Suicide and coronial problems

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Abstract
Suicide problems for the coroner may be increased by the attitude of the family and/or the public. This article explores the nature of problems arising from an investigation and a finding of suicide and the issues of the burden of proof, the role of coroner and of a jury when one is needed and the significance of suicide finding which may affect an insurance claim, or potential inheritance. What reforms should be considered?

Keywords
Suicide, coroner, powers, family attitudes, changing law, burden of proof

Suicide or possible suicide presents a number of actual or potential problems for the coronial system. There may be problems of proof. Suicide may not be so readily distinguished from other possible causes of death. Suicide still carries a potential stigma, even in contemporary times of an enlightened view towards mental health problems. The family often resist a possible finding of suicide. Suicide may result in legal consequences affecting property. The medical, police and other investigations may have been poorly carried out. The inquest has only limited capacity for investigation. The coronial practice and procedure may produce difficulties, such as the suitability of a jury for the purpose.

There are nearly 6,000 suicides every year, a rate of about 10 per 100,000 people, the biggest single cause of death in people under 45, and three quarters of them men. Government concern is such that there is now a Minister for Mental Health, Suicide and Patient Safety.

The deceased died by suicide, or it looks as though he probably did, or he might have done.

The Senior Coroner must hold an inquest with a jury if he has reason to suspect:

(a) that the deceased died while in custody or otherwise in state detention, and that
   (i) the death was a violent or unnatural one, or
   (ii) the cause of death is unknown,
(b) that the death resulted from an act or omission of:
   (i) a police officer, or
   (ii) a member of a service police force,
(c) that the death was caused by a notifiable accident, poisoning or disease.

(3) An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.

(4) For the proposes of subsection (2)(c) an accident, poisoning or disease is “notifiable” if notice of it is required under any Act to be given –
   (a) to a government department,
   (b) to an inspector or other officer of a government department, or
   (c) to an inspector appointed under section 19 of the Health and Safety at Work etc Act 1974 (c.37).

The purpose of the investigation is to ascertain how the deceased came by his or her death, who, when, how and why, but not civil or criminal liability. Where necessary in order to avoid a breach of any convention rights within the meaning of the Human Rights Act 1998 the purpose is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death because of the duty of the state to protect life (article 2). Individual negligence on
the part of hospital staff will not suffice; there must be systemic failure or dysfunction by the administration or a clear assumption of responsibility by the institution.4 The duty of the Senior Coroner is to hold a full, fast and fearless investigation, to act in an inquisitorial manner, to establish the facts, to decide whom to call as witnesses,5 to bear in mind the public interest, to ensure that the jury make a determination and findings, and to ensure that he reaches a conclusion.6 Suicide is never to be assumed or presumed, it must always be proved by evidence.7 The deceased may have left a note.8 It is not the function of the Senior Coroner to establish blame or guilt, civil or criminal liability, that is for the courts;9 nor to provoke or to gather evidence for proceedings elsewhere. An inquest is a civil investigation, not a criminal proceeding. Suicide has not been a crime for the last 60 years. Suicide can occur for many reasons. Public societal attitudes do not see suicide as criminal; there is usually no stigma. Therefore for both a suicide conclusion and a narrative conclusion the standard of proof is the civil standard: suicide was more likely than not, and was so intended by the deceased.10 This is the test applied to suicide clauses in insurance policies.

The Senior Coroner must reach a decision, called a conclusion. The conclusion must be one of the following: (1) accident or misadventure, (2) alcohol or drug related, (3) industrial disease, (4) lawful or unlawful killing, (5) natural causes, (6) open, (7) road traffic collision, (8) stillbirth, (9) suicide; as an alternative or addition, a narrative conclusion, a brief, neutral, factual statement, not expressing any judgment or opinion.11

How

The child died by asphyxiation due to an unsafe sleeping environment. The Senior Coroner concluded that, although not a cause of death in the factual matrix and circumstances, a little time before death the father had sexually abused the child, and this contributed to the unsafe environment, and was accordingly a proper conclusion, not to be removed from the coronial report.12 How wide or how narrow is the concept of “how” remains a matter of some dispute.

Challenge

The conclusion of the Senior Coroner may be challenged in the High Court with the consent of the Attorney General or by way of judicial review, with leave.

Significance and importance of suicide

Suicide is lawful.13 Suicide may take place for any number of reasons. Usually suicide is seen as regrettable, often tragic. Though suicide by terrorists, murderers, rapists and other serious criminals may not elicit much sympathy. However, suicide may carry legal and other consequences, and family and friends and others may oppose and resist a possible suicide conclusion. The jury and the Senior Coroner may or may not be reluctant to reach such a conclusion. Suicide may carry a stigma for the reputation of the deceased, and his (or her) family; they might suffer or fear social injury and economic damage. The spouse or partner may have left the deceased or been involved in an affair with a third party. The family may blame themselves for not having realised that the deceased was troubled or for not assisting him to overcome his problems. However, there is now a much greater awareness of mental health problems and social stress, and the stigma of suicide has been largely replaced with understanding and sympathy.

In contemporary times quite a number of people for what seem to them to be good moral, ethical or social reasons take their own lives, a lawful course, and anyway they are then beyond the reach of the law. However, for family and friends to encourage or assist a suicide, albeit in itself a perfectly lawful death, is potentially a most serious crime.14 A witness at risk must be warned against self-incrimination.15 The situation is governed by the DPP’s Guidelines16 which seek to distinguish between the genuine and the non-genuine, the compassionate and the malevolent. In practice nobody has in fact been prosecuted. But the fear of prosecution of spouse may well have deterred would-be suicides from going ahead, and would-be encouragers and assisters such as the spouse from assisting.

Inheritance

Prospective legatees may lose out. In his Will the deceased may say: “I leave £x to my friend X, or to his children if he predeceases me, unless he commits suicide in which case the gift shall lapse.”

Insurance

Benefits arising on the death of the deceased may be lost on suicide, e.g. insurance benefits for family members. As a matter of public policy an insured and his beneficiaries could not benefit as a result of suicide.17 This used to be the law, but may not be so today now that suicide is lawful,18 and there is no forfeiture by survivor of suicide pact. Although public policy basically prevents a criminal benefitting from his crime, the court may relax the public policy where the justice of the case so requires.19 In contemporary society public policy should not invalidate or forfeit the insurance
unless the deceased acted with some fraudulent, criminal or improper purpose in mind. The insurance policy should deal with suicide expressly. Some policies exclude suicide if occurring within say a year, so as to exclude fraud at the time of the making of the policy.

**Damages**

The estate of the suicide deceased and his family may sue for damages against a hospital or prison or employer for negligently failing to prevent the suicide, such as for loss of death benefits.\(^{20}\)

**The jury and the Senior Coroner**

The inquest is a statutory legal process, deriving from a long historical lineage. The procedure is inquisitorial, the Senior Coroner enjoys a wide discretion, though the rules of natural justice and the rule of law must prevail. The police should investigate the death and satisfy themselves so far as they can that no criminal offence is involved. Then the Senior Coroner, with any reason to suspect suicide, must hold an inquest, with such thoroughness as is possible, and compassion, so far as the law allows. The jury must find the facts according to the evidence.

**Possible reform or improvement**

Proposals for reform or improvement have recently been made by JUSTICE.\(^{21}\) Perhaps the most important overriding principle should be to gain and retain public trust and confidence. In structural terms a national legal judicial coronial service might be preferable to the local authority dominated system that still prevails. Under the present system a full-time Chief Coroner and a Service Inspectorate might improve efficiency and effectiveness. Much greater attention needs to be accorded to the needs of the bereaved, often suffering distress and trauma. The next-of-kin need to be defined, notified, assisted. Delay is upsetting. There is an enhanced duty to investigate under Article 2 of the European Convention of Human Rights where the state may be responsible for the death, e.g. requiring an independent, adequate, diligent, prompt scrutiny, the identification of those responsible and accountable, and equality of arms. There should be a statutory duty of candour upon the public bodies involved. The lack of legal advice and assistance in the face of legally represented public bodies remains an unjustified injustice. The family can never understand the divided or dual system, namely the coroner’s duty to find the facts but not to pass on liability. Systematic failure, e.g. on the part of the psychiatric holding unit, is so often in issue in a suicide case; and allegations are met with institutional defensiveness. Coronial procedure usually runs fairly informally under the control of the coroner, and legal formalisation would not be appropriate, but better witness protection is needed for the bereaved. The failure of Government or the appropriate agency to act upon the coroner’s recommendations is a continuing frustration, but that is essentially a political matter.

**Notes**

1. Coroners and Justice Act 2009, s 7.
2. Coroners and Justice Act 2009, s 5(1).
3. Coroners and Justice Act 2009, s 5(2).
4. *R (Maguire)* v HM Senior Coroner for Blackpool [2019] EWHC 1232 (Admin).
5. *Coroner for the Birmingham Inquests (1974)* v Hambleton [2018] EWCA Civ 2081, [2019] 2 All ER 251.
6. The Coroners (Inquests) Rules 2013 (SI 2013/1616), and Guidance of Chief Coroner.
7. *Jenkins* v HM Coroner for Bridgend and Glamorgan Valleys [2012] EWHC 3175 (Admin).
8. *Mueller* v HM Area Coroner for Manchester West [2017] EWHC 3000.
9. Coroners and Justice Act 2009, s 10(2).
10. *R (Maughan)* v HM Senior Coroner for Oxfordshire [2020] UKSC 46, [69]–[83].
11. Coroners (Inquests) Rules 2013 (SI 2013/1616), Schedule, Form 2 Record of an inquest and Chief Coroner Guidance no 17, Conclusions: Short-Form and Narrative.
12. *R (Worthington)* v HM Senior Coroner for Cumbria [2018] EWCA Civ 3386.
13. Suicide Act 1961, s 1.
14. Maximum 14 years’ imprisonment; Suicide Act 1961, s 2.
15. Coroners (Inquests) Rules 2013, rule 22(2).
16. Crown Prosecution Service. *Suicide: policy for prosecutors in respect of cases of encouraging or assisting suicide*, www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide (February 2010, updated October 2014).
17. *Beresford* v *Royal Insurance Co Ltd* [1938] AC 586, [1938] 2 All ER 602, HL.
18. *Gray v Barr* [1971] 2 All ER 949, 965d, and *Dunbar v Plant* [1998] Ch 412, [1997] 4 All ER 289 (Phillips LJ), 312–313.
19. Forfeiture Act 1982, s 2.
20. *R (Maughan)* v HM Senior Coroner for Oxfordshire [2020] UKSC 46, [75]–[81].
21. JUSTICE. *When things go wrong: the response of the justice system*, 2020. Chairman Sir Robert Owen. The Report makes 54 recommendations, but goes much wider than suicide. See also *Report of the independent review of deaths and serious incidents in police custody*, Dame Elish Angiolini DBE, QC, 2017. INQUEST, leading charity involved in suicides.
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