



Coronial Council of Victoria

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Our ref: BC/14/12050

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission

Thursday 19 June 2014

Dear Commissioner

SUICIDE REPORTING REFERENCE REPORT

Thank you for the opportunity to contribute to your examination of intentional self-harm and suicidal behaviour in children. On behalf of the Council, I present our report on suicide reporting in the Victorian coronial jurisdiction. The report contains advice and recommendations to the Victorian Attorney-General on improving suicide reporting, and was submitted to the Attorney under section 110 of the *Coroners Act 2008*.

The issue of accurate suicide reporting was the subject of a Senate Community Affairs References Committee inquiry. The Senate Committee tabled its report – *The Hidden Toll: Suicide in Australia* – in the Australian Parliament in 2010. The report made a number of recommendations around reducing suicide and improving suicide reporting in Australia. The issue remains one of national interest and continues to be of particular interest to the National Committee for Standardised Reporting on Suicide.

While there remains diverse opinion on the issue, the Council proposes *inter alia* legislative amendment in the Victorian coronial jurisdiction to require coroners to make clear findings about the intention of people whose actions cause their own death. The Council believes that similar requirements should be legislated throughout Australia.

On behalf of the Council, I thank you for the opportunity to contribute to your investigation, and I would be happy to discuss with you the content of our report.

Yours sincerely,

Professor Katherine McGrath MB BS, FRCPA FAICD.
Chair, Coronial Council of Victoria



Coronial Council of Victoria – Reference 3 – June 2014

Suicide Reporting in the Coronial Jurisdiction



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Our ref: CD/14/234195

The Hon. Robert Clark, MP
Attorney-General
Level 26, 121 Exhibition Street
MELBOURNE VIC 3000

Tuesday 17 June 2014

Dear Attorney

SUBMISSION OF COUNCIL'S SUICIDE REPORTING REFERENCE REPORT

On behalf of the Coronial Council of Victoria, I present to you the Council's report on suicide reporting in the coronial jurisdiction, pursuant to your reference in May 2012. The report contains advice and recommendations on improving suicide reporting, and is submitted under section 110 of the *Coroners Act 2008*.

The issue of accurate suicide reporting has been one of national interest over recent years. In 2010, the Senate Community Affairs References Committee tabled a report in the Australian Parliament – *The Hidden Toll: Suicide in Australia*. The report made a number of recommendations around reducing suicide and improving suicide reporting. The issue also continues to be of interest to the National Committee for Standardised Reporting on Suicide.

While there remains diverse opinion on the issue, the Council has formed the view that there is a need for coroners to make clear findings about the intention of people whose actions cause their own death, and for this to have a legislative basis. As such, the Council proposes legislative amendment in the Victorian coronial jurisdiction with further national consideration for similar amendments in other jurisdictions.

In developing the attached report, the Council has consulted with State and Chief Coroners, and the National Committee for Standardised Reporting on Suicide. The Council also intends to follow the progress of the National Children's Commissioner's examination of intentional self-harm and suicidal behaviour in children.

On behalf of the Council, I thank you for your consideration of this matter, and look forward to your response.

Yours sincerely,

PUBLIC WEBSITE COPY

Professor Katherine McGrath MB BS, FRCPA FAICD.
Chair, Coronial Council of Victoria



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Executive Summary

Suicide is the leading ‘external’ (non-natural) cause of death in Australia.

Australian coronial courts play a critical role in reporting suicide deaths. Coronial findings contribute to the data used by the Australian Bureau of Statistics to compile mortality statistics, which underpin suicide prevention strategies and their evaluation.

The public interest requires that coroners report suicide when it occurs so as to allow accurate statistics about the incidence of suicide to be collated, to promote efficient suicide prevention strategies and enable suicide prevention objectives to be achieved.

It is widely recognised that suicide is underreported.

The Coronial Council of Victoria (**Council**), whose membership includes medical and legal professionals as well as community and police representatives, has investigated problems with suicide reporting in the Victorian coronial jurisdiction. The Council aims to promote change within the Victorian coronial jurisdiction with a view to parallel changes being implemented throughout Australia.

The **key problem** identified by the Council is that inconsistencies in coronial practices hinder the accurate collection of suicide data. Too often, when the deceased took an action that caused their death, the circumstances of death are described generally but an explicit finding is not made about whether or not the deceased intended to end their life.

The Council has formed the view that there is a need for a legislative requirement that coroners make a clear finding about the intention of people whose actions cause their own death, where the evidence permits. There are a number of circumstances that may apply to such deaths, including accident and suicide.

In some cases, the deceased may not have had the capacity to understand the effects of their actions or there may be insufficient evidence for the coroner to come to a conclusion about the deceased’s intent. In these cases, it would be useful for suicide prevention activities for the coroner to identify whether death was a reasonably foreseeable consequence of the deceased’s action.

The **primary recommendations** of the Council are that the Attorney-General:

1. propose amendment to the *Coroners Act 2008 (Vic)* to require that coroners make a finding of intention, as supported by the evidence, in relation to all investigated deaths found to be caused by an action of the deceased; and
2. raise the issue of standardisation of coronial legislation and/or coronial systems in Australia in the Standing Council on Law, Crime and Community Safety and propose that changes be implemented in parallel in all Australian jurisdictions.

The Council’s recommendations are set out in further detail at the end of the report.



1. Background

Coronial findings of suicide

- 1.1. The role of the Coroner’s Court of Victoria (**Court**) is to investigate deaths and fires in order to find their causes and “... to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety...”.¹
- 1.2. In all Australian states and territories, suspected suicide deaths must be reported to the coroner for investigation,² which may include an inquest.³
- 1.3. Suicide has been defined as:⁴

voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing ...

and:⁵

[the deceased] was engaged in a voluntary and deliberate course of conduct or act or acts in which he consciously intended at the moment of engagement in the acts, by those acts, to end his own life.
- 1.4. Examples of recent findings of suicide by the Court are:⁶

I find that [the deceased] intentionally took her own life by hanging.

and:⁷

I find that the cause of death of [the deceased] to be heroin toxicity in circumstances in which [the deceased] committed suicide.
- 1.5. The legal significance of suicide has changed over time. Historically, suicide was a crime in all parts of Australia other than Queensland, Western Australia and Tasmania.⁸ Some coronial findings of suicide had implications for burial of the deceased and resulted in forfeiture of the deceased’s estate.⁹ Suicide also invoked exclusions from workers’ compensation¹⁰ and life insurance claims.¹¹

¹ *Coroners Act 2008 (Vic)* preamble

² For example, in Victoria see *ibid* ss4(2)(a) and 12

³ In Victoria, see *ibid* s52. The circumstances in which an inquest must be held vary between jurisdictions.

⁴ *R v Cardiff City Coroner, ex parte Thomas* [1970] 1 WLR 1475 1478

⁵ *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [244]

⁶ *Inquest into the death of Sibel Yilmaz* Coroners Court of Victoria (2009/4452) 12 February 2014 [79]

⁷ *Inquest into the death of Elijah Michael Shelley* Coroners Court of Victoria (2008/4973) 1 September 2011 7

⁸ I Freckelton, ‘Psychotherapy, Suicide and Foreseeable Risks of Decompensation by the Vulnerable’ (2011) 18 *J Law Med* 421-31 423

⁹ I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press Melbourne 2006) 632

¹⁰ *Southall v Cheshire County News Co Ltd* (1912) 5 BWCC 251 cited in *R v Cardiff City Coroner, ex parte Thomas* [1970] 1 WLR 1475 1477

¹¹ *Mutual Life Insurance Company of New York v Moss* [1906] HCA 70; (1906) 4 CLR 311



- 1.6. Today, a finding by a coroner that a person died by suicide has fewer legal implications. Suicide and attempted suicide have been decriminalised in all Australian jurisdictions.¹² There is no legal restriction on burying persons who take their own lives and no forfeiture of assets by the state.
- 1.7. However, the potential exclusion from insurance policy claims remains (normally only if a person takes their own life within a defined period of the policy commencing)¹³ and persons who injure themselves intentionally are normally excluded from workers' compensation claims.¹⁴ Variations of assisting and encouraging suicide are still crimes all Australian jurisdictions.¹⁵
- 1.8. A finding of suicide may have a significant social impact upon the family of the deceased. Suicide is still said to attract social and psychological stigma. Inquests can be particularly distressing when suicide is in question.¹⁶ Some religious groups place significance on death by suicide. It has also been reported that there are numerous appeals against coroners' findings of suicide.¹⁷ This suggests that family members sometimes find suicide findings difficult to accept.

Cause of death statistics

- 1.9. Australia's causes of death statistics are prepared by the Australian Bureau of Statistics (ABS) (an independent statutory authority) in accordance with the World Health Organization's International Classification of Diseases, version 10 (ICD-10).¹⁸ The ICD-10 is designed to promote international comparability in the collection, processing, classification and presentation of causes of death statistics.
- 1.10. Deaths from 'external' (non-natural) causes are classified according to the mechanism of death (how the person died) and intention, which identifies the role of human intervention in the injury (including 'intentional self-harm', 'accident', 'assault' and 'undetermined').¹⁹ 'Intentional self-harm' includes but is not limited to suicide deaths. The ICD-10 specifies sub-classifications

¹² PA Fairall and M Bagaric, 'Suicide and attempted suicide are not offences in Australia' in *The Laws of Australia* (Thomson Reuters online updated 17 March 2012) [10.1.780]

¹³ For example, Allianz Australia Life Insurance Limited, *Allianz Life Plan: Product Disclosure Statement and Policy Document* (25 October 2013) 4

¹⁴ Safe Work Australia, *Comparison of Workers' Compensation Arrangements in Australia and New Zealand* (Commonwealth of Australia Canberra July 2013) Table 3.13

¹⁵ PA Fairall and M Bagaric, 'Assisting or encouraging another person to commit suicide is an offence in all jurisdictions' in *The Laws of Australia* (Thomson Reuters online updated 17 March 2012) [10.1.790]

¹⁶ L Biddle, 'Public hazards or private tragedies? An exploratory study of the effect of coroners' procedures on those bereaved by suicide' (2003) 56(5) *Soc Sci Med* 1033-45

¹⁷ M Barnes, *Proof Committee Hansard* (18 May 2010) 50 cited in Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) 26

¹⁸ World Health Organization, 'International Classification of Diseases version 10' (2010) <<http://www.who.int/classifications/icd/en/>> accessed 25 March 2014

¹⁹ Other categories of intention are: 'legal intervention and operation of war', 'complications of medical and surgical care', and 'sequelae of external causes of morbidity and mortality': *ibid* Chapter XX



for different mechanisms of suicide deaths (eg ‘intentional self-harm by hanging, strangulation and suffocation’).

- 1.11. In compiling cause of death statistics, the ABS uses data from state and territory Registers of Births, Deaths & Marriages, supplemented by information from the National Coronial Information System (NCIS),²⁰ an internet-based data storage and retrieval system, which has been in use in Australia since 2000.
- 1.12. The NCIS collates information about cases referred to the coroner for investigation that is recorded by court staff and updated as the investigation progresses and completes.²¹ For all deaths from external causes, it is mandatory to record intention. Presumed intent is required to be specified at the time of notification,²² and determined intent at case completion.²³ NCIS intention categories mirror those of the ICD-10.
- 1.13. An investigation of a death is initiated by the ABS if the mechanism of death indicates a possible suicide and the coroner has not made a specific finding about the deceased’s intention. Information that would support a classification as ‘intentional self-harm’ by the ABS includes indications by the person that they intended to take their own life, suicide notes, and previous suicide attempts.²⁴ Thus, the ABS can classify a death as intentional self-harm even when the coroner has not made a finding of suicide. However, in the view of the Council, it is preferable for coroners to make clear findings that enable codification to take place without further investigation.
- 1.14. Given the substantial delays in completion of some coronial investigations, not all information is available to the ABS when its annual report on causes of death is prepared (15 months after the end of the reference period).²⁵ In these cases, if either the mechanism or intention remains unknown the ABS uses a less specific category, as required by the ICD-10.²⁶ Coroner-certified deaths registered after 1 January 2006 that remained open at the time of reporting are revisited periodically by the ABS to see if new information has been provided,

²⁰ Australian Bureau of Statistics, *3303.0 - Causes of Death, Australia, 2012* (Canberra 25 March 2014) Explanatory Notes [6]

²¹ National Coronial Information System, ‘Data from coronial files’ <<http://www.ncis.org.au/data-collection-2/data-from-coronial-files/>> accessed 17 April 2014. See the description of the NCIS codification process in L Bugeja and others, ‘Reliability of ICD-10 external cause of death codes in the National Coroners Information System’ (2010) 39(3) *HIM J* 16-26. For work-related deaths (excluding deaths from self-harm), information is also collected by the NCIS from Safe Work Australia: National Coronial Information System, ‘Data from other sources’ <<http://www.ncis.org.au/data-collection-2/data-from-external-sources/>> accessed 17 April 2014

²² National Coronial Information System, *Coding Manual and User Guide v10* (Victorian Institute of Forensic Medicine Melbourne 2010) 87

²³ Ibid 84

²⁴ Australian Bureau of Statistics, *3303.0 - Causes of Death, Australia, 2012* (Canberra 25 March 2014) Explanatory notes [94]

²⁵ Ibid [29]

²⁶ Ibid [30] and [60]



and are recodified accordingly. As a result of the reclassification process, the number of deaths attributed by the ABS to ‘intentional self-harm’ has risen.²⁷

Suicide reporting in Australia

- 1.15. The rates of suicide and attempted suicide in Australia are a significant public health concern. In 2012, suicide was the leading external cause of death in Australia, as well as the 14th leading cause of death overall, and the 10th leading cause of death for males.²⁸ The ABS recorded 2,535 deaths from ‘intentional self-harm’ in 2012, which amounts to 11 per 100,000 deaths.
- 1.16. Suicide by children and young people is a particularly sensitive issue and has been the subject of an Australian parliamentary inquiry²⁹ as well as various state initiatives.³⁰ In 2012, suicide accounted for 33 per cent of all deaths of 15-19 year old females and 29 per cent of all deaths of 15-19 year old males. Suicide also accounts for a significant proportion of all deaths of children under the age of 15.³¹ In Queensland in 2012-2013, suicide accounted for 47 per cent of deaths by external causes among children and young people aged 10-17 years.³²
- 1.17. The Australian Government, state and territory governments and other bodies undertake population health initiatives aimed at suicide prevention.³³ These initiatives rely on the accuracy of statistics and research to indicate the scale of the problem, the populations at risk, indicators of potential suicide, the impact of suicide prevention activities and other information.
- 1.18. However, concerns have arisen that suicide is underreported³⁴ and that suicide-reporting practices are inconsistent amongst states and territories.³⁵ The

²⁷ Australian Bureau of Statistics, 3309.0 - *Suicides Australia 2010* (ABS Canberra 24 July 2012) 7 of 22

²⁸ Australian Bureau of Statistics, 3303.0 - *Causes of Death, Australia, 2012* (Canberra 25 March 2014)

²⁹ House of Representatives Standing Committee on Health and Ageing, *Before it's too late: Report on early intervention programs aimed at preventing youth suicide* (Commonwealth of Australia Canberra 2011)

³⁰ For example, Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people Queensland 2012-2013* (State of Queensland Brisbane 2013); Western Australia Ombudsman, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (Perth 2014)

³¹ Australian Bureau of Statistics, 3303.0 - *Causes of Death, Australia, 2012* (Canberra 25 March 2014)

³² Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people Queensland 2012-2013* (State of Queensland Brisbane 2013) 62

³³ Department of Health and Ageing, *Living is for Everyone (LIFE) Framework 2007: Research and evidence in suicide prevention* (Australian Government Canberra 2007)

³⁴ AA Elnour and J Harrison, ‘Suicide decline in Australia: where did the cases go?’ (2009) 33(1) *Aust N Z J Public Health* 67-9

³⁵ JE Harrison, S Pointer and AA Elnour, *A review of suicide statistics in Australia* (Injury Research and Statistics Series Australian Institute of Health and Welfare Canberra 2009) 93; D De Leo and others, ‘Achieving standardised reporting of suicide in Australia: rationale and program for change’ (2010) 192(8) *Med J Aust* 452-6 454



standardisation of suicide reporting forms part of the Australian Government's Suicide Prevention Strategy Action Framework.³⁶

- 1.19. There have been two public inquiries into the issue of suicide prevention, which included broad consultation throughout Australia with relevant governmental and non-governmental organisations.³⁷
- 1.20. The 2010 Senate Community Affairs References Committee (**Senate Committee**) report *The Hidden Toll: Suicide in Australia* noted the following (amongst other issues):
- inconsistency and insufficiency in collection of information by the police;
 - differing coronial legislation and practices between jurisdictions;
 - difficulty in determining the deceased's intent;
 - pressure on coroners to resist finding suicide due to stigma; and
 - inconsistencies in data entry from coronial findings into the NCIS.
- 1.21. Although most of these issues are likely to be relevant to all findings of externally caused deaths,³⁸ this Report focuses on implications for suicide reporting.
- 1.22. The Senate Committee made a number of recommendations aimed at reducing suicide in Australia and improving suicide reporting, including:³⁹
- ... that the Standing Committee of Attorneys-General, in consultation with the National Committee for Standardised Reporting on Suicide, standardise coronial legislation and practices to improve the accurate reporting of suicide.*
- 1.23. The Australian Government supported this recommendation in principle, noting that the standardisation of suicide reporting is secondary to the varied legislation and judicial processes in place in different states and territories.⁴⁰ The House of Representatives Standing Committee on Health and Ageing further endorsed the Senate Committee's recommendation.⁴¹

³⁶ Australian Suicide Prevention Advisory Council, 'Living is for everyone' <<http://www.livingisforeveryone.com.au/ASPAC.html>> accessed 17 April 2014

³⁷ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010); House of Representatives Standing Committee on Health and Ageing, *Before it's too late: Report on early intervention programs aimed at preventing youth suicide* (Commonwealth of Australia Canberra 2011)

³⁸ See also L Bugeja and others, 'Reliability of ICD-10 external cause of death codes in the National Coroners Information System' (2010) 39(3) *HIM J* 16-2; J Pearse and L Daking, 'A response to Bugeja, Clapperton, Killian, Stephan and Ozanne-Smith' (2010) 39(3) *HIM J* 27

³⁹ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) xvii

⁴⁰ Commonwealth of Australia, *Commonwealth response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee* (Commonwealth of Australia Canberra 2010) 16

⁴¹ House of Representatives Standing Committee on Health and Ageing, *Before it's too late: Report on early intervention programs aimed at preventing youth suicide* (Commonwealth of Australia Canberra 2011) [2.21]



1.24. The National Committee for Standardised Reporting on Suicide (**NCSRS**) was instigated in 2009 to address the issue of suicide reporting. A wide range of stakeholders are represented on the NCSRS, including:⁴²

- Suicide Prevention Australia
- ABS and its Mortality Statistics Advisory Group
- NCIS
- Australian Institute for Health and Welfare
- Australian Institute for Suicide Research and Prevention
- Registries of Births, Deaths and Marriages
- Victorian Institute of Forensic Medicine
- State coroners, the Asia Pacific Coroners Society and interested individual coroners
- Coroners Prevention Unit, State Coroner's Office of Victoria
- Office of the Public Advocate (Victoria)
- Australian Suicide Prevention Advisory Council
- Australian Government's Department of Health
- Criminology Research Advisory Council
- Key university researchers
- Australasian Mortality Data Interest Group
- Victorian Police and Northern Territory Police
- Lifeline Australia
- Hunter Institute of Mental Health.

1.25. After an extensive process of consultation, meetings and workshops, the NCSRS has identified three priority projects:⁴³

- The National Police Form
- Law Reform
- Suicide Registers / National Minimum Dataset.

1.26. This reference contributes to the first two of these priority projects, both of which fall within the remit of the Victorian Attorney-General and other state and territory Attorneys-General.

1.27. It is recognised that any change in suicide reporting practices will have implications for the comparability of statistics across time.⁴⁴

⁴² National Committee for Standardised Reporting on Suicide, *Submission: Senate Community Affairs Reference Committee* (February 2010) Appendix A

⁴³ National Committee for Standardised Reporting on Suicide, 'Progressing the Senate Inquiry Recommendations' (Presentation to the State and Chief Coroners' Meeting, 11 April 2014)



The reference and the consultation

- 1.28. The Council is a statutory body whose functions include providing advice and making recommendations to the Attorney-General in relation to ‘issues of importance to the coronial system in Victoria’.⁴⁵ The membership of the Council is set out in **Appendix A**.
- 1.29. In May 2012 the Attorney-General made a formal reference (set out in full in **Appendix B**) to the Council pursuant to section 110 of the *Coroners Act 2008 (Vic)* to examine:
- a) policy that enables a consistent approach to coronial determination of intent;
 - b) the application of legal principles regarding suicide, including the operation of the presumption against suicide under the common law and consideration of the evidence broadly considered necessary to establish the mental element of suicide;
 - c) whether a change to the existing law regarding the standard of proof for a finding of suicide is desirable; and
 - d) the reporting of suicide in the media, including an appropriate position for the Court to adopt on this issue.
- 1.30. In April 2014, the Council distributed a consultation paper (**Consultation Paper**) to Australian State and Chief Coroners and to members of the NCSRS. Although the timeframe for consultation was short, nine responses were received (listed in **Appendix C**) and the Council has taken these into account in formulating this report.
- 1.31. This report is focused primarily on the first of the four issues included in the reference: coronial determination of intent, which the Council has identified to be the area in which change is needed (sections 2 to 0). The other three issues are dealt with towards the end of the report (sections 0 to 11).
- 1.32. The Council is a Victorian institution. However, given that no other Australian jurisdiction has an equivalent body and the prevailing view that reform should take place on a national basis, this report has been drafted with the national context in mind.

⁴⁴ CE Bradley, JE Harrison and A Abou Elnour, ‘Appearances may deceive: what's going on with Australian suicide statistics?’ (2010) 192(8) *Med J Aust* 428-9; S Walker, L Chen and R Madden, ‘Deaths due to suicide: the effects of certification and coding practices in Australia’ (2008) 32(2) *Aust NZ J Pub Health* 126-30; Australian Bureau of Statistics, 3303.0 - *Causes of Death, Australia, 2012* (Canberra 25 March 2014) Explanatory notes [94]

⁴⁵ Coroners Act 2008 (Vic) s110



2. Issues with Coronial Determination of Intent

The cause of death and the circumstances of death

- 2.1. Cause of death is not defined in Australian coronial legislation.⁴⁶ The difference between a cause and a circumstance is said to be a matter of degree.⁴⁷
- 2.2. In Victoria, intention to take one's life is treated as a circumstance of death and not as a cause of death. The cause of death is normally taken to be either the medical cause (eg asphyxiation),⁴⁸ the means by which this occurred (eg hanging),⁴⁹ or a combination of the two (eg asphyxia by hanging).⁵⁰
- 2.3. However, in accordance with the ICD-10, the ABS classifies the 'underlying cause' of externally caused deaths according to the circumstances of the fatal injury rather than the nature of the injury:⁵¹

a motorcyclist may crash into a tree (V27.4) and sustain multiple fractures to the skull and facial bones (S02.7) which leads to death. The underlying cause of death is the crash itself (V27.4), as it is the circumstance which led to the injuries that ultimately caused the death.

- 2.4. As a matter of law, intention forms part of the circumstances of death and not part of the cause of death. Nevertheless, from a public health perspective, the fact that a deceased intentionally took their life is equally significant as the mechanism by which they did so. Therefore, for suicide deaths the circumstances of death are very important.
- 2.5. The Council takes the view that coroners should make clear findings about the circumstances of death, including risk factors for suicide and the deceased's intention, as the evidence permits, in all cases in which death was found to result from an action of the deceased.

Insufficient evidence

- 2.6. In order to reach a finding of suicide, the coroner must determine that the deceased intended to end their life.⁵² In law, direct intent is required – recklessness or any lesser form of intention is insufficient. The coroner must also find that this intent was held at the time the deceased took the actions that caused their death and that the deceased's intent did not change part way

⁴⁶ cf Fijian legislation which defines 'cause' broadly to include 'how the deceased came by his death': *Inquest Act (Fiji)* s2 quoted in I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press Melbourne 2006) 638

⁴⁷ *Re Doogan ex p Lucas-Smith* [2005] ACTSC 74 [39]

⁴⁸ *Inquest into the death of Daniel Dalli* Coroners Court of Victoria (2010/3114) 30 July 2013

⁴⁹ *Inquest into the death of Hassen Yassin* Coroners Court of Victoria (2011/0291) 20 August 2013

⁵⁰ *Inquest into the death of Cody Jackson* Coroners Court of Victoria (2009/1457) 12 April 2013

⁵¹ Australian Bureau of Statistics, *3303.0 - Causes of Death, Australia, 2012* (Canberra 25 March 2014) Explanatory Notes [40]

⁵² *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [244]



- through the fatal acts.⁵³ This can be very complex, particularly given the interrelationship between recklessness, impulsivity and direct intent.
- 2.7. It has been suggested that coroners may sometimes have difficulty determining a deceased person's intent because of insufficient evidence.⁵⁴
- 2.8. It is inevitable that in some cases the evidence will be insufficient to make a finding about the deceased's intent. In addition, sometimes a finding of suicide is contentious and the evidence is disputed in the inquest.⁵⁵
- 2.9. When the coroner cannot be satisfied on the balance of probabilities as to whether or not the deceased intended to die, the correct approach under the current law is for the coroner to return an open verdict.⁵⁶ The death will then be coded as 'undetermined intent' for statistical purposes.⁵⁷
- 2.10. Nevertheless, the Council is concerned that potential suicide deaths for which the coroner is unable to reach a conclusion about intention are difficult to identify for suicide prevention purposes. The category of 'intentional action causing death' discussed in section 4 is intended to capture these deaths.

Mental capacity

- 2.11. The coroner cannot make a finding that a deceased person died by suicide if the person lacked the mental capacity to form an intention to end their life. Capacity is assumed in the absence of evidence to the contrary.
- 2.12. The deceased may have lacked capacity if they were mentally ill, intellectually impaired, psychotic, extremely distressed, under the influence of alcohol or drugs or very young.⁵⁸
- 2.13. Issues of capacity are particularly likely to arise for children and young people. Whether or not children can formulate concepts of the finality of death is controversial but it is clear that self-harming behaviour by children and young people, which sometimes leads to death, is a significant problem.
- 2.14. An example of a coronial finding that the deceased lacked capacity to form an intention to end their life is:⁵⁹

I find that when he was engaged in these acts, highly dangerous to his survival, it was at a time when he no longer had control of himself. He was so

⁵³ Ibid [244]

⁵⁴ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) [3.16]

⁵⁵ For example, in *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [240]

⁵⁶ *R v Huntbach, ex parte Lockley* [1944] 1 KB 606 608

⁵⁷ World Health Organization, 'International Classification of Diseases version 10' (2010) <<http://www.who.int/classifications/icd/en/>> accessed 25 March 2014 Chapter XX

⁵⁸ See the following examples: *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin) [27]; *R v HM Coroner for the County of Greater Manchester and others, ex parte Sreedharan* [2013] EWCA Civ 181 [71]; *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [282]

⁵⁹ *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [282]



overwhelmed by his emotions that it is not appropriate to conclude that he was acting voluntarily.

- 2.15. It is unclear how frequently this occurs in practice. However, the impact of mental incapacity on findings of suicide is important in light of relationships between suicide, mental illness and substance abuse.⁶⁰ Mental illness and substance abuse are treatable conditions and it is essential to know how often they contribute to a person voluntarily taking action that ends their life.
- 2.16. A brief review of recent publicly available coronial cases, undertaken on behalf of the Council, revealed mental health issues to be a factor in most cases but concerns about whether the deceased had mental capacity to be rare. Systematic research would be needed to reach firm conclusions.
- 2.17. The Council is concerned that deaths for which a finding of suicide is prevented due to mental incapacity are difficult to identify for suicide prevention purposes. The category of ‘intentional action causing death’ discussed in section 4 is intended to capture these deaths.

Absent or obscure findings of intention

- 2.18. There is no legislative requirement in any Australian jurisdiction for coroners to make an explicit finding about whether or not the deceased intended to end their own life.
- 2.19. Concerns have been raised that coroners sometimes do not make an explicit finding about intention⁶¹ and that the form and location of intention findings differ between coroners, increasing the likelihood of coding mistakes.
- 2.20. An informal review of potential suicide cases undertaken by the NCIS in 2009 revealed that in 29 per cent of cases, the coronial finding had no mention of intention.⁶² It is unclear whether there has been any improvement since 2009.
- 2.21. A brief review of recent publicly available Victorian suicide findings⁶³ undertaken on behalf of the Council confirmed that pursuant to the Court form, the mechanism of death is invariably indicated both at the top of the findings and at the bottom under the heading ‘Findings’, but that any statement about intention is almost always located amongst the ‘circumstances of death’.⁶⁴

⁶⁰ J Mendoza and S Rosenberg, *Suicide and Suicide Prevention in Australia: Breaking the Silence* (ConNetica Consulting Pty Ltd Moffat Beach 2010) 67-71 and 74-75

⁶¹ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) 22

⁶² *Ibid* 22

⁶³ Coroners Court of Victoria, ‘Coroners’ Written Findings’ <<http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/>> accessed 17 April 2014

⁶⁴ See for example *Record of Investigation into death of Brodie Rae Constance Panlock* Coroners Court of Victoria (2006/3625) 16 May 2008; *Inquest into the death of Glenn Stewart Hayes* Coroners Court of Victoria (2013/0592) 10 February 2014; *Inquest into the death of Renee Treen* Coroners Court of Victoria (2010/2062) 29 January 2014; *Inquest into the death of Adam Sasha Omerovic* Coroners Court of Victoria (2010/1114) 24 January 2014



- 2.22. This finding clearly identifies intention together with the cause of death:⁶⁵

On all the available evidence, I find [the deceased] died as a result of multiple injuries sustained from impact by a train. I find that [the deceased] intentionally put himself in the path of the train. There do not appear to be any suspicious circumstances surrounding his death.

- 2.23. This finding does not:⁶⁶

I find the cause of death of [the deceased] to be combined drug toxicity.

- 2.24. In the latter case the coroner did, however, include a statement that ‘[the deceased] chose to end her life’ as part of the circumstances of death.⁶⁷

- 2.25. In some cases it is implicit in the circumstances of death that the deceased intended to take their own life but it is not stated clearly.⁶⁸

- 2.26. In some cases it is unclear whether or not the finding is of suicide (and consequentially whether or not the death should be coded as ‘intentional self-harm’ in the NCIS):⁶⁹

Having considered all the available evidence I find that whilst the body of [the deceased] has never been located, she has presumably drowned and perished ... probably with the intention of ending her life.

and:⁷⁰

I am satisfied having regard to [the deceased]’s prior psychiatric history, his mental health status as at the time he left the in-patient psychiatric facility, and the circumstances in which [the deceased] was located, that [the deceased] took his own life ...

I am satisfied that [the deceased]’s actions were intentional in the sense that he activated the plan, however his mental health status suggests that his psychiatric illness was a significant factor in the action he took to end his life.

- 2.27. In the latter case it is unclear whether the Coroner found suicide or that the deceased lacked capacity to form an intention to take his life. Later in the finding, a reference to ‘his suicide’ is made.⁷¹

- 2.28. It is mandatory for court clerks to indicate intention when uploading information to the NCIS.⁷² However, if the coroner does not explicitly find

⁶⁵ *Finding into death without Inquest (Adam Joel Rickard)* Coroners Court of Victoria (2012/3776) 10 April 2013 7; see also *Inquest into the death of Imanthi Mayakaduwege* Coroners Court of Victoria (2012/1612) 23 September 2013 [17]

⁶⁶ *Inquest into the Death of Rosemary Haldane* Coroners Court of Victoria (2012/2267) 19 April 2013 [25]

⁶⁷ *Ibid* [23]

⁶⁸ *Inquest into the death of Cody Jackson* Coroners Court of Victoria (2009/1457) 12 April 2013;

Inquest into the death of Daniel Dalli Coroners Court of Victoria (2010/3114) 30 July 2013

⁶⁹ *Inquest into the death of June Parker* Coroners Court of Victoria (2011/2422) 9 July 2013 6

⁷⁰ *Inquest into the death of Hassen Yassin* Coroners Court of Victoria (2011/0291) 20 August 2013 [42]-[43]

⁷¹ *Ibid* [49]

⁷² National Coronial Information System, *Coding Manual and User Guide v10* (Victorian Institute of Forensic Medicine Melbourne 2010) 84 and 87



intention or if the finding is unclear, a conservative approach is taken and the death is coded on the NCIS as ‘unlikely to be known’.⁷³

- 2.29. In addition, findings that are uncertain or ambiguous as to intention may be legally flawed and at risk of judicial review or appeal proceedings.⁷⁴

Sensitivity to bereaved families

- 2.30. The Council recognises the impact of the death of a family member and of lengthy or protracted coronial investigations.⁷⁵
- 2.31. It has been suggested that some coroners may be reluctant to reach findings of suicide due to pressure from bereaved families.⁷⁶ As well as potential stigma, there may be financial implications of a finding of suicide for families in relation to life insurance policies, which often include exclusions for suicide within a certain period of commencement.⁷⁷
- 2.32. Victorian coroners have a legal duty to balance the public interest in protecting the privacy of living or deceased persons’ personal and health information with the public interest in legitimate use of that information.⁷⁸
- 2.33. It is important for coronial investigations to be conducted and for findings to be worded in a manner that does not exacerbate trauma to families. However, one of the primary roles of the Court is to promote public health and safety. As such, the Council takes the view that accurate identification of suicide should take priority.

⁷³ Ibid 86

⁷⁴ *Lang v Registrar-General* [1950] VLR 307 308

⁷⁵ *Coroners Act 2008 (Vic)* s8(a) and (b)

⁷⁶ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) 25

⁷⁷ For example, Allianz Australia Life Insurance Limited, *Allianz Life Plan: Product Disclosure Statement and Policy Document* (25 October 2013) 4

⁷⁸ *Coroners Act 2008 (Vic)* s8(e)



3. Requirement to make a Finding about Intention

- 3.1. The Council's view is that it would be beneficial for public health reasons and for the accurate collation of statistics, for coroners to be *required* to make an explicit finding of intention.
- 3.2. If, having considered all of the available evidence, a coroner is unable to be satisfied as to intention on the balance of probabilities, the coroner should be explicit that intention is undetermined.
- 3.3. One implication of this approach is that there would be fewer cases in which the coroner has not made a finding of intention and which are then coded in the NCIS as 'unlikely to be known' or 'could not be determined' and subject to investigation by the ABS (as described in paragraph 1.13).
- 3.4. The Council takes the view that coroners are the most appropriate people to determine intention because they have the greatest exposure to the evidence and the opportunity to test that evidence. If a coroner has been unable to reach a conclusion on the balance of probabilities, then a determination should not be made by the ABS.
- 3.5. One risk of this approach is that when faced with uncertainty but being required to make a finding, coroners may err on the side of finding intention to be undetermined and thereby *reduce* the number of recorded suicides. In section 4 the Council proposes a way of capturing cases that do not meet the legal definition of suicide but which result from intentional self-harm, so that they can be properly identified for statistical, research and policy purposes.
- 3.6. The Consultation Paper sought views on whether a requirement for coroners to reach a finding on intention would improve the quality of suicide reporting, and on the risks and implications of such a requirement. Most responses were supportive or cautiously supportive of this proposal, noting that it would ensure that coroners specifically address the issue and that it could potentially lead to better national data and improved coronial practice.
- 3.7. Potential problems identified included the risk that it may lead to an increase in findings of 'undetermined intent', the difficulty in predicting what impact such a requirement might have, and further delays in delivering findings.



4. Intentional Action Causing Death

- 4.1. Areas of particular concern to the Council are when:
- a coroner is unable to determine the deceased's intent; or
 - the deceased lacked capacity to form an intention to suicide
- in circumstances that the community would consider to be suicide.
- 4.2. The Council believes that it would be beneficial for coroners to clearly identify deaths from intentional self-harm that do not meet the legal definition of suicide so that these can be considered together with those that do for suicide prevention activities.
- 4.3. The category would include cases in which:
- the deceased took the fatal action intentionally; and
 - death was a reasonably foreseeable consequence of the deceased's action.
- 4.4. The identification of cases in this category would not affect the rule that a subjective standard of intention is required in order to find suicide.⁷⁹
- 4.5. Issues of capacity would be relevant in relation to the deceased's capacity to form an *intention to act* but not in relation to the deceased's capacity to form an *intention to end their life*. The category could include cases in which the deceased lacked capacity to form an intention to take their own life so long as the deceased intentionally took fatal action.
- 4.6. The category would also capture cases in which a person attempted a potentially lethal method of self-harm (for instance as a call for help) but did not intend to kill themselves and death resulted.
- 4.7. Examples of relevant cases (assuming the facts are proven to the civil standard of proof) are when the deceased intentionally:
- took a large quantity of drugs;
 - cut himself near a major vein or artery; or
 - jumped from a significant height (and it was not reasonable to expect this to be safe)
- and it is not established whether or not the deceased intended to suicide.
- 4.8. Examples of cases which would probably not be included (assuming the facts are proven to the civil standard of proof) are when the deceased:
- was crossing a road after checking for traffic and a car unexpectedly pulled out and hit her; or
 - jumped from a height reasonably believing it to be safe (for instance, over deep water) when in fact it was not safe.

⁷⁹ *Clark v NZI Life Limited* [1991] 2 Qd R 11 15



- 4.9. There will be grey areas at the margin of high-risk behaviour and recklessness. The coroner's evaluation of the circumstances of each case is clearly required.
- 4.10. The Consultation Paper sought opinions on whether identifying this group of deaths would be useful for suicide prevention purposes and on potential difficulties or implications with this approach.
- 4.11. This part of the Consultation Paper was the most controversial. The Council has made changes to the proposals in the Consultation Paper to address concerns expressed about the new category being seen as a sub-category of undetermined intent. The Council is confident that the proposals in this Report will facilitate appropriate coding by the ABS.
- 4.12. By and large, respondents were supportive of the idea of identifying cases in which action of the deceased resulted in death, even if the coroner could not make a finding of suicide. However, there was a general worry about coroners potentially over-utilising the category if they were disinclined to make findings of suicide or under pressure from families not to find suicide.
- 4.13. The Consultation Paper also sought views on whether change should take place via primary or secondary legislation. Views were mixed but the Council has formed the view that amendment to primary legislation would be the best way to ensure that changes are implemented in practice.
- 4.14. The *Coroners Act 2008 (Vic)* could be amended by the Parliament of Victoria. Alternatively, the Governor in Council could prescribe findings of intention to be mandatory under section 67(1)(d) using its powers to create regulations under section 117(1)(o).
- 4.15. Any formal requirement to make a finding on intention should be supported by ongoing education and resources such as coronial guidelines, bench books and practice notes.

Recommendation 1

The Council proposes that the *Coroners Act 2008 (Vic)* be amended to require that when a coroner finds a death under investigation to be caused by an action of the deceased, the coroner make a further finding of intent, based on the evidence, and clarify whether:

- a) the deceased intended to take the action which caused his or her death (intentional self-harm);
- b) the deceased intended his or her action to cause his or her death (suicide);
- c) the deceased lacked the capacity to recognise that his or her action would cause his or her death but death was a reasonably foreseeable consequence of the action;
- d) it is not clear from the evidence whether the deceased intended to cause his or her death.



5. Form of Findings about Intention

- 5.1. The Council takes the view that findings of intention should be made in a standardised manner across coronial jurisdictions in terms of:
- a) the location (for example, at the top or bottom of the written findings together with the cause of death); and
 - b) the language – it would be helpful for findings to be easily translated into ICD-10 categories used by the NCIS and the ABS (including ‘intentional self-harm’, ‘accident’, ‘assault’ and ‘undetermined intent’).⁸⁰
- 5.2. This would facilitate correct coding and entry by court staff into the NCIS, which would improve the accuracy of the information used by the ABS to compile the suicide statistics that are used for public health initiatives.
- 5.3. The Consultation Paper invited comments about whether a requirement that coroners’ findings on intention be in a standardised location and use standardised language would improve the quality of suicide reporting, as well as the potential risks and implications of this approach.
- 5.4. Nearly all responses were supportive. One respondent noted that this would improve the comparability of findings and allow for trend analysis over multiple years. Several respondents noted the importance of training and support for coroners in relation to the new standards, and one respondent noted the need to review the language from time to time. One response was unsupportive but did not provide reasons and another, from a coroner, noted that coroners dislike being prescribed to use particular language.
- 5.5. In Victoria, the State Coroner is empowered to issue practice directions, statements or notes in relation to coronial investigations.⁸¹ Additionally, the State Coroner together with two other coroners is empowered to make rules as to:⁸²
- forms to be used (for example, the form for inquest findings and the form for findings without inquest); and
 - any matter related to the practice and procedure of the court including the recording of determinations.

⁸⁰ Other categories of intention are: ‘legal intervention and operations of war’, ‘complications of medical and surgical care’, and ‘sequelae of external causes of morbidity and mortality’: National Coronial Information System, *Coding Manual and User Guide v10* (Victorian Institute of Forensic Medicine Melbourne 2010) 84-86; World Health Organization, ‘International Classification of Diseases version 10’ (2010) <<http://www.who.int/classifications/icd/en/>> accessed 25 March 2014 Chapter XX. Revisions to the ‘manner of death’ categories are currently under consideration by the WHO-FIC Mortality Reference Group.

⁸¹ Ibid s107(1)

⁸² *Coroners Act 2008 (Vic)* s105(1)



Recommendation 2

The Council recommends that the State Coroner together with two other coroners use their powers in section 105 of the *Coroners Act 2008 (Vic)* to amend the forms upon which inquest findings are made, to dictate a uniform location for the factors identified in Recommendation 1 to be indicated.

- 5.6. The Council proposes that standardised terminology be developed to describe intention in all cases where death was caused by an action of the deceased.
- 5.7. While it is appreciated that the development of standardised terminology may benefit from further input from coroners, the Council proposes the following terminology by way of example:

"Having considered all of the available evidence I am satisfied that there are no suspicious circumstances and that no further investigation is required. On the basis of the evidence available to me,

I find that <<the deceased>> intentionally took his/her own life.

OR

I find that <<the deceased's>> death was unintentional.

OR

I am unable to determine whether <<the deceased>> intended to take his/her own life or if his/her death was unintentional, however I am satisfied that he/she intentionally <<took action>> that resulted in his/her death and that death was a reasonably foreseeable result of his/her action.

OR

I am not satisfied that <<the deceased>> had the capacity to form an intention to end his/her life at the time he/she <<took the action that resulted in his/her death>>. However, I am satisfied that he/she acted voluntarily and that death was a reasonably foreseeable result of his/her action."

- 5.8. The Consultation Paper sought views on this proposed terminology and nearly all responses were positive. The one unsupportive response was concerned that the standardised terminology might not be able to cater for nuances that might otherwise be available to coroners.
- 5.9. The Council's proposal is that this (or similar) terminology would be used in addition to a broad description of all relevant circumstances by the coroner. Coroners would retain the flexibility to discuss the nuances of each case. There would still be an important role for coroners to consider issues such as capacity, causation and recklessness.



Recommendation 3

The Council recommends that the State Coroner issue a practice direction under his power in section 107 of the *Coroners Act 2008 (Vic)* to the effect that:

- a. it is always in the public interest to make a finding as to the circumstances of death when the deceased caused his or her own death; and
- b. all findings related to death caused by the deceased should include details of risk factors for suicide as part of the circumstances of death; and

proposing standardised terminology which coroners be encouraged to use to describe death caused by the deceased.



6. Standardisation of Coronial Legislation

- 6.1. The legislative requirements of coroners differ between jurisdictions in terms of when an inquest must be held, what findings the coroner is required to make and whether a finding of intention can be made without an inquest. This is a source of inconsistency in information available about suicide deaths.
- 6.2. For example, in relation to reportable deaths:
- In Victoria, if an inquest is held the coroner is required to make a finding about the identity of the deceased, cause of death and circumstances of death.⁸³ If an inquest is not held and the deceased was not in custody or care, the coroner need not make a finding as to the circumstances of the death if the coroner finds that no public interest is served by doing so.⁸⁴
 - In Queensland, whether or not an inquest is held, if possible the coroner is required to make a finding about who died, how, when, and where the deceased died and what caused the death.⁸⁵
 - In South Australia, if an inquest is held a coroner is required to make a finding about the identity of the deceased and the cause and circumstances of death.⁸⁶ If an inquest is not held, the State Coroner must make a finding as to the cause of death.⁸⁷ There is no requirement for the State Coroner to make a finding as to the circumstances of death.
 - In New South Wales, if an inquest is held the coroner must make a finding about the person's identity, the date and place of death, and the manner and cause of death.⁸⁸ If an inquest is not held, the coroner must determine the identity of the deceased and the date, place and cause of death.⁸⁹
- 6.3. The differences are most striking in cases in which inquests are not held. However, the public interest in the collection of comprehensive data about suicide deaths applies whether or not an inquest is held.
- 6.4. Differing legislative arrangements and court practices was raised as a concern before the Senate Committee, which recommended that coronial legislation be standardised throughout Australia.⁹⁰ The Council supports this recommendation, particularly in relation to dictating which matters are required to be found by the coroner.
- 6.5. In particular, as discussed in sections 3-5, the Council recommends that a duty be placed on all coronial jurisdictions to make a finding about intention based on the available evidence for all deaths caused by an action of the deceased, using standardised terminology, whether or not an inquest was held.

⁸³ *Coroners Act 2008 (Vic)* s67(1)

⁸⁴ *Ibid* s67(2)

⁸⁵ *Coroners Act 2003 (Qld)* s45(2)

⁸⁶ *Coroners Act 2003 (SA)* s25

⁸⁷ *Ibid* s29

⁸⁸ *Coroners Act 2009 (NSW)* s81(1)

⁸⁹ *Ibid* s34(2)

⁹⁰ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) 31



- 6.6. To ensure consistency and improve the quality of suicide reporting, change would ideally take place via nationally coordinated legislative reform.
- 6.7. Each jurisdiction would need to be considered individually in order to implement this change, based on agreed principles of reform. It is noted that potential reform may be more difficult to achieve in some jurisdictions than others and that the same end may be reached by different means.
- 6.8. State and chief coroners and governors also hold powers that could be used to issue practice directions or secondary legislation (regulations or rules) to further the same aims.
- 6.9. Additionally, revision of the forms used by coroners to record their findings, to promote standardised findings of intention, would facilitate more consistent practices and more useful data.
- 6.10. Even if national legislative reform is planned, changes to court forms or changes by practice direction are desirable in the meantime and could be implemented relatively quickly.

Recommendation 4

The Council recommends that the Attorney-General raise the issue of standardisation of coronial legislation and/or coronial systems in the Standing Council on Law, Crime and Community Safety and propose that legislative changes similar to those put forward in Recommendation 1 be implemented in all Australian jurisdictions.



7. Implementation of National Police Forms

- 7.1. The Council recognises the difficult conditions under which police are required to seek information from the families of deceased persons and the potential for lengthy police inquiry to be traumatic to families.
- 7.2. Nevertheless, society’s interest in preventing suicide is pressing and detailed information is needed to inform suicide prevention activities. The Court plays an important preventative role⁹¹ and part of the Council’s function is to advise the Attorney-General in relation to this role.⁹²
- 7.3. A template (**National Police Form**) has been developed to encourage the police to collect consistent and detailed information, promoting early identification of potential suicides and the presence of risk factors for suicide.
- 7.4. The National Police Form should inform decision-making in the investigation process and facilitate accurate presumed intent notifications to the NCIS while a death is under investigation.⁹³ Research has shown that coronial investigation results in a change to presumed classifications in only five per cent of cases.⁹⁴ Precise early information will also assist in the development of targeted prevention policies and programs.
- 7.5. The Senate Committee recommended that all states and territories implement the National Police Form.⁹⁵ However, currently just four of the eight jurisdictions are using a version of the National Police Form and only the Australian Capital Territory and Tasmania have implemented electronic transfer to the NCIS, although implementation is planned for Queensland.⁹⁶
- 7.6. In the Consultation Paper, the Council sought views on barriers to implementation of the National Police Form. No significant barriers were identified but the need to accompany the National Police Form with education about the significance of information to be gathered was noted.
- 7.7. The Council recommends that the National Police Form be implemented in all jurisdictions as a matter of priority.

Recommendation 5

The Council recommends that the Attorney General encourage Victoria Police to adopt the National Police Form.

⁹¹ Ibid preamble

⁹² Ibid s110(2)(b)

⁹³ L Daking and L Dodds, ‘ICD-10 mortality coding and the NCIS: a comparative study’ (2007) 36(2) *HIM J* 11-23 20

⁹⁴ DM Studdert and SM Cordner, ‘Impact of coronial investigations on manner and cause of death determinations in Australia, 2000-2007’ (2010) 192(8) *Med J Aust* 444-47 444

⁹⁵ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) xvii

⁹⁶ National Committee for Standardised Reporting on Suicide, ‘Progressing the Senate Inquiry Recommendations’ (Presentation to the State and Chief Coroners’ Meeting, 11 April 2014)



8. Coroners' Investigation Tools and Suicide Finding Templates

- 8.1. The Coroners Prevention Unit (CPU) of the Court is developing investigation tools to strengthen inquest briefs provided to coroners. These include a specific suicide investigation tool, which would promote the inclusion of factors relevant to suicidal behaviour in the inquest brief.⁹⁷
- 8.2. The CPU has also developed a suicide finding template to assist coroners to include information about risk factors for suicide in their description of the circumstances of death and to encourage coroners to make explicit determinations of intention. This template is now in use in Victoria.⁹⁸
- 8.3. The Council supports the development of coroners' investigation tools and suicide finding templates and would encourage that the investigation tools and templates be replicated as appropriate for each Australian jurisdiction and implemented in all states and territories.
- 8.4. The Consultation Paper asked whether any barriers to implementing coroners' investigation tools existed. No barriers were identified.

⁹⁷ L Bugeja, Coroners Prevention Unit, personal communication, 7 April 2014

⁹⁸ L Bugeja, Coroners Prevention Unit, personal communication, 7 April 2014



9. The Standard of Proof for a Finding of Suicide

- 9.1. It has been questioned whether the standard of proof for a finding of suicide is too high,⁹⁹ particularly when it is difficult to determine the deceased's intent.
- 9.2. This position may represent a misunderstanding about the standard of proof applicable in the coronial jurisdiction. The civil standard of proof – the balance of probabilities¹⁰⁰ – applies in Australian coronial courts.¹⁰¹ The standard of proof is no higher for suicide than for any other coronial finding.¹⁰²
- 9.3. The balance of probabilities amounts to an allegation being proven to the reasonable satisfaction of the coroner:¹⁰³

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 ... affect the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony or indirect inferences.

- 9.4. Although the strength of the evidence required depends on the subject,¹⁰⁴ the seriousness of the finding does not alter the standard of proof itself.
- 9.5. The issue of evidential strength is most relevant when a coronial finding might have implications for other legal proceedings such as professional disciplinary proceedings, a civil claim for negligence or criminal liability. It is for this reason that coroners 'should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death'.¹⁰⁵
- 9.6. In the context of an insurance claim, the Supreme Court of Queensland has characterised a finding of suicide as:¹⁰⁶
- not one to be made lightly, but neither is it one of such inherent unlikelihood or gravity as to bring it toward the top of the range of what it is sometimes called the Briginshaw test.*
- 9.7. The rationale for this statement was that suicide is no longer a crime. Although a coronial finding of suicide has few direct *legal* effects, it may nevertheless make a significant impact on the family of the deceased.

⁹⁹ Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Commonwealth of Australia Canberra 2010) 22

¹⁰⁰ *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66 as supplemented by the *Evidence Act 1995 (Cth)* s140 and uniform provisions in each jurisdiction

¹⁰¹ *Anderson v Blashki* [1993] 2 VR 89 95; *Re the State Coroner ex parte the Minister for Health* [2009] WASCA 165 [21]

¹⁰² *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66 [2]

¹⁰³ *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 362-262

¹⁰⁴ *The Secretary to the Department of Health & Community Services v Gurvich* [1995] 2 VR 69 74

¹⁰⁵ *Inquest into the death of Sibel Yilmaz* Coroners Court of Victoria (2009/4452) 12 February 2014 [74]

¹⁰⁶ *Clark v NZI Life Limited* [1991] 2 Qd R 11 16



- 9.8. A review of recent coronial findings undertaken on behalf of the Council revealed that discussions of the standard of proof and debates about whether or not a death was intentional are rare. The issue of standard of proof may have taken on unjustified significance in discussions about suicide reporting.
- 9.9. For example, in the following case, a finding of suicide was reached on the basis of the evidence as a whole without clear precipitating events:¹⁰⁷
- I find that [the deceased] died from multiple severe injuries from being hit by a train in circumstances where I am satisfied that he intended to take his own life.*
- AND I am unable to definitively identify the precipitating events or concerns that led [the deceased] to adopt this course of action ...*
- 9.10. It may be that the real problem is the unavoidable difficulty of determining the intention of a deceased person rather than the standard of proof. If the evidence as a whole is insufficient for the coroner to be satisfied whether a death was intentional, unintentional or by assault, then the correct legal approach is to make an open finding.¹⁰⁸ It is preferable that open findings are made explicitly to avoid ambiguity.¹⁰⁹
- 9.11. It important that when intention cannot be proven, sufficient circumstantial information is provided by coroners to enable researchers and policy-makers to identify and analyse the case for public health purposes.
- 9.12. If changing the standard of proof for potential suicide findings were to be contemplated, careful consideration would also need to be given to the:
- a) implications for other findings in the coronial jurisdiction;
 - b) implications of coronial findings for other legal proceedings; and
 - c) desirability of having a lower standard of proof in the coronial jurisdiction than other civil proceedings.
- 9.13. The Council is of the view that it would not be desirable to have a lower standard of proof for a finding of suicide than for other coronial findings.
- 9.14. No respondents to the Consultation Paper thought that a lower standard of proof would be desirable in the coronial jurisdiction. Importantly, one respondent pointed out that lowering the standard of proof could lead to the perception that coronial findings are unreliable.

It may be helpful for bench books, practice notes and guidelines to be reviewed for clarity about the application of the civil standard of proof in the coronial jurisdiction, with special attention to potential suicide cases.

¹⁰⁷ *Inquest into the death of Cory Irving Wright* Coroners Court of Victoria (2006/3504) 22 May 2013 9

¹⁰⁸ *R v City of London Coroner, ex parte Barber* [1975] 1 WLR 1310 1313; I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press Melbourne 2006) 634

¹⁰⁹ *Lang v Registrar-General* [1950] VLR 307 cited in I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press Melbourne 2006) 630



10. The Presumption Against Suicide

- 10.1. The legal presumption against suicide (**presumption**) arose due to the historically serious legal and financial consequences of a finding of suicide or attempted suicide.
- 10.2. The presumption sometimes has the effect of reversing the burden of proof. For example, in a life insurance dispute, although the burden of proving the death would fall on the executors of the deceased's estate, the insurer would hold the burden of proving that the deceased intentionally took their own life.
- 10.3. The High Court of Australia acknowledged the presumption in 1906 in the context of workers' compensation¹¹⁰ and in 1955 in the context of an insurance claim.¹¹¹ More recently, the Supreme Court of Queensland has noted that, 'the language of presumption and counter-presumption has been largely supplanted by the language of proper inference upon the whole of the evidence'.¹¹²
- 10.4. The language of presumption and rebuttal is even less relevant in a coronial investigation,¹¹³ because the coroners court is a specialist inquisitorial tribunal,¹¹⁴ which does not adjudicate claims between parties. In this context, the presumption means that 'a finding must not be presumed, based on what appears to be "a likely explanation" but rather by finding proof to the proper evidentiary standard'.¹¹⁵
- 10.5. The Consultation Paper asked whether respondents saw any reason to alter the current law on the presumption. Most responses agreed with the reasoning presented in the Consultation Paper. One respondent expressed the view that the presumption was effectively applied by statisticians in coding deaths as 'accident' when coroners do not make an explicit finding on intent.
- 10.6. The Council has considered the appropriateness of the presumption and takes the view that suicide should be proven on the balance of probabilities after considering the evidence as a whole. This does not require change to the law.

¹¹⁰ *Spiratos v Australian United Steam Navigation Co Ltd* (1955) 93 CLR 317

¹¹¹ *Mutual Life Insurance Company of New York v Moss* [1906] HCA 70; (1906) 4 CLR 311

¹¹² *Clark v NZI Life Limited* [1991] 2 Qd R 11 16

¹¹³ *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [248]

¹¹⁴ In Victoria, see *Coroners Act 2008 (Vic)* s1(d)

¹¹⁵ *Inquest into the death of Tyler Jordan Cassidy* Coroners Court of Victoria (2008/5542) 23 November 2011 [245]. In the United Kingdom, the standard of proof is debated and is sometimes said to be the criminal standard of beyond reasonable doubt: *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin); *R v HM Coroner for the County of Greater Manchester and others, ex parte Sreedharan* [2013] EWCA Civ 181 and other times said to be the balance of probabilities: I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press Melbourne 2006) 555



11. Reporting of Suicide in the Media and by the Court

- 11.1. Research has shown that depending on the way in which suicide is reported, suicide reporting in the media can either increase the incidence of suicide¹¹⁶ or contribute to effective suicide prevention activities.¹¹⁷
- 11.2. The Mindframe National Media Initiative¹¹⁸ was introduced as part of the Australian Government’s National Suicide Prevention Program. As part of the initiative, a range of resources and guidelines has been created. The media guidelines provide up to date evidence-based information to support the accurate reporting, portrayal and communication of mental illness and suicide.
- 11.3. Mindframe has also developed resources for courts¹¹⁹ for dealing with the media, conducting proceedings at which media may be present, managing culturally sensitive information in the courtroom and outlining the impact of judicial recommendations about preventative measures.
- 11.4. The Australian Press Council’s Standards Relating to Suicide¹²⁰ cover similar matters and refer to the SANE Australia’s Media Centre, which includes further guidance on the reporting and portrayal of mental illness and suicide-related issues.¹²¹
- 11.5. Research has shown substantial awareness of, support for and uptake of the media guidelines, although there is still some room for improvement.¹²²
- 11.6. An alternative approach is taken in New Zealand where there are legislative restrictions on the publication of information about potential suicide deaths.¹²³ The reporting ban has been controversial¹²⁴ and the New Zealand Law Commission has recommended that it be amended.¹²⁵
- 11.7. The Council favours an approach that encourages responsible reporting rather than prohibition.
- 11.8. The Court’s policy is to comply with the Mindframe guidelines. The Council does not recommend any changes to policy on media reporting. Respondents to the consultation were in agreement that no change is necessary.

¹¹⁶ JE Pirkis and others, ‘The relationship between media reporting of suicide and actual suicide in Australia’ (2006) 62(11) *Soc Sci Med* 2874-86

¹¹⁷ K Thom and others, ‘Reporting of suicide by the New Zealand media’ (2012) 33(4) *Crisis* 199-207

¹¹⁸ Commonwealth of Australia, ‘Mindframe National Media Initiative’ <<http://www.mindframe-media.info/>> accessed 17 April 2014

¹¹⁹ Mindframe, *Mental Illness & Suicide in the Media: a Mindframe Resource for the Courts* (Commonwealth of Australia Canberra 2008)

¹²⁰ Australian Press Council, *Standards Relating to Suicide Reporting* (Sydney 2011)

¹²¹ S Australia, ‘SANE Media Centre’ <<http://www.sane.org/sane-media>> accessed 17 April 2014

¹²² J Pirkis and others, ‘Changes in media reporting of suicide in Australia between 2000/01 and 2006/07’ (2009) 30(1) *Crisis* 25-33

¹²³ *Coroners Act 2006 (NZ)* s71

¹²⁴ Media Freedom Committee and Newspaper Publishers' Association, *Reporting Suicide: A resource for the media* (December 2011) 10

¹²⁵ New Zealand Law Commission, *Suicide Reporting* (Report 131 Wellington 2014) [1.34]



Recommendations

Recommendation 1

The Council proposes that the *Coroners Act 2008 (Vic)* be amended to require that when a coroner finds a death under investigation to be caused by an action of the deceased, the coroner make a further finding of intent, based on the evidence, and clarify whether:

- a. the deceased intended to take the action which caused his or her death (intentional self-harm);
- b. the deceased intended his or her action to cause his or her death (suicide);
- c. the deceased lacked the capacity to recognise that his or her action would cause his or her death but death was a reasonably foreseeable consequence of the action;
- d. it is not clear from the evidence whether the deceased intended to cause his or her death.

Recommendation 2

The Council recommends that the State Coroner together with two other coroners use their powers in section 105 of the *Coroners Act 2008 (Vic)* to amend the forms upon which inquest findings are made, to dictate a uniform location for the factors identified in Recommendation 1 to be indicated.

Recommendation 3

The Council recommends that the State Coroner issue a practice direction under his power in section 107 of the *Coroners Act 2008 (Vic)* to the effect that:

- a. it is always in the public interest to make a finding as to the circumstances of death when the deceased caused his or her own death; and
- b. all findings related to death caused by the deceased should include details of risk factors for suicide as part of the circumstances of death; and

proposing standardised terminology which coroners be encouraged to use to describe death caused by the deceased.

Recommendation 4

The Council recommends that the Attorney-General raise the issue of standardisation of coronial legislation and/or coronial systems in the Standing Council on Law, Crime and Community Safety and propose that legislative changes similar to those put forward in Recommendation 1 be implemented in all Australian jurisdictions.

Recommendation 5

The Council recommends that the Attorney General encourage Victoria Police to adopt the National Police Form.



Acknowledgements

The Council wishes to thank the individuals and organisations who provided feedback on the Consultation Paper, as well as the State and Chief Coroners who participated in a group discussion of the Consultation Paper.

The Council is grateful for assistance provided by Ms Caroline Aebersold, Suicide Prevention Australia, who facilitated feedback from members of the National Committee for Standardised Reporting of Suicide. The Council's work was enhanced by Ms Aebersold's participation.

The Council also thanks the Secretariat for their capable assistance in the preparation of its advice –

Ms Erica Capuzza	
Ms Lisa Nicholas	
Ms Lara Wentworth	to February 2013
Ms Gillian Raleigh	
Mr Tony Sabatino	from March 2013
Mr Jason V Ngam	from July 2013

The Council also appreciates the work of Dr Rhonda Tombros – an independent researcher engaged by the Council to assist in the finalisation of this reference, from January 2014.



Appendix A – Coronial Council Members

Current Council Members

- Professor Katherine McGrath (Chair)
- Judge Ian Gray (*ex officio*)
- Professor Stephen Cordner AM (*ex officio*)
- Deputy Commissioner Graham Ashton AM (*ex officio*)
- Dr Ian Freckelton QC
- Mr Christopher Hall
- Dr Celia Kemp
- Dr Robert Roseby
- Professor Mark Stevenson

Former Council Members

- Judge James Duggan
- Judge Jennifer Coate
- Mr Stephen Dimopoulos
- Dr Sally Wilkins



Appendix B – The Reference

In May 2012 the Attorney-General made a formal reference to the Council pursuant to section 110 of the *Coroners Act 2008 (Vic)* in the following terms:

The Coronial Council is requested to provide advice on:

1. *the application of legal principles regarding suicide, including the operation of the presumption against suicide under the common law and consideration of the evidence broadly considered necessary to establish the mental element of suicide;*
2. *whether a change to the existing law regarding the standard of proof for a finding of suicide is desirable;*
3. *policy that enables a consistent approach to coronial determination of intent; and*
4. *the reporting of suicide in the media, including an appropriate position for the Coroners Court to adopt on this issue.*

In formulating its advice, the Council may have regard to the interests of families, the Registry of Births Deaths & Marriages, public health bodies, and any other relevant entities.

The Council is also invited to make recommendations or any further comments that it deems appropriate regarding the issue of suicide reporting in the coronial jurisdiction.



Appendix C – Responses to Consultation

During the course of its investigations, the Council distributed a Consultation Paper for comment by stakeholders including State and Chief Coroners, and the National Committee for Standardised Reporting of Suicide. Responses were received from the following (in alphabetical order):

- Australian Bureau of Statistics
- The Brisbane Coroner
- Chief Coroner of the Australian Capital Territory
- Commission for Children and Young People and Child Guardian, Queensland
- Dr Michael Dudley, University of New South Wales
- Queensland Police Service
- Dr Andrew Stocky
- Associate Professor Susan Walker, Queensland University of Technology, Member of the WHO-FIC Mortality Reference Group
- Western Australian Ombudsman