Regulating Bereavement:
Inquests, family pressure and the gate keeping of suicide statistics

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Abstract

This study of English Coronial practice raises a number of questions, not only regarding state investigations of suicide, but also of the role of the Coroner itself. Following observations at over 20 inquests into possible suicides, and in-depth interviews with six Coroners, three main issue emerged: first, there exists considerable slippage between different Coroners over which deaths are likely to be classified as suicide; second, the high standard of proof required, and immense pressure faced by Coroners from family members at inquest to reach any verdict other than suicide, can significantly depress likely suicide rates; and finally, Coroners feel no professional obligation, either individually or collectively, to contribute to the production of consistent and useful social data regarding suicide—arguably rendering comparative suicide statistics relatively worthless. These issues lead, ultimately, to a more important question about the role we expect Coroners to play within social governance, and within an effective, contemporary democracy.

Introduction – the Coronial Gate-keeping of Suicide Statistics

Much is often made of changes in our suicide rates. As a society, we are relieve when we are informed that fewer people are ending their own lives (Australian Bureau of Statistics, 2012), confused when we are told exactly the opposite (Haesler, 2010), and concerned when our own rates are compared unfavourably with other nations and peoples (Georgatos, 2013). It is often difficult to ascertain the precise trajectory of our suicide rates, let alone where we stand in relation to anyone else.

The difficulty here is that suicide statistics are notoriously unreliable. Most research in the area estimates that suicide is significantly more common than our statistics would have us believe (Harrison, Abou Elnour, & Pointer, 2009). This systemic under-counting may be for a range of reasons. Walker, Chen and Madden (2008) contend that factors such as disparities between jurisdictions, lack of standardisation in the reporting of Coronial deaths, and issues over forms for police reports contribute to inaccuracies in the coding of our data. They also point to the reluctance of some Coroners to reach a finding of suicide in the first place. It is this final factor which forms the focus of this paper.

The central role of the Coroner has always been to investigate deaths 'considered worthy of inquiry' (Burney, 2000, p. 3). This would include deaths such as those by accident, where there was some suspicion of wrongdoing, and those by suicide. This became seen as a largely administrative task, conducted in a non-adversarial environment, as part of the effective administration of the populace. However, in addition to the recording, assessing and categorizing of death, the Coroner's role has more recently expanded to incorporate elements of social management and prevention of harm (The Victorian Institute of Forensic Medicine, 2013)

> Much of the operation of the office of Coroner or Coroners courts in Australia is centered on injury and death prevention, with the Coroner empowered to make recommendations on matters of public health and safety and judicial administration.

Consequently, the Coroner is not only an essential part of our legal system—in that they manage the relationship between the State, and the death of its citizens, and in particular, those deaths deemed to warrant investigation—now they are also an important element of the process by which the State accumulates social data, data which is used to identify problems and shape policy. The problem here is clear: if Coroners are reluctant to reach a finding of suicide, as Walker, Chen and Madden (2008) contend, then their role in production of valid statistics, which in turn direct social policies and programs (targeting, for example, suicide prevention), becomes significantly compromised.

Democracy and the Coronial Inquest

This research seeks to investigate the English and Welsh Coronial Inquest, particularly as it relates to the accurate investigation of potential suicides. In doing so, it also seeks to make some comparisons with how similar deaths are managed in Australia. There are a number of important differences between the two systems. The most significant concerns the role played by the inquest. In England and Wales, all deaths that are considered worthy of inquiry—which includes potential suicides—are necessarily the subject of a public inquest. In Australia, the same deaths are assessed solely on the basis of the documentary evidence, unless specific circumstances dictate otherwise.

It is important to note that the role of the Coroner, and the functioning of the Coronial Inquest, is not just matters of abstract social and administrative interest. It has been argued that, historically, both are central to how English democracy came to be shaped and understood, and as such, questions about how well the Coronial system works, and about how different former British colonies have chosen to refract this original office for their own purposes, continue to be asked.

In *Bodies of Evidence*, Burney (2000) examines the historical role played by the public inquest in placing important checks on State abuse of power, by insisting that all prison deaths—and most famously, the deaths of 18 protesting workers killed by in the Peterloo Massacre in 1819—face public scrutiny and judgment. This notion, that questionable deaths be the subject of public investigation, an investigation accessible to, and readily understood by, all interested parties within the community, became central to English conceptions of justice and democracy. Indeed, much of Burney's book examines the complex tension that arose within the Coronial Inquest, between the voices of this participatory tradition, and the bearers of new, scientific knowledge that sought to bring medical expertise to the Inquest process, often at the expense of public understanding and involvement.

> '…the benefit of expert governance, particularly in an era of mass democracy, was that it could draw upon advanced, universalizing knowledge in the service of public well-being and, ultimately, public education. Its shortcomings, however, lay in its tendency to stifle the very instruments of civic education—the local, participatory institutions in which an active, informed, and morally elevated citizenry was forged.' (Burney, 2000, 9)

Arguably, this tension—or at least a modern variant on it (ie. between medicine and the law)—can still be clearly seen within the fabric of contemporary death investigation (Carpenter & Tait, 2010). Certainly, there was some expectation that this tension would be evidenced within this study, and there were some minor examples of this. However, what was uncovered was a far more significant tension, a tension between the pastoral and the governmental functions of the Coroner; between what appears to be a therapeutic role (in looking after the well-being of bereaved families), and an investigative and preventative role (investigative, in delivering an appropriate finding, and preventative, in contributing accurate data to inform social policy). This paper will address this specific issue in some detail.

Coronial Inquests and Interviews

This study was conducted within one geographic area in England. The Research consisted of observations made at twenty public inquests into possible suicides, followed by hour-long, semi-structured interviews with six of the coroners who had presided over the above inquests.

From the observations made at inquest, three relevant conclusions were drawn. First, there appears to be no single model for running a Coronial inquest. Far from being a uniform and consistent element of the English legal system, the Coronial Inquest takes a wide range of different forms. Though the Coroners are uniformally professional, patient, and skilled at managing grieving families, each Coroner seems to organise their own courtrooms as they see fit. Second, to be able to reach a finding of suicide, the standard of proof is extremely high. In England, suicide determination is based around the criminal standard of 'beyond reasonable doubt', rather than the Australian model, which has adopted the civil standard of 'on the balance of probabilities'. Finally, the Coroners are often placed under significant pressure throughout the proceedings by the deceased's family not to bring in a finding of suicide. Almost all inquests are attended by family members, and even where they appear inclined to accept a finding of suicide, attempts are still continually made to control the general narrative.

From interviews with Coroners**,** four further issues emerge, issues which are both tied to the above observations, but which also raise some important questions about just what is going on in Coronial suicide investigations:

Inconsistency between Coroners

First, there exists considerable slippage between different Coroners as to what is likely to be considered suicide, and what is not. There are likely to be a number of reasons for this. As mentioned previously, there has always been a tension within Coronial death investigations between those who regard the process as a useful application of the scientific quest for truth—often exemplified by a different approach to the use of invasive autopsy—and those who place far more weight upon legal processes, and information gathered at the scene of death. This tension extends to disagreement of who ought, and who ought not, be eligible to be a Coroner:

> *'I have nothing against my medical colleagues, but I do think it's a job for a lawyer … I think that Inquest law is now becoming so complex—it's nothing to do with intellectual ability, but I think you need legal training, and to have performed in the court system to really be able to deal with it.*' Coroner 4

A further reason for a seeming lack of consistency in reaching findings of suicide involves considerable differences in experience, ability, and levels of training of Coroners.

> '*When I started, there was no training whatsoever for Coroners … the Coroner Society of England and Wales established some training for Coroners; it was pretty limited with a very small budget. There's no requirement for us to have that training … so there is inevitably a lack of consistency, and there are some people who do not go on any training at all*.' Coroner 2

There are also variations in funding and responsibilities. Some Coroners are well-funded and well-resourced; others are not, which affects their ability to complete the work effectively and consistently:

> *'You go and see Coroners in some other parts of the country and they're working out of the back kitchen, they're working out of a Portacabin … there was one Coroner starting to hold an inquest, could only have the village hall for the day, had to move to the next town to actually conclude the inquest.*' Coroner 3

While these are interesting and relevant in their own right, for the purposes of this paper, one final reason why there appears to be significant slippage between Coroners over findings of suicide is perhaps more important, and more telling, than the others. That is, there appears to be a difference of opinion over the central role of the Coroner; some Coroners take a fairly hard line over their determinations—understanding their role as fundamentally administrative—while others see their role in a more pastoral light, pertaining first and foremost to helping the grieving family.

> 'I'm not a social service. I'm supposed to be making an inquiry on behalf of the State, not on behalf of the family, and if this person has taken their own life, and the evidence satisfies me beyond a reasonable doubt that this is the case, what verdict can I possibly come to other that that they have taken their own life?' Coroner 6

Which can be directly contrasted with:

> *'I often engage the family and will say, 'I'm thinking along these lines. What's your view?' Sometimes if you carry the families with you, it's more cathartic—it's totally wrong, but it's a more cathartic experience for them … you put the family at the heart of the inquiry.'* Coroner 4

> *'It's all about enabling people to get on with their lives … giving them closure, actually lifting them up and explaining things … it's not what the law tells us it's about, but that's the reality of what it should do …'* Coroner 3

Underestimating rates of suicide

The second issue to emerge from the interviews involves the general admission by the Coroners that the Coronial inquest process acts to depress suicide rates, an observation supported by most research in the area (Harrison et al., 2009; Walker et al., 2008). The Coroners note that the standard of proof is at the very highest end of 'beyond reasonable doubt'. That is, the notion of 'beyond reasonable doubt' is not a singular measure; it is a continuum, with the finding of suicide placed at the furthest end.

> 'The standard of proof of beyond a reasonable doubt as applied in the public prosecution services is quite a lot lower really … I doubt many people would be prosecuted if you needed the level of sureness you need for a suicide verdict … Don't misunderstand that there's only

> one standard of proof, which is beyond a reasonable doubt, but then of course it's up to you to interpret what's beyond a reasonable doubt.' Coroner 1

Consequently, findings of suicide can be relatively hard to attain, which means that many suicides are classified as something else—even when most impartial observers might have reasonably concluded otherwise. This results in a significant reduction in the numbers of suicides recorded each year.

> 'Every Coroner does things differently, and like I say, a rough rule of thumb—if you're looking at statistics, I can guarantee that suicide is under-represented. Roughly, I say you could add a third onto the figure …' Coroner 4

> 'We're left with about 300 cases a year which we inquest … I would say we do 50 suicides a year out of 300—genuine suicide verdicts. Then there are probably about another 30 odd, which probably are.' Coroner 1

Family pressure and the 'therapeutic' Coroner

The third issue emerging from the interviews explains, at least in part, why many Coroners appear reluctant to reach a finding of suicide. Historically, the desperation of the family not to have a suicide finding by the coroner is perfectly understandable:

> 'If you go back in English law 150 years or so, suicide was an absolutely dreadful thing to do to yourself. You were cheating on God; you would not have any hope of resurrection … At that stage Coroners had been giving burial orders which said that the deceased must be buried at the junction of four roads with a stake through their body—and no, I'm not getting mixed up with Transylvania here, this is really what it said—where beggars could spit upon their graves as they went past.' Coroner 5

While some Coroners profess relative immunity to the wishes of family members, others are aware that such wishes often factor into their overall decision-making process.

> 'I think a lot of Coroners—me included—sometimes take a sympathetic view of the family, and perhaps, well, you know … why leave the family with the stigma of this, when we can actually make their situation better? … So, I think Coroners, to some extent, are softies, and might not necessarily bite the bullet and say, yes, this is suicide.' Coroner 4

> 'They tend to come in numbers. If you've got 10 members of the family with their eyes burning on you, and they really don't want that verdict, it is very, very hard …' Coroner 4

This can be contrasted with the standard stated approach:

> A Coroner has to divorce his own sensibilities from his legal responsibilities.' Coroner 5

> 'It boils down to evidence as far as I'm concerned. It boils down to evidence, and if there's doubt … I wouldn't be persuaded just because they're all shouting [the family] … I'm afraid you've just got to be robust about it and stick by your guns.' Coroner 2

Clearly, there is a division here between those Coroners who see their principal task as providing comfort and closure to grieving families, and those for whom the job remains steadfastly administrative. Interestingly, this tension may well be relatively new, as there is little sign of it in Burney's excellent book mentioned earlier, on the English Coronial inquest during the late nineteenth and early twentieth centuries. What may

have happened here are the effects of what Freckelton (2008, p. 576) refers to as the rise of 'therapeutic jurisprudence'—defined as 'the study of the role of the law as a therapeutic agent'.

Within this approach, the law is not simply a set of codes to be followed without reflection, much in the manner of Legal Positivism; such codes have consequences for all those caught up in the proceedings. As such, our legal institutions, and those charged with making them work, are now deemed to have some responsibility for the mental and emotional wellbeing of all participants. King (2008, p. 4) is quite explicit in his call for an increasingly therapeutic approach to Coronial practice:

> *Coroners' work is intimately connected with well-being—a concern of therapeutic jurisprudence. Part of the Coroner's role is to determine whether there are public health or safety issues arising out of the death and whether any action needs to be taken to remedy any problems, particularly those that may cause future deaths ... Moreover, the dead person's family suffer grief and, depending upon circumstances of the death, significant trauma.*

Coroners vs. statisticians

Such 'therapeutic' concern for the wellbeing of the grieving family leads on to the fourth and final issue emerging from the interviews. It is clear that Coroners feel under no obligation to make their findings amenable to the production of accurate and useful suicide statistics. As can be seen, most see their task as a fundamentally administrative function concerning the management of particular kinds of death, as well as helping families deal with the passing of a loved one. They do not see their job as making life easy for those charged with turning such deaths into meaningful numbers, and by adopting this approach, Coroner's become—consciously or otherwise—the principal gatekeepers of our suicide statistics.

> 'The statisticians will try and drill down, and sometimes we'll get psychological surveys of my files ... they go through and the try and figure out what the file means so they get the true suicide picture. So I said; 'Hang on a second; I sit in court, I've heard the evidence, I've made a judgment on what's happening here, and you want to go through the same material to see if you come to the same judgment or a different judgment? They said 'Yeah'. 'That's fine,' I said, 'what you're doing is meaningless, but just do it if you want to.'' Coroner 3

> 'We've now introduced narrative verdicts which are here to stay as far as I'm concerned, and are a huge boon for the public, and a huge benefit to the Coroner' court. So I'm not very sympathetic to somebody coming along and saying: 'well, you're disturbing our statistics'.' Coroner 6

Those Coroners who place greater emphasis upon the non-governmental, non-administrative elements of their job—that is, who emphasise more pastoral, therapeutic approaches to running an inquest—appear to have even less concern for the difficulties faced by those coding statistical data for later interpretation:

> 'You know, I do the job as I think fit, and by trying to put families first. I think I'm as guilty as anyone sometimes of being a softy. I appreciate that it must rankle statisticians completely, but in terms of perhaps the way people can live with themselves thereafter, I think that probably is a better aim.' Coroner 4

> 'You can make a difference because one of the non-statutory functions which is not recorded anywhere but a lot of us do it, is to try and help the family in closure, without being

> paternalistic. It can be a cathartic exercise and to that extent I think you've justified your own existence, never mind the State's work which you do.' Coroner 5

This relative disregard for the governmental aspects of the Coronial role—governmental in a Foucaultian (1977) sense of the word, the effective sketching out of the contours of community life; numbers and types of deaths being a very important contour—raises questions about just what Coroners' principal functions ought to be. If the statistics their actions give rise to bear only a passing resemblance to any reasonable ontology of suicide, perhaps that governmental responsibility should be dealt with elsewhere.

Or perhaps it raises questions about which elements of governance Coroners actually contribute to. Rather than simply managing the data of death, do Coroners now form part of the governance of *subjective* experience? That is, particularly on the issue of suicide, are they are now a component of the administrative apparatus that manages the emotional wellbeing of the population? Rose (1990) refers to the notion of a 'therapeutic community'; it may well be that Coroners have allocated themselves a role within that.

That said, it is important to avoid describing a binary, where none necessarily exists. In his book on education, Hunter (1994) notes that attempts to ascribe simple, two-sided logics to the fabric of the modern school, ignore the complex relationship between its bureaucratic components, and it's long history of pastoral guidance. The English Coronial inquest appears to have an equally complex relationship between its bureaucratic and pastoral functions, a relationship that has yet to be fully, or even partially, resolved.

Conclusion

This study leads to three central observations: first, given the evidence assembled here, if the British inquest is any measure of the idiosyncratic and locally-organized way in which potential suicides are addressed and adjudicated upon, then comparative suicide statistics (both local and international) are, at best, problematic, at worst, all but meaningless.

Second, while the UK Coroners expressed near unanimous support for the stringent standard of proof required (in spite of the statistical inaccuracies this most certainly produces), and unanimous support for the continued existence of a compulsory inquest for all potential deaths by suicide, there appears to be few advantages in Australia adopting the same protocols and procedures. The only argument that could run counter to this would involve a greater emphasis upon therapeutic models of Coronial practice, which would lean towards emphasizing the benefits of suicide inquests in aiding the grieving process of bereaved families. Given the problems outlined above, and given we have no historical expectation of an inquest, let alone the high costs involved and the extra workload placed upon our already taxed Coroners, this seems highly unlikely.

Finally, the important question arises: what *is* the principal role of the inquest in suicide investigations? There seems to be little agreement among the English coroners interviewed. While most understand and accept their role within the governmental

regulation of death, this often seemed secondary to their less tangible pastoral role in helping the families deal with bereavement. The disagreement and relative confusion over their responsibilities may eventually need formal clarification.

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