a single vehicle head-on crash into a tree, pole or truck, and without skid marks or other indicators of loss of control.⁴⁰

When a person is contemplating suicide, the availability, familiarity and knowledge of a certain method can be the factors that lead from a suicidal thought into a suicidal action, while its lethality might determine whether the outcome is fatal or not.⁴¹ Interestingly, these same three issues – availability, familiarity and knowledge – cause coroners particular difficulty and reticence when determining intent in a drug overdose.

If you've taken an overdose of drugs and you're a poly drug user, did you try to commit suicide or did you just take too many? Same with some opioids – are you a bit, your tolerance down a bit this week or this month because you've just come out of rehab or is your tolerance you know different than you used to? All these, there's so many things where you think it might be suicide but it could have also been a mistake. (Coroner 9)

Drug users, illicit drug users, less likely to find them as a case of suicide unless there's some very clear circumstances, because they just take, say, a shot of heroin and no one knows how strong it is or what it is. We get a lot of people who have just been released from prison who've died under those circumstances. (Coroner 28)

But typically it's benzodiazepines, opiates, amphetamines and a bit of cannabis thrown in for good measure and sometimes alcohol ... you don't know whether it's just – philosophically you might say it's risk taking behaviour of a high order, so you kind of, you're almost willing it to happen. But in terms of pure intent, probably not. (Coroner 27)

39 Antony F Henderson and Anthony P Joseph, 'Motor Vehicle Accident or Driver Suicide? Identifying Cases of Failed Driver Suicide in the Trauma Setting' (2012) 43 *Injury* 18, 20.

40 *Ibid.*

41 Silverman et al, 'Rebuilding the Tower of Babel (Part 1)', above n 23, 256; Hawton and van Heeringen, above n 32, 1374.

The person might have taken all of those pills with the intention of killing themselves. They might have taken all of those pills with the intention of harming but not killing themselves. They might have just wanted a really good night's sleep and completely got it wrong. I don't know how you get suicide from that ... in the absence of anything else. (Coroner 6)

For Rockett et al, it is the difference between 'more active' injury mechanisms (firearms and hanging) and 'less active' injury mechanisms (poisoning and drowning) which is the key differentiator between deaths determined by coroners as a suicide versus those found to be accidental or undetermined.⁴² In the United States ('US') for example, medical examiners and coroners were 46 times more likely to classify a death as undetermined intent for the less active group than for the more active one. According to Rockett et al, the rapidly growing burden of deaths due to prescribed and illicit drug intoxication – where such mortality rose in the US 156 per cent between 2000 and 2011 – likely obscures drug intoxication suicides.⁴³

This is supported by the literature. Substance use is a risk factor for suicide and access to the means of suicide heightens the risk of self-harm. Illicit drug users, for example, are 14 times more likely than peers to die from suicide, and drugs as a method of suicide plays a larger role in suicide among illicit drug users than the general population.⁴⁴ Moreover, like the literature on individuals who make previous attempts, individuals who have experienced an overdose are more likely to suicide than patients who have not previously overdosed.⁴⁵ However, related research into non-fatal illicit drug overdoses indicates that while the incidence of suicidal intent is high, such intentional overdosing is not always driven by a clear and unambiguous desire to die.⁴⁶ In fact, suicidology research indicates that any suicidal individual is rarely 100 per cent intent on dying, irrespective of their method or its lethality, and it may be more accurate to assert that 'death is just a more appealing option than living'.⁴⁷ In many cases, suicide may be more associated with an intention to cease suffering using death as a means, rather than an intent to die. It may thus be that an intention to cease suffering distinguishes more acceptably between suicidal and non-suicidal acts than an intention to die.⁴⁸ Such research suggests that legal definitions of intent may need to be broadened if suicide from overdose is to be captured.

42 Ian R H Rockett et al, 'Confronting Death from Drug Self-Intoxication (DDSI): Prevention through a Better Definition' (2014) 104(12) *American Journal of Public Health* e49, e50.

43 Ibid e49–e50.

44 Shane Darke and Joanne Ross, 'Suicide among Heroin Users: Rates, Risk Factors and Methods' (2002) 97 *Addiction* 1383, 1391.

45 Amy S B Bohnert, Kathryn Roeder and Mark A Ilgen, 'Unintentional Overdose and Suicide among Substance Users: A Review of Overlap and Risk Factors' (2010) 110 *Drug and Alcohol Dependence* 183, 189.

46 Joanne Neale, 'Suicidal Intent in Non-fatal Illicit Drug Overdose' (2000) 95 *Addiction* 85, 92.

47 Leo et al, above n 21, 10.

48 Ibid 11.

3 Capacity

As noted above, the final piece of evidence required to enable a decision that self-destructive behaviour was intentional is a capacity to understand the likely consequences of the act and to form the desire to die. The focus on capacity in suicide relates to its legal 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’.⁴⁹ Concerns about capacity open up a large grey area where the approach of the coroner matters considerably as:

The current definition requires a level of certainty around something that’s very ephemeral and unknowable in some cases and unretrievable [sic] in other cases. (Coroner 8)

In the sphere of coronial law, the primary circumstances that may impact capacity are where the deceased is a child, is mentally ill, or is under the influence of alcohol.⁵⁰

(a) Children

The coroners interviewed for this research generally presumed that children do not, or can not, form the intent to end their own lives.⁵¹ This is based on the reported belief that children do not fully understand the implications of their actions, despite their lethal behaviour resulting in their death. This was reconciled by some by reference to the common law presumption of incapacity to commit a crime under the age of 14; *doli incapax*.

I think it’s easier to say that if a 25 year old conducts himself in that way then they are doing so with knowing that that is fatal and for them to then choose to conduct themselves in that way for a fatality then they must have an appreciation of the risk and the likelihood of fatality. An 11 year old child, I don’t think has that thought process. (Coroner 15)

She was 15, I think. She hanged herself over in [regional location], and I fudged it. I mean, maybe there is a technical correctness in what I did. But what I said was I wasn’t – it was clear, she intended to put the rope around her neck – it wasn’t clear that she understood the finality of her actions. (Coroner 8)

I couldn’t be satisfied that he was able to make the necessary – or had the necessary intent. I mean I couldn’t work out whether it was that or whether it was, you know, a game of chicken or whatever. If I do have the doubt, I will err on the side of not making that finding. But having said that, I mean you look at, say, the mental capacity rules that apply in criminal cases for young people. So, you’ve got *doli incapax* because he’s under the age of 14. So, it would make sense. Maybe that should be a – you know, a yard measure in terms of whether we make the finding or not. (Coroner 25)

Coroner 31: If you’re going to get – the law presupposes that children under the age of 10 can’t be guilty of an offence. You might be stretching it if someone was 10, or nine, or eight, you might start to think, well that can’t be right.

Facilitator: So, you’d use the criminal age of responsibility as a guide?

49 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 236 [44] (French CJ).

50 Coronial Council of Victoria, above n 2, 10 [2.12].

51 Interestingly, some coroners have reported less hesitancy towards making findings of suicide for Indigenous children. For further discussion see Tait, Carpenter and Jowett, ‘Coronial Practice, Indigeneity and Suicide’, above n 26.

Coroner 31: I probably would in my mind, I'd use that as a guide.

I think it is more unusual because I think children don't have the capacity to think that this is the way they're going to deal with the problem. They might deal with the problem by taking drugs, or running away, or committing an act of violence, an act of frustration. But I don't think too many of them decide, well, I'm going to continue to ... I don't think children reach that level of desperation. (Coroner 20)

A reluctance by coroners and medical examiners to classify self-inflicted deaths in children as suicides is found elsewhere in the literature and tends to rely on the belief that children cannot adequately conceptualise the finality of their actions.⁵² However, in a comprehensive review of all published research since the 1980s, Kenyon concluded that by the age of 10 most children have a clear understanding of the concept of death across all five components: non-functionality (all life sustaining functions cease with death); irreversibility (death is final and a dead person cannot come back to life); universality (all living things die); causality (an understanding of what causes death); and personal mortality (an extension of universality – I will die).⁵³

In a similar fashion, Normand and Mishara found that of the 60 children they interviewed between the ages of five and nine in Canada, 87 per cent understood the concept of universality, 90 per cent understood death's finality, 53 per cent recognised its unpredictability and 90 per cent its inescapability.⁵⁴ By age nine, 95 per cent of the children interviewed knew the meaning of the word suicide, with the majority gaining that knowledge from the media (77 per cent) rather than personal experience (16.7 per cent).⁵⁵ In a follow up study, Mishara confirmed that even by age five, most children understand that death is final and that 'most 5–7-year-olds and almost all older children know full well that an intentional act of suicide will result in death and understand that death is permanent and final'.⁵⁶ This research proposes that there should not be an a priori presumption against a finding of suicide for a child aged 10–14.

(b) *Mental Illness*

There is a strong correlation between suicide and a history of mental illness. According to Hawton and van Heeringen, the vast number of psychological autopsies in developed countries have shown that 90 per cent of people who kill themselves have a psychiatric disorder.⁵⁷ Specifically, more than half the people who die by suicide have a current depressive disorder, and as a consequence, about four per cent of depressed individuals will die by suicide, usually at their first attempt. A number of Australian studies have similarly shown that

52 Franci Crepeau-Hobson, 'The Psychological Autopsy and Determination of Child Suicides: A Survey of Medical Examiners' (2010) 14 *Archives of Suicide Research* 24, 30.

53 Brenda L Kenyon, 'Current Research in Children's Conceptions of Death: A Critical Review' (2001) 43 *OMEGA – Journal of Death and Dying* 63, 65.

54 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, 191–2.

55 *Ibid* 198, 200.

56 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, 115.

57 Hawton and van Heeringen, above n 32, 1374.

disproportionately large numbers of individuals who have committed suicide have a psychiatric disorder, though 90 per cent is argued to be ‘somewhat of an over-estimate’.⁵⁸ For example, according to the Queensland Suicide Register, 47.2 per cent of all suicide cases between 2011–13 had at least one psychiatric disorder recorded.⁵⁹

Mental illness and suicide have a complicated relationship at law. Capacity to commit a crime, not displaced by mental illness, was once a prerequisite for a criminal finding of suicide; the act of ‘felo de se’.⁶⁰ In those days, in order to avoid a deceased being labelled as having suicided, coroners would invoke language indicative of mental illness such as ‘whilst temporarily insane’ or ‘while the balance of his mind was disturbed’ even where no overt mental illness played a role in the death.⁶¹ However, Waller notes that those phrases have not been used for many years in New South Wales at least.⁶² The extent to which mental illness impacts upon coroners’ decision-making in contemporary Australia is largely unknown. A brief review of cases undertaken on behalf of the Coronial Council of Victoria revealed 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.⁶³ However, it was noted by the Coronial Council that there is a need for systematic research in order to reach firm conclusions. To that end, during interviews for this project, coroners were asked how mental illness factors into their decision-making process for suicide. Coroners were quick to appreciate the strong link between mental illness and suicide.

Mental illness is obviously the first thing we think of if someone commits suicide. We think it’s a sort of *res ipsa loquitur* situation, almost. (Coroner 1)

If I see chronic mental illness with suicide attempts in the past, then I’m more likely to find it suicide probably. (Coroner 22)

Well a lot of them, mentally ill people, suicide; and it’s a conscious decision by them, and they eventually do. (Coroner 11)

You can’t rule out mental illness from a suicide verdict or you’d have no suicide verdicts. Because almost all of them have got something wrong with them in terms of – I mean, not all of it is documented, but they’re generally unwell, aren’t they? ... suicide flows from mental illness. You need to know that. (Coroner 21)

One way that the law has tackled this is through a distinction between depressive illnesses and psychosis; with evidence of a depression not seen as depriving a person of their ability to appreciate the consequences of their actions and thus capacity to suicide.⁶⁴ Coroners were consistent with that approach and

58 Boyd Potts et al, ‘Suicide in Queensland: Mortality Rates and Related Data 2011–2013.’ (Australian Institute for Suicide Research and Prevention (2016) 100 [6.3].

59 Ibid.

60 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 236 [44] (French CJ).

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

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

63 Coronial Council of Victoria, above n 2, 11 [2.16].

64 Waller, above n 62, 62.

were not reluctant to make a finding of suicide where the deceased was depressed.

Depressive illness is much more in tune with the here and now. People arrive to get themselves together and make decisions about what they want to do. It's not a clear, not a well thought out decision, but it is a decision that they reach with some application of a process. I'm far more comfortable in making findings of suicide in those cases. (Coroner 24)

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.⁶⁵ When interviewed however, coroners varied in whether they thought psychosis would displace a deceased's capacity to suicide. Some coroners were firmly of the view that a psychotic state would preclude a finding of suicide while others were of the view that they would still make a finding of suicide where the deceased was psychotic.

If you consider that subjective test when you look at people who suffer from psychosis ... then I would often conclude that it is not suicide. The person concerned did not have the state of mind to be able to form that intent. (Coroner 24)

I don't think it's suicide if you think you can fly because you're not intending to kill yourself. (Coroner 10)

If you're having a psychotic episode and you think you're superman, and you're going to stop the train ... that's not suicide. (Coroner 19)

Facilitator: So, a psychotic episode: I'm jumping off a building, I think I'm a bird. Am I committing suicide?

Coroner 3: Yes.

If they're of unsound mind and they commit suicide, it's still suicide from my point of view. (Coroner 28)

This almost polar opposite approach, reportedly taken by coroners to circumstances where there is psychosis present, poses a serious issue for consistent approaches to suicide findings. It is also not well supported by the literature, with a range of studies identifying suicide as the main cause of premature death among individuals experiencing a psychotic illness.⁶⁶ According to Dutta et al, suicide is 12 times more likely in patients with a psychotic illness than in the general population, and while the risk is highest in the first year after diagnosis, it is still a strong risk more than five years after the first psychotic episode.⁶⁷ It is clear that, without the clarity of a criminal offence and the principles associated with that, coroners are mixed in their approach to psychosis and suicide. Clarification, at law, of the relevance of mental illnesses such as

65 See, eg, *Inquest into the Death of Rebekah Anne Lawrence* [2009] Coroner's Court of New South Wales 13 [69] (Deputy State Coroner MacPherson). For further discussion of that inquest, see Ian Freckelton, 'Complementary Health Issues: Psychotherapy, Suicide and Foreseeable Risks of Decompensation by the Vulnerable' (2011) 18 *Journal of Law and Medicine* 467.

66 Nicholas Tarrier et al, *Cognitive Behavioural Prevention of Suicide in Psychosis: A Treatment Manual* (Routledge, 2013) 11–15.

67 Rina Dutta et al, 'Reassessing the Long-Term Risk of Suicide after a First Episode of Psychosis' (2010) 67 *Archives of General Psychiatry* 1230, 1236.

psychosis to a modern finding of suicide would likely impact upon consistency in approach.

(c) *Intoxication*

In a review of coroners' cases in England, intoxication was used as grounds for coroners not returning verdicts of suicide; even in some cases where a suicide note was present.⁶⁸ At first glance, a similar approach to intoxication appears in the responses from Australian coroners interviewed, where intent was obfuscated by intoxication.

Well that's the problem, isn't it, because even if it's objectively very dangerous behaviour, what's their intent once they're intoxicated? (Coroner 1)

If, after he wrote it (a suicide note), it's quite possible he might have changed his mind so in theory at least if after he wrote it you could demonstrate he got so drunk that he couldn't think ... he mightn't have. (Coroner 29)

However, closer inspection reveals that the role of alcoholic intoxication is more nuanced. Coroners were less likely to perceive alcohol as obscuring intent when the method was more violently active, or lethal (hanging or gassing). Conversely, they were more likely to believe alcohol obscured intent when the method was less actively violent (drowning or overdose). This may suggest that the lethality of the method rather than the intoxication was in fact the decisive factor in the coronial determination.

It's never in my experience do you find somebody who gasses themselves who isn't drunk. Apparently, you have to, because it is so foul. The smell and the burning sensation and the overpowering sensation of the carbon monoxide that you want to get out. As I understand it, what they do is get themselves rip-roaring, blinding drunk and then they cope with it that by the time they wake up they're dead, if you know what I mean? It's a means to an end. (Coroner 31)

How intoxicated do you have to be to be able – to not be able to tie a rope around a rafter, put it around your neck, get on a chair and jump? You – I mean, there's all steps to that and those steps all need some consciousness that you're doing what you're doing. (Coroner 2)

I can't think of too many people that are obviously suicide that haven't had a lot to drink. (Coroner 30)

Well then it would depend on the clearness of everything else. So, I think drunk people who have drowned are a bit complicated. Drunk people with ambivalent quantities of overdose – I had a suicide where I think he was drunk but he took huge amounts of pills. I'm happy that's suicide. But if he's taken a little bit too much and you're not sure that his mental state was altered when he decided, yeah. (Coroner 10)

Alcohol use is a well-established risk factor for both suicide and deliberate self-harm.⁶⁹ In prevalence studies of completed suicides, acute alcohol intoxication was evident in up to 69 per cent of cases, while the prevalence of acute alcohol intoxication in attempted suicides/deliberate self-harm ranged from 10 to 73 per cent of cases. Similarly, prevalence estimates of alcohol abuse

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

69 Barbara Schneider, 'Substance Use Disorders and Risk for Completed Suicide' (2009) 13 *Archives of Suicide Research* 303.

among completed suicides ranged from 15 to 61 per cent while the prevalence of alcohol abuse in deliberate self-harm ranged from 12 to 35 per cent.⁷⁰ Finally, research on the role of alcohol in suicide attempts reveals that the consumption of alcohol does not reduce intent.⁷¹ This suggests that the prevalence of alcohol should, at the very least, not mitigate against a finding of suicide by coroners.

C Standard of Proof

Alongside determinations of intent, 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.⁷² 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’.⁷³ It is little wonder that coroners diverge in their approach as there currently exists very little guidance as to how coroners should apply the *Briginshaw* sliding scale to suicide findings in the contemporary Australian coronial system.⁷⁴

Some coroners expressed an inherent difficulty in working with the balance of probabilities as opposed to the criminal standard of ‘beyond a reasonable doubt’. Others took the opposite view, finding that working with the balance of probabilities was relatively unproblematic.

I’m always a bit staggered when people tell me how hard it is to do beyond reasonable doubt, because I don’t think that’s hard at all. What’s really quite hard is balance of probabilities, because – and I think that in my opinion there is – in my personal opinion, that can lead to some real difficulties in coroners’ matters around suicide and a lack of understanding of that test. (Coroner 6)

Well in *Briginshaw* it’s not as hard, beyond reasonable doubt is hard ... I think it’s just clarity but it’s balance of probabilities with some particular clarity in the cogency in the evidence. (Coroner 10)

Coroners varied significantly in how they discussed the application of the *Briginshaw* scale in practice. In particular, coroners in some states reported thinking of *Briginshaw* as requiring a very high standard of proof in this area, whereas others thought it required much less. For example, when asked how ‘sure’ they would need to be that the evidence supported a suicide finding in numerical terms, coroners in some jurisdictions consistently gave relatively high

70 Thor Norström and Ingeborg Rossow, ‘Alcohol Consumption as a Risk Factor for Suicidal Behavior: A Systematic Review of Associations at the Individual and at the Population Level’ (2016) 20 *Archives of Suicide Research* 489, 493–4.

71 Michel Lejoyeux et al, ‘Characteristics of Suicide Attempts Preceded by Alcohol Consumption’ (2008) 12 *Archives of Suicide Research* 30, 35.

72 *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361–2 (Dixon J); *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] (State Coroner Coate); *State Coroner’s Guidelines 2013* (Qld) ch 8 [8.1].

73 *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362 (Dixon J); *State Coroner’s Guidelines 2013* (Qld) ch 8 [8.9].

74 Jowett, Carpenter and Tait, ‘Determining a Suicide’, above n 5, 370–2, 377.

percentages. By contrast, coroners in others reported applying a much lower standard, comfortable with 51 per cent.

For me it's got to be the *Briginshaw* test, that's very highly probable. So, if you want a percentage terms, probably 70 to 75. (Coroner 2)

More probable than not ... that's 51 per cent. But I think most of us are not really in that realm, we're really around the kind of 75 per cent comfort level, if you want to put a figure on it. (Coroner 27)

I'd be down round the 60 per cent I'd say. (Coroner 5)

No, 50 per cent, 51 per cent ... only 51, whatever that means. I came from being a criminal lawyer before into coronial, nowhere the same, didn't think it was remotely near the same standard of proof. (Coroner 10)

I'm more a 51 per center in many regards. (Coroner 12)

While ascribing a numerical figure to judicial decision-making is somewhat of a false exercise, the *Briginshaw* standard was complicated not just by jurisdiction,⁷⁵ but by the role of the family in the coronial process. From the 1980s, as Coroners Acts across Australia were re-enacted, families have been increasingly invited into the coronial system.⁷⁶ It has been argued elsewhere that as a consequence,⁷⁷ coroners have begun operationalising a form of therapeutic jurisprudence into their findings, based on a belief that coronial processes can be harmful or anti-therapeutic to families,⁷⁸ and that therapeutic jurisprudence is a mechanism for promoting wellbeing. Indeed, there was a suggestion from some coroners that concern for the family of the deceased might lead to the application of a higher standard of proof.

If there's a doubt I'd rather go with an accident, to save the family where possible. That's my personal view. If I can't say definitely, he did it, or she did it, I won't say it. (Coroner 7)

If you wanted me to put a percentage on it, I'm probably more than 50 per cent to convince me and that's because I'm ... mindful about the effects of a finding of suicide on the living, the people connected with that person. (Coroner 26)

Research has demonstrated that Australian coronial investigations are subject to familial involvement, despite the vast majority being concluded 'on the papers' rather than at inquest. This is especially apparent when a suicide verdict is being resisted.⁷⁹ It also appears that the standard of proof required by coroners is influenced by what is perceived to be a range of negative consequences for the family flowing from a suicide finding. While research has found that the legal

75 It is interesting to note that the approach to balance of probabilities appears to be correlated with whether the jurisdiction has a high Indigenous population. Those with a high rate of Indigenous deaths (Western Australia, Queensland and Northern Territory) seemed to be more comfortable with a 51 per cent approach. In contrast, coroners from jurisdictions that encounter less Indigenous deaths, such as New South Wales and Victoria, require far higher levels of certainty in order to make a finding of suicide. For a further discussion see Tait, Carpenter and Jowett, 'Coronial Practice, Indigeneity and Suicide', above n 8.

76 Gordon Tait et al, 'Decision-Making in a Death Investigation: Emotion, Families and the Coroner' (2016) 23 *Journal of Law and Medicine* 571, 577.

77 Belinda Carpenter et al, 'When Coroners Care Too Much: Therapeutic Jurisprudence and Suicide Findings' (2015) 24 *Journal of Judicial Administration* 172.

78 Alison Chapple, Sue Ziebland and Keith Hawton, 'A Proper, Fitting Explanation? Suicide Bereavement and Perceptions of the Coroner's Verdicts' (2012) 33 *Crisis* 230.

79 Tait and Carpenter, above n 19, 561–3.

implications of a suicide for life insurance for example, are no longer enforceable in Australia,⁸⁰ families bereaved by suicide are more likely to feel guilt and shame than other families bereaved by a sudden violent death.⁸¹ 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.⁸² Similarly, a finding without an understanding of the implications of legal processes on bereaved families can create an unnecessarily harsh environment and cause more harm.⁸³ However, these may not necessarily represent contradictory positions.

I guess the starting point is that suicide for me is a very difficult finding for most families to receive. So part of our approach to therapeutic justice is to be very careful to try and ensure – whilst not causing a difficulty with the integrity of the finding – but to try and ensure that the findings are accepted and are able to be consumed without too much pain by the family. I think that leads us into being very, very careful to make sure that it's the right case for a suicide finding. (Coroner 24)

I don't think it's inconsistent to perform the traditional and legalistic functions of the coroner, to also have a role in relation to therapeutic justice. There will be times when there's a tension between them, and one will take precedence. That may be, for example, when a coroner refuses to hold a hearing, despite the family's desire for one, because the coroner considers there is no benefit in doing so. By the same token ... we are required to take into account family considerations. Sometimes, it is enough that the family needs to understand more than they do with the finding on paper. (Coroner 19)

The growing commitment to therapeutic jurisprudence by coroners is not necessarily incompatible with their fact-finding role. In fact, coroners have a responsibility to participate in public education campaigns aimed at reducing the stigma associated with suicide and dispelling the misconceptions that loved ones have failed a relative who takes his/her own life. Indeed, assisting family members to better understand the uncertainty of mental illness and the impetuosity of suicide could be framed as important elements of therapeutic jurisprudence. Ultimately, however, the applicable standard of proof for suicide findings must be clarified and communicated to coroners so that consistency in approach may be improved.

IV CONCLUSION

Interviews with 32 coroners in Australian states and territories revealed that there were three interrelated areas that caused coroners the most concern with respect to suicide and the law: definitions of suicide; clarity of intent; and the legal standard of proof. In these areas, consistency in approach within and across jurisdictions could be improved through law reform as well as training that takes

80 Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 370–1.

81 John R Jordan, 'Is Suicide Bereavement Different? A Reassessment of the Literature' (2001) 31 *Suicide and Life Threatening Behaviour* 91, 93–5, 99.

82 Carpenter et al, above n 77, 173.

83 Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effects of Coroners' Procedures on Those Bereaved by Suicide (2003) 56 *Social Science and Medicine* 1033, 1041.

into account the current state of knowledge as derived from the literature on suicide and self-harm.

More specifically, it was found that coroners differ significantly in terms of the definition of suicide they apply in practice, if one is employed at all. This has the likely implication that deaths may be treated very differently depending upon the coroner who makes the finding. This bolsters the recommendation made in an earlier article by the authors that, as there is currently no clear legal definition of suicide in any of the Coroners Acts, this needs to be rectified.⁸⁴

Second, and despite variance in suicide definitions, discerning intent was agreed by most coroners to be the central issue in suicide determinations. Coroners appear well versed in the evidence that needs to be gathered when considering suicide as a legal finding, with many of the issues raised by coroners in interviews supported in the literature on suicide risk factors. However, it was found that coroners relied overly on certain risk factors and methods to indicate intent, and were inconsistent around key determinants of capacity, especially concerning age, alcohol and mental illness. It was identified that clarification of the law and/or training around particular elements that could be considered to fall within a suicide definition may contribute to greater consistency in approach:

- *Drug Intoxication*: In many cases, suicide may be more associated with an intention to cease suffering using death as a means, than an intent to die. It may thus be that an intention to cease suffering distinguishes more acceptably between suicidal and non-suicidal acts than an intention to die.⁸⁵ Legal definitions of intent may need to be broadened if suicide from overdose is to be captured.
- *Motor Vehicle Accidents*: Coroners encounter difficulty in discerning whether single vehicle accidents constitute suicide. Literature suggests that clues are available for coroners when discerning if a motor vehicle crash is intentional and that these should be clearly understood when determining intent.
- *Suicide Notes*: Requiring a suicide note for intent is clearly not well aligned with the literature and an absent note should not be seen as a negative indicator of intent.
- *Alcohol*: Alcohol use is a well-established risk factor for both suicide and deliberate self-harm, and research on the role of alcohol in suicide attempts reveals that the consumption of alcohol does not reduce intent. The prevalence of alcohol should not mitigate against a finding of suicide by coroners.
- *Mental Illness*: Coroners take opposing approaches to circumstances where there is psychosis present, which poses a serious issue for consistent approaches to suicide findings. Clarification, at law, of the relevance of mental illnesses such as psychosis to a modern finding of suicide would likely impact upon consistency in approach. Taking into

84 Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 379.

85 Leo et al, above n 21, 11.

account the literature on suicide and mental illness, the existence of a psychotic illness should not be an a priori presumption against a finding of suicide.

- *Children*: Regarding the capability of children to form suicidal intent, research suggests that many children can adequately conceptualise the finality of their actions, and therefore there should not be an a priori presumption against a finding of suicide for a child aged 10–14.

Finally, it was revealed that coroners vary considerably on their application of the standard of proof required to reach a finding of suicide. This further supports a recommendation made in an earlier article by the authors that the law guiding the application of standard of proof in suicide findings needs to be clarified in order to move towards nationally consistent approaches.⁸⁶

86 Jowett, Carpenter and Tait, 'Determining a Suicide', above n 5, 377–9.