Suicide: The Coroner as Catalyst

Suicide: The Coroner as Catalyst

Hal Hallenstein
State Coroner
Melbourne
Victoria

Suicide in our community has always occurred and will continue to occur. Although there is great change in our community’s preparedness to speak openly about suicide the issue will never receive the attention it warrants until there is public understanding and acknowledgment that a problem even exists.

In general terms, suicide is the second largest class of death by external causes after motor vehicle collisions. Between the ages of 25 and 44 years, as many people have died by suicide as by motor vehicle collision and that age bracket comprises approximately 40 per cent of all suicides. The next largest group of suicides comprises the 15 to 25 age group nearly being 20 per cent of all suicides. The relative percentage is greater by reason of the latter age group comprising a nine-year age bracket, while the former group comprises a nineteen-year age bracket. Approximately 10 per cent of all coroner's cases in Victoria involve suicide.

Youth suicide is a most concerning area of suicide and its destruction of young life has implications for the long-term affairs of our community. The real question is whether our community even knows of the issue.

In a learned gathering of experience and expertise, one speaks with the converted, the specialist and the informed. In the context of expertise in the subject of suicide and, in particular, youth suicide, it is accepted that the coroner is not an expert. However, there is an area in which a modern coronial service can assist in a manner which has not previously occurred and which is not generally understood.

The qualification for coroner in Victoria is a law degree and, in the context of suicide, its issues and its specialty understanding, the coroner is not an expert. However, it is the coroner's statutory duty to administer the coronial service in a manner to enable appropriate investigation of death by suicide by harnessing the knowledge of experts for broad use and advantage of the general community.

In the coroner's investigation, the coroner is not a source of expert knowledge but is a catalyst by which the information and conclusions of that expert knowledge can be converted to broad community use and understanding.
Failure

Coroners around Australia, and indeed throughout the world, have not really come to grips with suicide. One significant reason is the limitation imposed by considering only one case at a time independently of all other cases. A consideration in isolation of one set of facts has tended to result in coroners concluding substantially the factual mechanism of death, whether or not it is suspicious, whether or not the deceased's conduct resulted in his own death and whether or not the deceased intended to take his own life. This constitutes a legalistic approach to one case and provides legal conclusions for one case but does little else.

Another significant reason for the failure of coroners in dealing with suicide is a preoccupation with legal admissibility of evidence. This is seen clearly in British coroners whose concern in suicide is whether or not the deceased's intent to take his own life has been proved beyond reasonable doubt. In other words, the consideration is one of criminal law standard of proof.

In the face of the compelling public issues of suicide, the function of coroners in a manner just described is accepted as being a legal function which has some value. However, in the context of social function and in considering community learning, understanding and prevention, the coroner's traditional legalistic role does not adequately serve a modern community, does not deal with important community issues and has failed.

Fresh Approach

It has been necessary to abandon the traditional British coroner and develop something different and of relevance to our modern society. In Victoria, this has been done and it is necessary to describe the changes in order to understand the modern coroner's function.

Prior to mid-1986, being the commencement of the Victorian Coroners Act 1985, a coroner in Victoria was substantially identical to a coroner in England. The strength of an English coroner is his ability to conduct an inquest in which, in theory, public issues and concerns can be dealt with and concluded in a public forum. The weakness of the English coroner is his function being limited to a court-based process of conducting a public hearing to the exclusion of broad involvement in an investigating process for which he is responsible.

On the other hand, the American Medical Examiner is an investigator for the purpose of determining medical cause of death. He is responsible for his investigation process but the investigation stops with the medical cause of death. The weakness of the American Medical Examiner is that he has no ability to deal publicly with public issues which may apply to cases he investigates.

The Victorian Coroner is a statutory hybrid of the British Coroner and the American Medical Examiner. He is an investigator with responsibility for his own investigation. He has a resource in the Victorian Institute of Forensic Pathology which provides the medico-scientific process akin to that of the medical examiner. He also has a public hearing process in which matters of learning, understanding and prevention are placed in the public domain.

The modern coroner's process is not limited by legal considerations of evidence. Instead, the Victorian Coroners Act provides that the coroner is not bound by the rules of evidence and can be informed in any manner which is reasonable.

The modern coroner's process is not limited to considering one case at a time. Rather, the Victorian Coroners Act enables the investigation and public hearing of many cases considered together. This enables consideration of broad issues and the obtaining of broad understanding with a view to securing the best prospect of meaningful prevention.
Functions

The functions of the modern coroner are as follows.

- In circumstances of the coroner's absolute and exclusive control of the body of the deceased the coroner's first function is to enable registration of death and the lawful disposal of the body of the deceased.

- The coroner's second function is to investigate every aspect of death reported to him in order to conclude:
  - the deceased's identity;
  - all the circumstances surrounding the death;
  - the medical cause of death;
  - the particulars to enable registration of the death; and
  - the identity of any person who contributed to the cause of death.

In this investigation, the coroner relies not only on his own administration and understanding of the event being investigated but also on specialist investigators which may comprise police experts, scientists, forensic pathologists, aviation investigators, dangerous goods and industrial investigators and any and every other specialist who can assist in the coroner's investigation.

- The coroner's third function is to investigate every aspect of those fires which raise public issues in order to conclude:
  - the source and origin of the fire;
  - all the circumstances surrounding the fire; and
  - the identity of any person who contributed to the cause of fire.

In this investigation also, the coroner relies not only on his own administration and understanding of the event but also on specialist investigators which may include police experts, arson chemists, fire service investigators, explosives experts and any and every other specialist who can assist in the coroner's investigation.

- The fourth function which the coroner performs is to draw together the expert materials and conclusions so far as relevant to his investigation in order to analyse, learn and understand the event being investigated and with a view to seeing if there is anything which could be done to avoid the unnecessary repetition of tragedy.

- The fifth and perhaps most important function which the coroner performs is to inform the community and government publicly of the matters analysed, learned and understood and of how to avoid the unnecessary repetition of tragedy.

The coroner's work is not involved with civil or criminal liability. Rather, he is a civilian investigator obtaining fact and causation for the purpose of public analysis, public learning and public understanding. By this process, the coroner informs the community about its own affairs to enable the community to take whatever action is needed to prevent repeated injury to itself.

The coroner is a public messenger whose task is completed on delivery of the message. It is then up to the community itself to decide how or indeed whether it will act on the information provided.
In other words, the coroner is a social catalyst. He converts the expertise of specialists into public knowledge and public conclusion with a view to the community acting on the learning. In that process, the coroner is not consumed but simply contributes to the public process.

Structure

The Victorian Coronial Service is a tiny organisation in which the full-time, twenty-four hour per day central administration of the state Coroner's Office comprises a total of thirty people. Around the state of Victoria, there are coroners and coroner's clerks constituted by magistrates and clerks of the Magistrate's Court and totalling some seventy people. The whole of the Victorian Coronial Service comprises approximately one hundred people.

The Coronial Service has a broad range of activity and responsibility. Its work and jurisdiction cuts across all areas of society in its general affairs. The coroner is able to perform his task only by relying on every outside individual, organisation, institution, government service and specialist function relevant to any investigation. Indeed, the coroner relies on the community as a whole.

Immediately, it is seen that the art of a viable Coronial Service is its ability:

• to harness many disparate forces to a concentrated point in the civilian affairs of society;
• to cause a process of reaction between the harnessed forces of specialist investigation and the community's affairs; and
• with a view to public analysis, learning, understanding and social change.

In every sense of the word, the Coronial Service is not a force in itself but rather is a catalyst by which many forces in the community expend their own energy in social change.

Process

The coroner's process is now that of an investigator as opposed to his former sole task of hearing inquests. The coroner's investigation commences at the scene of event and may or may not involve an inquest. The inquest is both a process of public investigation and a statutory public forum for public information and public learning.

The purpose of the investigation is to find the surrounding circumstances, fact and causation with respect to death and to perform that task in a way that enables meaningful, informed and broad-based public comment, recommendation and report for the purpose of public learning, understanding and prevention.

Expertise

It is apparent that the coroner's process is only as good as the information, expertise and knowledge provided it. Consideration must, therefore, be given to a mechanism whereby specialist knowledge may be obtained.

The Victorian State Coroner's Office has commenced a process whereby suicide could be considered by the Coronial Service in a manner that may be meaningful for modern times. Thereby ceasing the process of traditional case-by-case consideration, completion and then filing for nothing more than posterity of each suicide case considered by a coroner.

Instead, there is a compiling of all current suicide cases as they occur over a period of time. There is then a consideration of factors such as number of cases, age, gender,
method, attempts, prior indications and underlying factors—all of which may identify particular types of cases as a class, group or having similarities. There is then produced a crude working picture of current cases.

A panel of specialists has been formed under the organisation of the Victorian branch of the Royal Australian and New Zealand College of Psychiatrists. We have commenced to send a copy of every file to the panel for advice of what the materials mean to a specialist, what further information may be required, what can be learned and whether there is prospect of realistic prevention.

This is but a humble beginning of a Coronial Service conceding that it has previously failed and accepting that it needs guidance and direction to enable appropriate meaningful specialist information and understanding to be placed into the public arena.

It is apparent that there are many specialties and areas of expertise involved in suicide. There is clearly needed an involvement in the coroner’s process of the range of specialists and expertise.

The mechanism of approach may commence, for example, with a group of fifty current coroner’s cases which could generally be described as comprising a class of identifiable group of cases. The fifty files could be considered by, and advice obtained from, a range of experts. That consideration and advice may require more information but ultimately will provide interpretation, understanding and consideration for prevention.

Five of those cases may be worthy vehicles for public hearing as containing all the issues which need to be considered in detail in the public process. The remaining forty-five cases could be concluded without inquest and then produced as exhibits in the public hearing process in order to provide a broader basis to the facts in the hearing process and the issues to be considered.

As well as calling witnesses of fact in each of the five cases heard together in one continuous hearing, there would also be called as expert evidence a representation of the specialists which have previously considered the materials and advised. The expert evidence is the means by which the interpretation, understanding and questions of possible prevention are placed into the public arena.

Coroners’ findings, comments and recommendations are made to cover the facts and the expert materials. These matters are recorded and produced in a public forum for the purpose of public information. The same materials are provided by way of report by Coroner to the Attorney-General by way of information to government.

**Benefit**

One benefit from the type of process envisaged is that there can be made available to experts in the field the real primary source facts of suicide as and when they arise. It is clearly of great importance that any interpretation and understanding which may be derived from considering the current materials is disseminated, published and discussed by experts in the field as a matter of current knowledge and ordinary process of specialty.

No-one thinks that any issue of public concern can be remedied overnight. Everyone involved in the issue is interested to resolve the issue of concern in one way or another. The coroner has a role to play along with many other players. What is significant is that the coroner’s role may be able to contribute something worthwhile to the process of public learning and understanding as a basis of community response. Without community response we will never properly tackle one of the most difficult areas of unnatural death.
Conclusion

The ultimate benefit which may be derived from effective use of the coroner's process is the informing of a community and the converting of specialist knowledge and understanding to public learning, understanding and consideration of prevention. Until we can communicate the issue of suicide and its community consequences to the community as a whole and to those who organise its affairs, we will all continue to be restricted to discussion amongst ourselves. The first steps in the community responding to our concern with suicide as a significant issue of the community's affairs is the community sharing our awareness and concern.