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SUICIDE: THE SCOPE OF THE INVESTIGATION IN THE CORONER'S COURT

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ABSTRACT

There has been public concern that some suicides are not investigated to identify causes or triggers, unless required by the European Convention on Human Rights. The paper reviews the statute and case law governing the decision of the Coroner as to the scope of investigation into suicide. The role of the Coroner in assessing public interest is discussed. There is particular reference to allegations of bullying. The science of suicide and bullying is reviewed and their impact on how an inquest is held is considered. Drawing together the science and caselaw, a framework is proposed for judicial decision making.
Keywords: coroner, suicide, scope of investigation, inquest, public interest, bullying

INTRODUCTION

There were 5,642 suicides in England and Wales in 2022, 10.7 deaths per 100,000 population, a level not falling from the level in 2018, with about three quarters being male and highest in 50–54 year aged group; for young people aged 15–19 the figure is 5.1 and for 20–24 10.1.[1] The impact of a suicide is devastating and widespread and has led the government to adopt a Suicide Prevention Strategy in

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[1] Office for National Statistics, 'Suicides in England and Wales' (19 December 2023) https:www.ons.gov.uk accessed 24 September 2024.

England.[2] In particular, it funds anti-bullying organisations to support schools to tackle bullying, seeks opportunities to support employers in promoting mental well-being and seeks to collate data on victim suicides from domestic abuse.

The English and Welsh Coroner's investigation of a suspected suicide may be brief or very thorough. The Coroner must record how a person met their death.[3] What is recorded may be a short-form conclusion of "suicide", with a brief sentence describing the means of death, or a more detailed narrative conclusion of the circumstances: Guidance indicates that it is preferable to use the short-form and normally adopt a brief description of the mechanism of death and whether the deceased intended to end their life when they did the act causing their death.[4] There may or may not be investigation of possibly contributory matters such as bullying, which may or may not be recorded. Why is there such variation? How should the Coroner decide when the investigation needs to extend beyond the means of death and what conclusion is appropriate? Can the law keep pace with public concern and the public interest in the investigation of deaths? Lord Denning would have relished identifying the legal principles to be observed in determining scope of a suicide inquest to fulfil his much quoted dictum "let justice be done".

SUICIDE: THE LAW

In coronial law, for suicide to be recorded, there must be evidence proven[5] that:

a. the deceased took an action which ended their life
b. they intended to do so and
c. they did so, whilst in their mind knew what they were doing.

The standard of proof is now on the balance of probabilities.[6]

The first of these is determined by a combination of the circumstances and the medical cause of death provided after autopsy, and the third by toxicology where

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[2] Department of Health and Social Care, 'Suicide Prevention Strategy, Action Plan' (11 September 2023) www.gov.uk accessed 24 September 2024.

[3] Coroners and Justice Act 2009, s 5(1)(b), Coroners and Justice Act 2009 (legislation.gov.uk) accessed 29 September 2024.

[4] Chief Coroners Guidance Number 17 (revised September 2021), *Conclusions: short-form and narrative*, Chief Coroner's Guidance No.17 Conclusions: Short-Form and Narrative - Courts and Tribunals Judiciary accessed 1 October 2024.

[5] It must never be presumed: *R (Jenkins) v HM Coroner Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin) [18ff].

[6] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46, [2021] AC 454.

it is possible that intoxication had rendered the deceased without capacity. Intent may be evidenced by an ante-mortem note and/or require further investigation into the circumstances leading to death.

DEATHS OF PUBLIC CONCERN

Suicides with underlying circumstances inevitably catch the public eye. The Senior Coroner in the Molly Russell inquest in 2017 concluded she *"died from an act of self-harm whilst suffering from depression and the negative effects of online content"*.[7] This led to the Online Safety Act, after her family had campaigned to access her on-line accounts, which gives Coroners the power to access online data records through Ofcom where there is reasonable suspicion that the information is relevant to the child's death. Meta, which owns Facebook, WhatsApp and Instagram, is reducing the minimum age to access social media sites from 16 to 13 years old, which, because of end-to-end encryption, is reported as giving untraceable anonymous access by bullies to vulnerable children.[8] More recently a Coroner has issued a Preventing Future Death ("PFD") report to Quora, bringing their attention to the lack of monitoring or moderation of their website after a teenage girl took her life after reading a suicide section of the website.[9]

The inquest into the suicide of 24-year-old Jack Ritchie in Vietnam in 2017 was the first in England and Wales to examine the State's role in a gambling-related death.[10] The Senior Coroner concluded that the regulation, information and treatment for gambling problems at the time of Jack's death were "woefully inadequate" and probably contributed to his death. The treatment available for gambling problems was insufficient, there was a lack of training for medical professionals and a lack of information available to the public. The Senior Coroner concluded that Jack did not understand that gambling was not his fault, and this

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[7] Independent, 'Molly Russell inquest – coroner's conclusion in full' (30 September 2022) https://www.independent.co.uk/news/uk/molly-russell-inquest-coroner-s-conclusion-in-full-b2183287.html accessed 29 September 2024.

[8] *The Times*, 'The Times view on WhatsApp: Minors Matter' (15 April 2024) https://www.thetimes.com/article/the-times-view-on-whatsapp-minors-matter-d3jckr8w6 accessed 29 September 2024.

[9] The Times, 'Girl took her life after reading suicide Q&A on Quora' (8 June 2024) https://www.thetimes.com/uk/technology-uk/article/girl-took-her-life-after-reading-suicide-q-and-a-on-quora-fzp3s8dpj accessed 29 September 2024.

[10] Matrix Chambers, 'Inquest concludes that gambling led to the death of Jack Ritchie and "woeful" State inadequacies contributed to his death' (4 March 2022) https://www.matrixlaw.co.uk/news/inquest-concludes-that-gambling-led-to-the-death-of-jack-ritchie-and-woeful-state-inadequacies-contributed-to-his-death/ accessed 29 September 2024.

led to feelings of shame and helplessness. The Senior Coroner also found that government regulation of gambling did not prevent Jack gambling despite clearly and obviously being addicted. This has led to a gambling white paper proposing a statutory levy and financial checks.[11]

A Senior Coroner sitting on the inquest into the suicide of university student Natasha Abrahart in 2019 instructed a psychiatric expert who reviewed the medical care provided to this 20 year old, who suffered extreme anxiety and had self-harmed.[12] He found there was an unacceptable delay in her having a specialist assessment following her referral to the Mental Health ("MH") Trust, her risk of self-harm was not adequately assessed, and the failure to provide a timely and detailed management plan contributed to her death. The Senior Coroner recorded a narrative conclusion, finding that Natasha's death was contributed to by gross failures by the MH Trust. In 2022 it was held that the University contributed to the death by discriminating against her under the Equality Act 2010[13] and the number of other similar deaths of university students have led to calls for there to be a legal duty of care of universities to their students.[14]

Headteacher Ruth Perry took her own life after receiving a draft inspection report downgrading the previously "outstanding" school to "inadequate" because of failures in child protection records. As a result, the school was likely to be forced to become an Academy with loss of jobs for senior staff.[15] She described the inspection system as untherapeutic and inhumane and the inspector as a bully. The Coroner concluded that her suicide was contributed to by the inspection in November 2022. Since publicising her concerns, her sister reported that hundreds

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[11] Steven Swinford, 'Gambling white paper: New curbs to save young from addiction' (*The Times*, 28 April 2022) https://www.thetimes.com/life-style/health-fitness/article/gambling-white-paper-uk-dcms-commission-curbs-save-young-addiction-6b7wl97n5 accessed 29 September 2024.

[12] Inquest, 'Coroner Finds Neglect Contributed To Suicide Of University Of Bristol Student Natasha Abrahart' (16 May 2019) https://www.inquest.org.uk/natasha-abrahart-conclusion accessed 29 September 2024.

[13] Equality Act 2010 (legislation.gov.uk) accessed 29 September 2024.

[14] Sian Griffiths, 'Anxiety makes university a fight for survival. This is what must change' (*The Sunday Times,* 18 February 2024) https://www.thetimes.com/uk/healthcare/article/anxiety-makes-university-a-fight-for-survival-this-is-how-wed-change-it-rt0zmll9z accessed 29 September 2024. Editor's Note: See also David Sykes, 'The Legal Relationship Between Universities and Their Students – How Accountable and to What Extent in Law are Universities Liable for Student Suicides?', this volume.

[15] Richard Adams, '"Dark thoughts": how Ruth Perry's resolve fell apart after Ofsted visit' (*The Guardian*, 7 December 2023) https://www.theguardian.com/education/2023/dec/07/ruth-perry-reading-headteacher-after-ofsted-visit accessed 29 September 2024.

of teachers and families had experienced feeling broken by Ofsted inspection and were forced to sign a Non-Disclosure Agreement ("NDA") in return for payment and a reference.[16] The National Association of Schoolmasters and Union of Women Teachers reported 84% of teachers experienced work related stress in 2023 and has called for mandatory suicide prevention training for school leaders and caseworkers.[17] A Coroner noted in a suicide inquest the failure of the police to investigate harassment of and threats to the teenager at school for being a "grass" and recorded the failure of the school to comply with its anti-bullying policy.[18] A Senior Coroner conducted an inquest into the death of a medical student who jumped in front of a train after failing her exams, and called fellow students anonymously to the inquest to investigate parental concerns of bullying.[19]

These are but four illustrations of contemporary underlying causes or triggers of suicide–bullying in the educational world, negative effects of the internet, regulation of gambling, and anxiety of university students. They have all generated considerable public concern and the Coroner has investigated in some detail the broader circumstances of the deaths, rather than the more narrow question of simply by what means the deceased came by their death.

CORONER'S LEGAL DUTY TO INVESTIGATE

A Coroner has a statutory duty to investigate a death where they have reason to suspect that the cause is unknown, the death is unnatural, or the death occurred in state detention.[20] The purpose of the investigation is to ascertain the identity of the deceased, and how when and where they came by their death.[21] In a detention death (typically but not solely deaths in prison, police custody or under mental health section), how is to be interpreted as by what means *and in what*

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[16] Sian Griffiths, 'My sister Ruth Perry and the Ofsted report that ended in tragedy' (*The Sunday Times,* 10 December 2023) https://www.thetimes.com/uk/education/article/ruth-perry-ofsted-headteacher-school-death-gsljfvd78 accessed 29 September 2024.

[17] Emma Yeomans, 'School leaders need suicide prevention training, union says' (*The Times*, 31 March 2024) https://www.thetimes.com/uk/article/school-leaders-suicide-prevention-training-nasuwt-8b0dz9zhh accessed 29 September 2024.

[18] Personal communication from Senior Coroner for Cheshire re death of Lauren Lelonek in 2016.

[19] David Churchill, 'Trainee doctor jumped in front of train after attacking fellow student "in a trance"' (*The Standard,* 16 December 2014) https://www.standard.co.uk/news/london/trainee-doctor-attacked-fellow-student-while-in-a-trance-just-hours-before-jumping-in-front-of-train-9928385.html accessed 29 September 2024.

[20] Coroners and Justice Act 2009 (n3), s 1.

[21] Coroners and Justice Act 2009 (n3), s 5(1).

circumstances, to comply with Article 2 of the European Convention on Human Rights ("A2").[22] To discharge the State's A2 duty an investigation must be independent and effectively involve the family,[23] which is why there is a statutory obligation for Coroners to investigate even natural detention deaths. This investigation might include acts or omissions of third parties:

> "The crux of the argument was whether he should have been recognised as a suicide risk and whether appropriate precautions should have been taken to prevent him taking his own life… By one means of another the jury should, to meet the procedural obligation in A2, have been permitted to express their conclusion on the central facts before them." [24]

Coroners are not permitted to express an opinion on other matters (than the four key questions and Registration particulars),[25] nor record a determination which appears to determine criminal liability of a named person or civil liability.[26]

An example of a conclusion recording an omission in an A2 inquest, complying with the restrictions, is an Assistant Coroner in Manchester recording in an inquest into an adult woman of 26 with Emotionally Unstable Personality Disorder ("EUPD"), who ordered poison on the internet: despite being in a mental health unit, she had *"unfettered access to the internet, including foul sites that assist and encourage suicide"*.[27]

There is now a substantial body of Judicial Reviews of Coroners to determine whether, in non-detention cases, the wider investigation is mandatory due to engagement of A2 in circumstances where the State has assumed some responsibility for the deceased. In short, there needs to be an arguable breach of A2 either from a failure of an operational duty to take measures to avert a real and

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[22] Now incorporated in statute: Coroners and Justice Act 2009 (n3), s 5(2).

[23] *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51, [2004] 1 AC 653; *R (Khan) v Secretary of State for Health* [2003] EWCA Civ 1129, [2004] 1 WLR 971.

[24] *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] UKHL 10, [2004] 2 AC 184 [45].

[25] Coroners and Justice Act 2009 (n3), s 5(3).

[26] Coroners and Justice Act 2009 (n3), s 10(2).

[27] Chris Slater and Chloe Parkman, 'Beth Matthews suicide: Mental health blogger saved lives, but no one saved hers' (*Cornwalllive*, 19 January 2023) https://www.cornwalllive.com/news/cornwall-news/beth-matthews-inquest-mental-health-8052615 accessed 30 September 2024; Megan Agnew and Katie Tarrant, 'Why didn't the Priory keep our Beth safe?' (*The Sunday Times*, 16 April 2023) https://www.thetimes.com/article/why-didnt-the-priory-keep-our-beth-safe-rnmbgv302 accessed 30 September 2024.

immediate risk to life[28] or from a defective system that may have failed to afford adequate protection to human life.[29] Examples include a Local Authority's successful challenge that A2 was not engaged the death of a child from parental neglect who was on the at risk register on the basis of an alleged failure to apply for an interim supervision order,[30] given the lack of evidence of the authority knowing (or ought to have known) of a real and immediate risk to life.[31] Note that the conclusion of the Plymouth case was that the Coroner was not *required* to hold a broadened inquest and it is *suggested* it is not appropriate.[32] *Takhousis*[33] is an example of a case where it may not be known whether A2 is be engaged, but a wider investigation is nevertheless appropriate: a voluntary patient with schizophrenia self-discharged from an Emergency Department where he had been identified by triage as at risk and jumped to his death in the river. The Coroner declined to call an expert to consider the hospital's system of handling those at risk of self-harm. The Court of Appeal held that there had been an insufficiency of evidence in investigating the matter and ordered a new inquest. *Rabone*[34] sets three indicia for considering whether the scope of an inquest into a voluntary patient who has taken their life might require an A2 investigation. They are an assumption of responsibility (usually), vulnerability and exceptionality of risk, together with the reason to suspect a real and immediate risk to life. In a recent Judicial Review[35] the question of the duty of the State to a voluntary patient who died from suicide was revisited and it was held that the foreseeable real and immediate risk of the type of harm in question was a necessary condition of the existence of the duty, not merely relevant to breach. Without identifying such foreseeable risk of the type of harm involved, it was impossible to answer the question whether there was an operational duty to take steps to prevent it.

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[28] *Osman v UK* (2000) 29 EHRR 245.

[29] *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] UKHL 10, [2004] 2 AC 184.

[30] *R (Plymouth City Council) v HM Coroner for the County of Devon (Plymouth and South West District)* [2005] EWHC 1014 (Admin).

[31] The legal test laid down in *Osman v UK* (2000) 29 EHRR 245.

[32] *R (Plymouth City Council) v HM Coroner for the County of Devon (Plymouth and South West District)* [2005] EWHC 1014 (Admin) [86].

[33] *R (Takoushis) v HM Coroner for Inner North London* [2005] EWCA Civ 1440, [2006] 1 WLR 461.

[34] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 AC 72.

[35] *R (Morahan) v HM Assistant Coroner for West London*, [2021] EWHC 1603, [2021] QB 1205 [66].

Boyce[36] confirmed that a child who suspended herself whilst being subject to a care order under s31 Children Act 1989,[37] which gave responsibility to the local authority, was not analogous to state detention, noting that the care home had no powers of compulsion or detention. For engagement of A2, there is a need for more than evidence of systemic failures; there must be evidence of their causative role in the specific death, specifically whether the deceased lost a substantial chance of surviving because of the failure.[38] This was not made out in *Boyce,* where challenge on the effect of A2 on the scope of the inquest failed, since the Coroner had left open the possibility that the scope would need to be enlarged, even though the evidence did not amount to its engagement of A2.[39]

INVESTIGATING THE CIRCUMSTANCES OF A PRESUMED SUICIDE

In an inquest not engaging A2, the how question is to be interpreted as *by what means*.[40] In the original *Jamieson* case, the application of the equivalent statutory restrictions was cited and it was determined that a missed opportunity to avoid a prisoner at risk of suicide from being in a single cell was insufficient to warrant a finding of neglect, which has a special meaning in coronial law and high threshold.[41]

On a literal interpretation of *by what means* in a suicide inquest, the determination to be recorded[42] might be suspension or intoxication and the Coroner might decide that a *Jamieson* inquest does not require the reasons to be explored, for example, investigation of the matter of alleged bullying. Yet in the examples cited above, the investigations have had a wider scope, despite not

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[36] *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool* [2022] EWHC 107, [2022] 4 WLR 15 [33]–[36].

[37] Children Act 1989 (legislation.gov.uk) accessed 30 September 2024.

[38] *Van Colle v Chief Constable of Hertfordshire* [2008] UKHL 50, [2009] 1 AC 225.

[39] *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool* [2022] EWHC 107, [2022] 4 WLR 15 [67], [73]–[74].

[40] *R (Jamieson) v HM Coroner for North Humberside Coroner* [1995] QB 1 (CA), [1994] 3 WLR 82.

[41] Definition of neglect: 'a gross failure to provide or procure basic medical care for a vulnerable person, whose need was or should have been obvious, and had the failure not occurred, the deceased would not have died where and when they did': *R (Jamieson) v HM Coroner for North Humberside Coroner* [1995] QB 1 (CA), [1994] 3 WLR 82; *R (Chief Constable of Staffordshire Police) v HM Coroner for Coventry* (2000) 164 JP 665.

[42] Coroners and Justice Act 2009 (n3), s 10.

engaging A2. The extent of the scope of the investigation is considered to engage the Coroner's wide margin of discretion.

There is considerable public concern about the restriction of scope in some cases. A father of an autistic teenage girl who killed herself at a boarding school is challenging a Senior Coroner who excluded expert evidence on autism as to whether it contributed to her death.[43] There has been a successful Judicial Review of an inquest conclusion where the scope was held to have been wrongly restricted and was amended to record that the suicide was due to an emotionally abusive relationship.[44] A Private Member's Bill[45] was introduced by the Bishop of St Albans, initially in relation to gambling deaths, but subsequently wider, in the 2022–23 session of Parliament seeking to establish a legal rule that Coroners had an obligation in suicide inquests to record an opinion as to the factors which were relevant to the death. Whilst the format was inappropriate, a statute could extend the scope of suicide deaths as with detention deaths, but the government was not prepared to do so and doubted the quality of data would be of value.[46]

Consequently, the Coroner's discretion on scope remains. Coroners must apply case law to their decisions and, in this field, the law is developing and the apparently rigid distinction between *Middleton* and *Jamieson* investigations has been progressively blurring. The scope of a *Jamieson* inquest may be the same as a *Middleton* one,[47] recognised by Lord Phillips even in 2011:

> "I question whether there is, in truth, any difference in practice between a Jamieson and Middleton inquest, other than the verdict [now "conclusion"].[48]

Boyce suggests that where a Coroner has set the scope widely, there is, in effect, no difference between an A2 and a non-A2 investigation even extending

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[43] David Brown, 'Inquest into suicide of Wycombe Abbey pupil "unlawful", father claims' (*The Times*, 17 June 2024) https://www.thetimes.com/uk/law/article/caitlyn-scott-lee-wycombe-abbey-father-review-inquest-g3l636lvc accessed 29 September 2024.

[44] Yvonne Roberts, 'Domestic Abuse Drove our Daughter to Suicide Say Families: So What Stops Coroners Acknowledging That?', *Observer* Saturday 1 June 2024, Domestic abuse drove our daughters to suicide, say families. So what stops coroners acknowledging that? | Domestic violence | *The Guardian* accessed 29 September 2024.

[45] Coroners' Determination of Suicide Bill (HC 372) House of Lords 2022–23, Hansard 28 October 2022.

[46] Coroners' Determination of Suicide Bill, 3rd Reading, House of Lords, Lord Bellamy, Hansard 16 June 2023

[47] *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181, [2013] Med LR 89 [18], [40ff].

[48] *R (Smith) v Secretary of State for Defence* [2010] UKSC 29, [2011] 1 AC 1 [78].

to conclusions (albeit that the Coroner has discretion to consider possible causal factors as part of the conclusion in A2 inquests).[49] Absent the A2 duty, the Coroner may record the matters that have contributed to the death from the wider circumstances but should do so neutrally and avoid recording them as failings.[50]

There is a need to explore how a Coroner should exercise discretion in determining scope in a suicide inquest that does not engage A2 and highlight whether further investigation is of motive, intent and causation or just the immediate circumstances, as well as when expert evidence might be necessary.

In a suspected suicide, the death is suspected to be unnatural and so, whatever the medical cause of death ("MCD") offered, a coronial investigation is consequently mandatory. If the pathologist finds a natural MCD but the police report finds a note that appears to be one, suggesting suicide, the investigation should explore whether the medical cause was incidental, whether there is any abnormal toxicology, the timing of the note and supportive evidence around intent. An important role of the Coroner is to allay suspicion and rumour.[51]

The test of what should be the subject of the investigation in the first instance is relevance, not necessarily potential causation. The Court of Appeal supported a Coroner who admitted evidence about performance reviews of the previous prescribing of a GP, which enabled the patient to overdose fatally. The evidence was not directly related to the death and some was peripheral, but it did not undermine the inquest process or conclusion.[52] The Coroner has considerable discretion as to scope:

> "A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory

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[49] Approving that the coroner recognising that an enlarged scope in a non A2 inquest might need to determine events leading to death and feed into conclusions: *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool* [2022] EWHC 107, [2022] 4 WLR 15 [73]–[74].

[50] *R (Longfield Care Homes Ltd) v HM Coroner for Blackburn* [2004] EWHC 2467 (Admin): see proposed narrative at [31].

[51] One of the purposes of the coronial investigation identified by the Broderick Committee [1971] Cm5831, Committee on Death Certification and Coroners (Brodrick Committee): Minutes and Papers | The National Archives accessed 1 October 2024. See also 343471PAG1 (parliament.uk) accessed 1 October 2024.

[52] *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181, [2013] Med LR 89 [48].

functions to be discharged. These are not hard-edged questions. The decision on scope..... and the breadth of evidence adduced, is for the coroner."[53]

However, even such broad discretion inevitably has limits. In *Butler*[54] the High Court set aside the Coroner's decision to call expert Health and Safety Executive ("HSE") opinion evidence to explore unlawful killing and to consider a PFD report. The HSE evidence at its highest did not provide the ingredients of an unlawful killing conclusion and admitting substantial new evidence that could not be properly admitted for the primary purpose of the inquest should not be admitted for PFD purposes. Arguably, the approach in *Butler* may be distinguished, in that particular care needs to be taken with unlawful killing conclusions, although *Butler* obviously preceded *Maughan* which clarified the standard for unlawful killing as being the civil standard. Even given *Maughan, Butler* should probably be confined to inquests in which unlawful killing is being considered.

What if the cause of death is uncontrovertibly suicide and the note found indicates that the action was taken as she could not face suffering from a newly diagnosed cancer? Establishing the facts in the investigation is relevant, but if it is discovered that the fear was misplaced as the test result showed another minor diagnosis and not cancer, the error is not evidently relevant, but the fear of cancer is relevant to intent as it is in the chain of causation and thus should be recorded. Coroners, especially in complex inquests, will investigate several key issues, which may on further enquiry fall away, or others may emerge. The process has been described as a funnel, becoming narrower as the evidence required is honed and defined.[55]

POSSIBILITY OF ALTERNATIVE OUTCOME

The possibility of an alternative outcome to the inquest must be a critical consideration. For example, consider the police reporting a deceased fall from a height as probable suicide and the evidence of intent is circumstantial involving depression and a conversation about suicidal ideation, but the family request investigation of the non-repair of the balcony, reported 6 weeks ago to the Council, which they allege was not secure, suspecting an accident, not suicide. The allegation must be investigated as it is relevant to the medical cause of death, just as the Divisional

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[53] *Coroner for the Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081, [2019] 1 WLR 3417.

[54] *R (Butler) v HM Coroner for the Black Country District* [2010] EWHC 43 (Admin).

[55] *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ1403, [2010] 1 WLR 1836.

Court held when accepting the application of the family of an elderly patient with dementia for a fresh inquest, on the basis that her leg fractures 4–6 weeks prior to admission allegedly caused immobility which may be an antecedent cause of her immediate cause of death from pneumonia, rather than the stroke, which was long standing: the determination of death from natural causes was quashed as there was a real possibility that a fresh investigation might give rise to an alternative outcome.[56]

However, even in an inquest engaging A2, the Coroner does not have to investigate every alleged issue.[57] Crucial for sufficiency of evidence is a level of confidence that causation is not likely to be altered by alternative or supplementary evidence. Showing that a different conclusion was probable is not required, but that it is possible is of first importance.[58]

POSSIBILITY OF A CRIMINAL ACT IN THE CHAIN OF CIRCUMSTANCES

A Coroner has a statutory duty to suspend their investigation when they are notified that criminal homicide proceedings are being or may be brought.[59] There is no statutory duty on a Coroner conducting an investigation to report a possible or suspected homicide to the police, although former Home Office Guidance recommended that it should be followed and the referral to the DPP be announced in court.[60] Coroners have the discretionary power of suspension, which may allow adjournment of inquest where it appears to the Coroner that it would be appropriate to do so, a subjective test.[61] Where new information comes to light creating suspicion of homicide causing the death, prosecuting authorities expect referral[62] and Interested Persons ("IPs") who are suspected defendants submit it is necessary, not least because witnesses in a Coroner's court have a common law right against self-incrimination and arguably an Article 6 right against

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[56] *Rushbrookev HM Coroner for West London* [2020] EWHC 1612, (2020) 176 BMLR 99.

[57] *R (Gorani) v HM Assistant Coroner for West Lindon* [2022] EWHC 1593 (QB) at [71].

[58] *R (Mulholland) v HM Coroner for St Pancras* [2003] EWHC 2612 (Admin).

[59] Coroners and Justice Act 2009 (n3), Schedule 1 [1]–[2].

[60] Home Office Circular No 187 of 1997, Appendix C.

[61] Coroners and Justice Act 2009 (n3), s 11; Coroners and Justice Act 2009 (n3), Schedule 1 [5].

[62] Agreement between CPS, National Police Chiefs' Council, the Chief Coroner and Coroner's Society of England and Wales, March 2016 [5]; Coroners (Inquests) Rules, SI 2013/1616 Rule 25.

self-incrimination, but must in any event be given a warning against self-incrimination.[63] In practice, a prior police investigation (and where appropriate a domestic homicide review) provide much information which enables a Coroner to identify the key evidence and witnesses in a resumed inquest efficiently and proportionately exclude others from scope.

Bullying and harassment is generally behaviour that makes someone feel intimidated or offended. Harassment is a persistent and deliberate course of unacceptable and oppressive conduct, targeted at another person, which is calculated to and does cause that person alarm, fear or distress and must have gravity of a level which would sustain criminal liability.[64] Examples of bullying or harassing behaviour at work include spreading malicious rumours, unfair treatment, picking on or regularly undermining someone and denying someone's training or promotion opportunities.[65] Research from the Department of Education looking at pupils in year 10 found that 40% of young people were bullied in the last 12 months, 6% of all young people had experienced bullying daily, 9% between once a week and once a month and those with mental health problems were more likely to be bullied, which in turn causes mental ill health.[66] There is an overlap with domestic abuse, which in addition to physical, sexual, economic and psychological abuse, includes violent, threatening, controlling or coercive behaviour.[67] The government, advised by scientific experts, recognises potentially causative links between bullying and domestic abuse and suicide.

Bullying is not *per se* a criminal act. Harassment is unlawful under the Protection from Harassment Act 1997.[68] Controlling and coercive behaviour in an

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[63] Coroners (Inquests) Rules, SI 2013/1616 Rule 22; the common law and, arguably, ECHR Article 6 if Article 6 applies to inquests: Guide on Article 6 - Right to a fair trial (criminal limb) (coe.int) accessed 30 September 2024.

[64] *Hayden v Dickenson* [2020] EWHC 3291 (QB).

[65] GOV.UK, 'Workplace bullying and harassment' https://www.gov.uk/workplace-bullying-and-harassment accessed 29 September 2024.

[66] Anti-Bullying Alliance, 'Prevalence of Bullying' https://anti-bullyingalliance.org.uk/tools-information/all-about-bullying/prevalence-and-impact-bullying/prevalence-bullying accessed 29 September 2024; Anti-bullying Alliance, 'Mental Health' https://anti-bullyingalliance.org.uk/tools-information/all-about-bullying/mental-health-0 accessed 29 September 2024.

[67] Domestic Abuse Act 2021, s 1(3), Domestic Abuse Act 2021 (legislation.gov.uk) accessed 29 September 2024.

[68] GOV.UK, 'Workplace bullying and harassment' https://www.gov.uk/workplace-bullying-and-harassment accessed 29 September 2024.

intimate or family relationship is also a separate criminal act.[69] However, bullying, harassment and/or controlling and coercive behaviour may not have been recognised by either perpetrator or victim as criminal acts, still less in the chain of causation. Coroners ensuring these are investigated appropriately to exclude a criminal act, to identify causation and to promote prevention of future deaths would be entirely consistent with the government Suicide Prevention Strategy and in the wider public interest.

INSUFFICIENCY OF INQUIRY

Matters may need investigating that are not just the last link in the chain of causation.[70] Remoteness in time should be considered in considering what circumstances are relevant but cannot always be beyond scope. There may be insufficiency if the circumstances of *by what means* are not complete. In the inquest of a young person with Aspergers Syndrome (Autism Spectrum Disorder; ASD) and physical disease was found dead at home with the medical cause of death intoxication from a prescribed drug only available on prescription, the Coroner held the conclusion was Open.[71] A full and proper investigation of the means by which the deceased met his death would have involved investigating, in particular, whether the dose of fentanyl prescribed could have been fatal in certain circumstances and whether it was present. Further, there was a possibility of a different conclusion, namely a conclusion of accidental death, if a further inquest was held.[72]

A not uncommon scenario for a Coroner is the contemporary ante-mortem note beside a suspended body indicating intent, consistent with the autopsy MCD, but no reason being given. The question arises as to whether there a need to comply with a submission for further *investigation* into the circumstances to ensure sufficiency of inquiry in a *Jamieson* inquest? A recent Court of Appeal decision considered the question of whether a matter that potentially affects the state of mind of a person committing suicide needs to be or may be in scope.[73] An

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[69] Serious Crime Act 2015, s 76; GOV.UK, 'Controlling or coercive behaviour: statutory guidance framework' https://www.gov.uk/government/publications/controlling-or-coercive-behaviour-statutory-guidance-framework accessed 29 September 2024.

[70] *R (Dallaglio) v Inner West London Coroner* [1994] 4 All ER 139, 155.

[71] *R (Jones) v HM Coroner for the Southern District of Greater London*, [2010] EWHC 931 (Admin), [2010] Inquest LR 80.

[72] *R (Jones) v HM Coroner for the Southern District of Greater London*, [2010] EWHC 931 (Admin), [2010] Inquest LR 80 [27]–[28].

[73] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2021] EWHC 2511 (Admin).

application for a fresh inquest into the death of a woman who had EUPD, due to the failure to investigate the effect of the withdrawal of her Employment Support Allowance ("ESA") shortly before she took an overdose was initially dismissed. At first instance, it was held (correctly) that A2 was not engaged and:

> "(i) the public interest did not require the Coroner to undertake a broader enquiry; the policies, practices and conduct of the DWP [Department of Work and Pensions] raised multi-factorial questions which were matters for ministers and Parliament….
>
> (iii) Fresh evidence: Different conclusion likely at fresh inquest: The inquest… had covered the necessary legal ground on a Jamieson basis and considered the views of Ms Whiting's family [and] it is likely to remain a matter of speculation as to whether or not the department's decision caused ... the suicide." [74]

It is notable that the considerations in the Divisional Court included public interest, fresh evidence and the likelihood of a different conclusion.

On appeal, the decision was reversed and a fresh inquest ordered.[75] The key reason for overturning the Divisional Court was two pieces of fresh evidence which showed that there had been insufficiency of enquiry. The first was the report from the Independent Case Examiner ("ICE"), which revealed a number of breaches by the Department of Work and Pensions ("DWP") of its own guidance and five missed opportunities which should have prompted consideration of the mental health status of the deceased.[76] The second was an expert psychiatric report, which identified her vulnerability and impulsivity as a sufferer of Borderline Personality Disorder (BPD; also known as EUPD) and opined that there was, on the balance of probabilities, a causal link between DWP's failings and the state of mind immediately before the death.[77]

The Court of Appeal overruled the Divisional Court that the conduct of the Department was not a matter for the Coroner, considering that there was good

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[74] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2021] EWHC 2511 (Admin) [93].

[75] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289.

[76] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [41].

[77] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [45].

reason to admit the ICE report as background evidence, particularly the sequence of contacts, reaffirming the discretion of the Coroner:

> "I believe it would be undesirable to restrict a coroner's discretion to conduct whatever investigations are appropriate within the ambit of a Jamieson inquest to establish "how" the deceased came by their death."[78]

The Divisional Court in *Dove* erred in rejecting a causative link between cessation of ESA and suicide. The test is whether on the balance of probabilities the decision more than minimally, trivially or negligibly contributed to the death and not the classic civil "but for" test.[79] Further, it was held that the separation of mental health deterioration and death by the Divisional Court was artificial, as the impact of past events and expert evidence on the state of mind is relevant to determination of intent:

> "... part of a coroner's role is to investigate whether the deceased intended to take their own life, and that will often lead to a consideration of whether the deceased acted whilst their mind was disturbed, with that fact being recorded if it is established…. An investigation of the cause or causes of disturbance of the mind may therefore be part of or very close to matters which are already before the coroner."[80]

It can be concluded that where there is good evidence of potentially causative additional factors in any suicide inquest, there is a need for these to be investigated. This potentially makes it difficult not to accept family submissions inviting the Coroner to do so.

INTERESTED PERSON SUBMISSIONS AND PUBLIC INTEREST

There is a statutory duty to recognise the rights of Interested Persons, which amount to rights of notification of various stages of the investigation and hearings,

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[78] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [64], [70].
[79] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [69].
[80] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [70].

as well as the rights to examine witnesses[81] and disclosure.[82] The common law requires the Coroner to hear submissions and give reasons for decisions.[83] Thus, a key consideration in exercising the discretion to extend scope is to hear and consider submissions of Interested Persons. The previous Chief Coroner of England and Wales described the goal of the inquest process as keeping "*constantly in mind that the bereaved is at the heart of the proceedings*" so they "*feel confident the inquest will get to the facts of what happened and so they feel listened to and involved in the process.*"[84] Not only does keeping the family at the forefront of the process protect the interests of the family, but it also instils the faith of the public in the Coroner's Court system as a whole, which in turn creates a stronger, more effective resolution of issues for the good of the larger public. The family are arguably custodians and representatives of the broader public interest, giving them the status of first amongst equal IPs.[85]

There is no statutory duty for Coroners to consider the public interest, but it is a key part of the statutory test to order a fresh inquest and the second limb of the Galbraith plus test in deciding whether it is safe for a conclusion to be considered. In *Jones*,[86] it was held that there was a wider public interest in fully investigating how the deceased came to die from fentanyl toxicity in the light of the evidence that there had been a considerable number of deaths both in the USA and in the UK that had been linked to unintended overdoses of fentanyl.

It is also a function of the inquest: *"To seek out and record as many of the facts concerning the death as the public interest requires"*.[87] There are many

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[81] Coroners (Investigations) Regulations, SI 2013/1629 Regulations 6, 10, 13, 17–18; Coroners (Inquests) Rules, SI 2013/1616 Rules 9, 10, 19.

[82] Coroners (Inquests) Rules, SI 2013/1616, Part 3 Rules 12–16; Coroners (Investigations) Regulations, SI 2013/1629 Regulation 23.

[83] The need to give reasons for leaving unlawful killing as a conclusion for the jury: *R (Cooper) v HM Coroner for North East Kent* [2014] EWHC 586 (Admin) [20].

[84] Bar Standards Board, 'Understanding the Unique Nature of Inquests' https://www.youtube.com/watch?v=cuhICcHUxJc&t=1s accessed 29 September 2024.

[85] Examples of the successful submissions of the family in relation to public interest: *S* (*Medihani) v HM Coroner for Inner South District of Greater London* [2012] EWHC 1104 (Admin); *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin).

[86] *R (Jones) v HM Coroner for the Southern District of Greater London*, [2010] EWHC 931 (Admin), [2010] Inquest LR 80 [30].

[87] *R (Sutovic) v HM Coroner Northern District of Greater London* [2006] EWHC 1095 (Admin); approved in *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [72].

different interpretations of what public interest means, but an essential feature is a central mission of achieving public good.[88]

An argument can be made that there is a public interest in widening the scope of all potential work-related suicides in England and Wales. In Japan "karojisatsu" or suicide from overwork may be recorded. In France a study has found a peak of suicides blamed on company restructuring;[89] one in five employee suicides reported to the Securite Sociale are work related;[90] and in law the burden of proof is on the employer to show the death is not work related.[91] In England and Wales, there is no such presumption and there is no other statistical method for recording such deaths, so work related suicides are probably going significantly unrecognised and/or unrecorded.

Where there is a wider scope of inquest, the public interest will be served as hearings must be in public, coupled with the common law duty to open justice that may lead to disclosure of documents to the press as proper persons to receive such documents under the statutory test for disclosure.

Public interest also applies where a Coroner has a duty (previously only a discretion) to take steps to prevent future deaths from arising when an investigation reveals to them a concern that future deaths will occur and they are of the opinion that action should be taken to reduce this risk.[92] The duty of a Coroner to make a PFD report[93] is not a primary reason to expand scope it is "ancillary to the investigation,"[94] but it was held that it was in the public interest that the Coroner be

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[88] Information Commissioner's Office, 'What are the substantial public interest conditions?' https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/lawful-basis/special-category-data/what-are-the-substantial-public-interest-conditions/#:~:text=Substantial%20public%20interest%20means%20the,wider%20benefits%20of%20your%20processing accessed 29 September 2024.

[89] Sarah Waters. 'Suicide Voices: Testimonies of Trauma in the French Workplace' (2017) 43 Medical Humanities 24–29.

[90] Sarah Waters, 'Suicide as Protest in the French Workplace' (2015) 23 Modern and Contemporary France 491–510.

[91] The Communications Union, 'The Law Against Work Related Suicide in France' (30 September 2019) http://www.cwu.org/wp-content/uploads/2020/01/Law-against-work-related-suicide-in-France-2019.pdf accessed 29 September 2024.

[92] Chief Coroner's Guidance, 'Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths', Microsoft Word - GUIDANCE No. 5 REPORTS TO PREVENT FUTURE DEATHS.doc (judiciary.uk) accessed 1 October 2024.

[93] Coroners and Justice Act 2009 (n3) s 32; Coroners and Justice Act 2009 (n3) Schedule 5 [7].

[94] *R (Dillon) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin) [43]; Chief Coroner's Guidance, 'Revised Chief Coroner's

given an opportunity to consider whether to make a report, when an application for a new inquest to consider fresh evidence is reviewed.[95] A Coroner may admit evidence relevant to preventing future deaths, even though its relevance to the circumstances of the death is marginal,[96] but, although he will often find it helpful, the Coroner is not obliged to hear submissions from Interested Persons before deciding whether to issue a report.[97]

It can be concluded that submissions from IPs that highlight a matter of potentially wider public interest consequently will very frequently require investigation.

WHETHER THE MATTER IS POTENTIALLY CAUSATIVE

(i) The Law

The Coroner will consider remoteness (distance, connection or closeness) of cause of death in determining scope.[98] The Coroner must also consider the proportionality of the investigation[99] and should not undertake disproportionate investigations to investigate unsubstantiated theories or facts which are already clear on the evidence.[100] So, for example, even in an A2 inquest, a matter that is not even arguably causative, simply involving speculation (in *Speck,* the detention of a mentally ill person in a police station rather than a health-based place of detention),[101] may lawfully be excluded from scope. Potential causation is a critical consideration: in *Allen,* the Coroner did not investigate the alleged inadequacy of delivery of oxygen in resuscitation of a detained patient dying of an arrythmia. On that case, it was observed that it would have been better if it had

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Guidance No. 5 Reports to Prevent Future Deaths' (n92), [14].

[95] *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289 [72].

[96] *R (Davison) v HM Senior Coroner for Hertfordshire* [2022] EWHC 2343 (Admin) [32].

[97] *R (Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1680 (Admin) [95]–[96]; Chief Coroner's Guidance, 'Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths' [15].

[98] *R (Dallaglio) v Inner West London Coroner* [1994] 4 All ER 139, 164.

[99] *Coroner for the Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081, [2019] 1 WLR 3417.

[100] For example, the substantial evidence for the identity of the deceased: *R (Trivedi) v HM Senior Coroner for Inner South London* [2016] EWHC 4166 (Admin), in which permission to appeal was refused.

[101] *R (Speck) v HM Coroner for District of York* [2016] EWHC 6 (Admin), [2016] 4 WLR 15 [28], [46]–[47].

been investigated, but its omission was not a defect in the A2 investigation, as it could not have been causative.[102]

The test of causation is that, at inquest, the Coroner may record (usually in the conclusion in Box 4 of the Record of Inquest), matters which on the balance of probabilities more than minimally or trivially contribute to the death.[103] If the outcome is suicide, but there is an issue that has contributed to the death, it can be recorded in the inquest. The House of Lords in *Middleton* approved the much quoted dictum:

> "A [conclusion] such as … the deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so, embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death…. Not therefore infringing [Coroner's rules]."[104]

It may be that in investigating bullying, it is ultimately found not to be causative, but other matters are discovered that are; these may and arguably must be recorded.[105] A fact that is relevant to the death but cannot be concluded to have been causative may be recorded factually and neutrally in the circumstances in Box 3, such as the prior sexual assault giving the context in which a 13 month old child was appeared to have been left in an unsafe sleeping position.[106]

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[102] *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, [2009] LS Law Medical 430 [40]–[41].

[103] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), [2016] 4 WLR 157 [41], [62].

[104] *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] UKHL 10, [2004] 2 AC 1 [37].

[105] Senior Coroner Philip Spinney found that the Royal Marine was not treated any differently, but recorded doctors not referring him and anxiety over losing equipment as contributory matters in the inquest into the death of Connor Clark: itvNEWS, 'Royal Marine inquest: Mental health failings contributed to recruit's death, says coroner' (4 July 2024) https://www.itv.com/news/westcountry/2024-07-03/lack-of-mental-health-support-contributed-to-marines-death-inquest-told accessed 29 September 2024.

[106] *R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin); approved by the Court of Appeal in *R (Dove) v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289.

(ii) The Science

Determining whether there is good evidence of potential causative factors in suicide requires scientific evidence. Risk factors for suicide include male sex, divorce, death of a spouse and socio-economic deprivation, mood instability/ presence of an underlying mental health disorder (especially with hallucinations),[107] disablement, making suicide plans, being a victim of abuse, access to harmful substances or weapons, and previous suicide attempts,[108] particularly hanging rather than self-poisoning.[109] Low maternal care in childhood is significantly associated with suicide attempts,[110] as are a history of being bereaved by suicide.[111] It is known that the antecedents to suicide occur in the context of vulnerabilities (long term unemployment, poor physical health, alcohol misuse, lack of protective factors such as social support or positive relationships) which create cumulative risk.[112] The bereaved may find it helpful to hear expert evidence on risk, but it is not conclusive of causation.

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[107] Kjelby E, Sinkeviciute I, Gjestad R, Kroken RA, Loberg EM, Jorgensen HA, Hugdahl K, Johnsen E. 'Suicidality in schizophrenia spectrum disorders' (2015) 30 *European Psychiatry* 830–836.

[108] House of Commons Library, 'Suicide Statistics' (12 January 2024) https://researchbriefings.files.parliament.uk/documents/CBP-7749/CBP-7749.pdf accessed 30 September 2024; Office for National Statistics, 'Who is most at risk of suicide?' (7 September 2017) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/whoismostatriskofsuicide/2017-09-07 accessed 29 September 2024; Office for National Statistics, 'Sociodemographic inequalities of dying by suicide' (Dr. Isobel Ward, 6 March 2023) https://blog.ons.gov.uk/2023/03/06/sociodemographic-inequalities-of-dying-by-suicide/#:~:text=Our%20work%20shows%20that%20the,suicide%20than%20non%2Ddisabled%20women accessed 30 September 2024; World Health Organisation, 'Suicide' (19 August 2024) https://www.who.int/news-room/fact-sheets/detail/suicide accessed 29 September 2024.

[109] Runeson B, Haglaund A, Lichtensein P, Tidemalm D., 'Suicide risk after non fatal self-harm. A national cohort study 2000-2008' (2016) 77 Journal of Clinical Psychiatry 240–246.

[110] Johnstone JM, Carter JD, Luty SE, Mulder RT, Frampton CM, Joyce PR. 'Childhood predictors of lifetime suicide attempts' (2016) 50 Australian and New Zealand Journal of Psychiatry 135–144.

[111] Pitman AL, Osborn DP, Rantell K, King MB. 'Bereavement by suicide as a risk factor for suicide attempt: A cross sectional national UK wide study' (2016) 6 BMJ 1–11.

[112] National Confidential Inquiry into Suicide and Safety in Mental Health, 'Suicide by Middle Aged Men' (May 2021) https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/#:~:text=Common%20antecedents%20of%20suicide&text=30%25%20of%20men%20were%20unemployed,at%20the%20time%20of%20death. accessed 29 September 2024.

Most suicides are unexpected, often coming out of the blue for those close to them, often causing shock and disbelief. 83% of the minority who have been assessed by a psychiatrist before the act mostly were found to be of little or no risk.[113] The causative factors in any individual suicide are complex and multifactorial and have been well summarised by Dr. Rachel Gibbon, a suicidologist:[114] Some suicidologists believe that around 30–50% of the risk is genetic.[115] Contemporary psychoanalysts conceptualise suicide as resulting from complex unconscious mental mechanisms, not yet fully understood, where the destructive pathway is set in motion as a response to loss where the capacity to mourn is overwhelmed.[116] Bereavement was reported in 36% of middle-aged men in a National Confidential Inquiry.[117] Fantasies are experienced, in which the body, being the source of the pain and anxiety, is split from the mind and liberated by suicide, avoiding awareness of the finality of death.[118] Dr. Gibbon's research suggests that there is a pre-existing vulnerability, a trigger loss event creating a suicidal state and then a trigger event before the act, but that in any individual case the reasons may never be learnt as we do not ultimately know what is in the mind of the deceased. About a quarter of suspected suicides leave an ante-mortem note and they rarely give full reasons for their death.[119] It is multifactorial at heart, and

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[113] Friedlander A, Nazem S, Fiske A, Nadorff MR, Smith MD. 'Self-concealment and Suicidal Behaviours (2012) 42(3) *Suicide Life Threat Behav* 332–340.

[114] Rachel Gibbons, Eight 'Truths' about Suicide' (14 September 2023) BJPsych Bulletin 1–5.

[115] Coon H, Darlington TM, DiBlasi E, Callor WB, Ferris E, Fraser A, et al, 'Genome-wide Significant Regions in 43 Utah High-risk Families Implicate Multiple Genes Involved in Risk for Completed Suicide' (2020) 25(11) *Mol Psychiatry* 3077–3090.

[116] D Campbell D and Hale R. *Working in the Dark: Understanding the Pre-Suicide State of Mind* (Routledge 2017); Maltsberger JT, Buie DH. 'The Devices of Suicide: Revenge, Riddance, and Rebirth' (1980) 7(1) *International Review of Psycho-Analysis* 61–72.

[117] National Confidential Inquiry into Suicide and Safety in Mental Health, 'Suicide by Middle Aged Men' (May 2021) https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/#:~:text=Common%20antecedents%20of%20suicide&text=30%25%20of%20men%20were%20unemployed,at%20the%20time%20of%20death. accessed 29 September 2024.

[118] Gibbons R, Adshead G. 'Psychodynamic Aspects of Suicide and Homicide' in R Gibbons and J O'Reilly (eds). *Seminars in the Psychotherapies, College Seminars Series* (2nd edn, CUP 2021).

[119] Paraschakis A, Michopoulos I, Douzenis A, Christodoulou C, Koutsaftis F, Lykouras L, 'Differences between Suicide Victims who Leave Notes and Those who do not: a 2-year Study in Greece' (2012) 33(6) *Crisis* 344–349.

nobody realistically can be blamed.[120] Further there is a risk of generating guilt and delusions in the bereaved[121] which may affect the health of the psychiatrists involved too.[122] This has implications for the Coroner's investigation and inquest, both in relation to psychiatric and causation evidence being considered and the handling of witnesses.

Families seeking an explanation for the suicide will be assisted by understanding this complexity which may be provided by a consultant psychiatrist involved in care or an independent expert. To answer specific causation questions, there sometimes will need to be further enquiry, particularly when it is alleged that a third party was responsible, such as with bullying. A PubMed search by the lead author revealed that all articles accepted that there was a known association between bullying and suicide. The qualitative findings from a large cross-sectional study of public servants in Australia in 2015 found palpable mental distress and illness stemming from exposure to workplace bullying. Survey respondents reported emotional and psychological problems including suicidal ideation and attempted suicide as effects of workplace bullying.[123] A meta-analysis of three prospective Scandinavian cohort studies concluded that workplace bullying was associated with an increased suicide risk, but the association was attenuated after adjustment for baseline mental health problems.[124] A prospective study of adolescents found that being victimised by peers at 13 years predicted suicidal

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[120] Gibbons R. 'Someone is to blame: the impact of suicide on the mind of the bereaved (including clinicians)' (30 May 2024) BJPsych Bulletin, 1–5.

[121] Ferrey AE, Hughes ND, Simkin S, Locock L, Stewart A, Kapur N, Gunnell D, Hawton K, 'The impact of self-harm by young people on parents and families: A qualitative study' (6 January 2016) BMJ Open 6(1).

[122] Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G, Hawton K. 'Effect of Patient Suicide on Psychiatrists: Survey of Experiences and Support Required' (11 April 2019) BJPsych Bulletin 1–6.

[123] Hurley John, Hutchinson Marie. 'Nexus between Preventive Policy Inadequacies, Workplace Bullying, and Mental Health: Qualitative findings from the experiences of Australian public sector employees', (2015) 25(1) International Journal of Mental Health Nursing 12–18.

[124] Linda L Magnusson Hanson, Jaana Pentti, Mads Nordentoft, Tianwei Xu, Reiner Rugulies, Ida E H Madsen, Paul Maurice Conway, Hugo Westerlund, Jussi Vahtera, Jenni Ervasti, G David Batty, Mika Kivimäki. 'Association of Workplace Violence and Bullying with Later Suicide Risk: a multicohort study and meta-analysis of published data' (2023), 8(7), Lancet Public Health 494–503.

ideation and suicide attempt two years later, even after adjusting for baseline suicidality, mental health problems and a series of confounders.[125]

From the scientific literature, it is apparent that there is a strong association between bullying and harassment and subsequent suicidal ideation and actions. Although a causal relationship is not proven scientifically, surveys have found that victims attribute their suicidal behaviour to bullying. In conclusion, there is a potential direct causal relationship between bullying and suicide, especially in young persons and probably more so for females. Where there is scientifically plausible potential causation, as with credible allegations of bullying, the Coroner should extend the scope to investigate the bullying, with expert evidence as to whether the bullying contributed to the mental state and was a trigger event to the suicide act.

CONCLUSIONS ABOUT THE CORONER'S INVESTIGATION OF A PRESUMED SUICIDE

The principles that can be drawn for extending the scope of a presumed suicide inquest to examine the reasons for the suicidal act or other contributing factors have been outlined. The Coroner should consider possible alternative outcomes, possible criminal acts, sufficiency of enquiry, submissions of Interested Persons especially as to wider public interest and potential causation of other matters. Such applications will not always be easy. Where the family press for the investigation to include why the deceased took their life, as it was unexpected, but any proposed causes are speculative, there is no merit in expanding scope. It is important in any suicide where there is a submission to investigate factors potentially contributing to state of mind such as bullying, that the Coroner ensures that the bereaved family understands the complexity of suicide causation and the limitations of apportioning blame.

If the family allege that a particular matter is causative, there is a need to establish whether that matter is potentially causative. It is clear from the scientific research that potentially causative matters will need to be investigated. as otherwise such an investigation would not comply with the statutory requirement of the investigation into how the deceased came by their death. This is a bright line legal rule, as opposed to mere coronial discretion.

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[125] Geoffroy MC, Boivin M, Arseneault L, Turecki G, Vitaro F, Brendgen M, Renaud J, Seguin JR, Trenblay RE, Cote SM. 'Associations between peer victimization and suicidal ideation and suicide attempt during adolescence' (2016) 55 *Journal of the American Academy of Child and Adolescent Psychiatry* 99–105.

Coroners, as with any judicial officers, cannot assume that their own knowledge constitutes a sufficient threshold to instigate an investigation into causation. Either expert evidence is required or IPs should be asked whether they agree that a matter is "common knowledge". In the instance of bullying, not only is it well recognised in scientific publications about suicide that bullying has a causal association, but from the many news items cited, such a matter may well be accepted as being "common knowledge". This should inevitably trigger an investigation into the circumstances of bullying.

The evidence should be sought as neutrally as possible, avoiding suggesting bullying is to blame for the death. If it appears speculative, an investigation into bullying should be discontinued and no reference to bullying should appear in the Record of Inquest. But if any evidence emerges that there was bullying, the investigation should seek to establish whether there is sufficient evidence to be able to answer the question as to whether bullying occurred and contributed to the death, applying the coronial test for causation.

There may have been a psychiatrist in attendance, who should be asked to describe the nature of suicide, the extent to which it is predictable and the difficulties in determining causation. The doctor should be provided with the factual evidence and the nature of the bullying. The psychiatrist should then be asked to provide a statement as to any mental illness, the vulnerabilities to bullying, the triggers for an act of fatal self-harm, the likely effect on the pre-morbid mental state and whether there was evidence of intent to end life.

If there is evidence of bullying, the psychiatrist should then be asked to provide the most appropriate medical cause of death, if possible with any antecedent causes. The Coroner is permitted to amend the MCD on the Record following medical evidence on certification from the investigation and inquest.

The context must be distinguished from *Wandsworth,* where the Coroner was criticised for permitting an expert to say: *"living in accommodation where asbestos exposure has occurred has led to and caused this death", "a comment which strayed far beyond the sphere of his medical expertise."*[126] In that case, there was no evidence of exposure in the premises and the nature of causation of mesothelioma from asbestosis was that it had an extremely long latent period and other sources could not be excluded.[127] The test of *"some evidence specific to the*

[126] *R (Wandsworth Borough Council) v HM Senior Coroner for Inner West London* [2021] EWHC 801 (Admin) [21] (HHJ Teague).

[127] *R (Wandsworth Borough Council) v HM Senior Coroner for Inner West London* [2021] EWHC 801 (Admin) [35] (HHJ Teague).

index case" to infer a causal link[128] may be made out by bullying in an appropriate time frame, but it will be important to clarify from the psychiatrist the likely multifactorial nature of matters that contribute.

If there is no psychiatrist who had attended to the deceased in life, an expert may need to be instructed to provide a general professional opinion on the nature of suicide and the complexities of causation. However, instructing an independent expert on suicide causation should be exceptional and be confined to cases where the medical cause of death or the professional view of the state of mind is contested, in particular when there is not acceptance of the contribution of bullying amongst a range of other factors which arguably have also contributed.

Unless a statutory duty to extend scope in suspected suicide is created, the decision on scope will remain a matter of judgement for the Coroner. The decision as to whether A2 is engaged should be kept open if there is any possibility of its engagement. In the interests of expediency and efficiency, Coroners would be assisted by the production of scientific guidance as to the potentially causative matters in the pathway to suicide. They can take note of the issues in the Prevention of Suicide Strategy, which include bullying and domestic abuse. Potentially causative matters should generally be investigated. The investigation may not lead to the matter being the subject of the inquest, if there is a lack of relevant evidence, but the Interested Persons should receive disclosure and, in any event, the bereaved would obtain a degree of closure and, most importantly, the public interest be served.

[128] *R (Wandsworth Borough Council) v HM Senior Coroner for Inner West London* [2021] EWHC 801 (Admin) [39] (HHJ Teague).