

## BMJ 2019;366:I4745 doi: 10.1136/bmj.I4745 (Published 29 July 2019)

## **EDITORIALS**



## New standard of proof for suicide at inquests in England and Wales

Suicide can now be concluded on "balance of probabilities"

Louis Appleby *professor of psychiatry*<sup>1</sup>, Pauline Turnbull *project director*<sup>1</sup>, Nav Kapur *professor of psychiatry and population health*<sup>12</sup>, David Gunnell *professor of epidemiology*<sup>3</sup>, Keith Hawton *professor of psychiatry*<sup>4</sup>

<sup>1</sup>National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), Centre for Mental Health and Safety, School of Health Sciences, University of Manchester, Manchester, UK; <sup>2</sup>Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; <sup>3</sup>Centre for Academic Mental Health, Bristol Medical School, University of Bristol, Bristol, UK; <sup>4</sup>Centre for Suicide Research, Department of Psychiatry, University of Oxford, UK

In May 2019 the Court of Appeal in England and Wales handed down a ruling on the determination of suicide at inquest that is likely to affect the national suicide rate and influence policy priorities.<sup>1</sup> The ruling upholds a critical decision taken in 2018 by the High Court<sup>2</sup> that the standard of proof required for a suicide conclusion (previously verdict) should be the civil standard—balance of probabilities—rather than the previous criminal standard—beyond reasonable doubt. The lowering of the threshold is expected to lead to an increase in deaths recorded as suicide.

The standard of proof has been debated for several years. Suicide prevention charities, in particular, have campaigned for the civil standard, arguing that it will give a more accurate picture of the extent of the problem by reducing the underestimation that a higher standard makes inevitable.<sup>3</sup> Higher figures, they believe, will also bring higher political priority. In addition, the criminal standard is widely seen as stigmatising, a throwback to a time when suicide was a crime; decriminalisation occurred only in 1961.

The government response to the campaign has been cautious, an opposing argument being that a suicide conclusion could add to the distress of bereaved families, especially those whose religion or culture viewed suicide as taboo. However, the parliamentary health committee in its 2017 inquiry into suicide prevention called for change.<sup>5</sup>

The case that produced the change was brought by a family opposing the lower standard, not supporting it.<sup>2</sup> This concerned a death by hanging in an English prison. At inquest the coroner allowed the jury to come to a narrative conclusion that it was "more likely than not" that the deceased had intended to take his own life, effectively a suicide determination on the balance of probabilities. A legal challenge followed and the case reached the High Court, where judges decided that, although the higher

standard had been widely applied, it had no legal justification. The appeal court has now agreed, though the Ministry of Justice will take a further appeal to the Supreme Court.

## Effect on suicide rates

How will the change affect reported suicide rates in England and Wales? Suicide numbers will probably rise and will be hard to compare to previous years. There will be a similar rise in high risk groups such as patients with mental health problems, whose suicide rate has been falling,<sup>6</sup> as well as in eligibility of deaths for suicide research and serious incident investigation.

These increases, however, could be less than might be expected. Firstly, official statistics are already adjusted so that deaths in which intent is unclear ("open" conclusions, recorded as "undetermined") are viewed as probable suicides and included in national figures.<sup>7</sup> In 2017 this amounted to an additional 924 cases, raising the suicide rate by 24%.<sup>8</sup> Many of the deaths that will now meet the standard for suicide may have previously been recorded as undetermined.

Furthermore, any increase may not be uniform across the population, and new prevention priorities may arise. Uncertainty over a person's intent is often the reason a death does not meet the criminal standard. Any rise may therefore be greater in groups whose suicidal intent can be harder to ascertain—for example, young people or those who die from self poisoning,<sup>9</sup> which is more often associated with women.<sup>8</sup> Provisional figures show that the number of suicides did rise after the 2018 High Court ruling, most clearly in young people,<sup>10</sup> although the rise began before the new standard of proof came in.<sup>11</sup>

Even so, if a lower standard of proof reduces underestimation and increases the accuracy of suicide reporting, there is an unarguable public health benefit and the change should be welcomed. The effect on inconsistency of inquest outcomes, a

Correspondence to: P Turnbull p.turnbull@manchester.ac.uk

longstanding problem limiting comparisons over time and between areas, is harder to predict. Coroners are independent legal officers, and their use of conclusions varies.<sup>12</sup> Allowing more ambiguous cases to be considered as suicides may add to that inconsistency.

Most important is the effect on bereaved families. Some will find the greater chance of a suicide conclusion unwelcome because of religion, guilt, or even insurance. Others will see it differently, already bewildered by the current process that may result in a decision that cause of death is undetermined after the family has accepted that the circumstances suggest suicide.<sup>13</sup> Most families are looking for accuracy—a true reflection of what happened—and that may include an acknowledgment of the despair their loved one was feeling.<sup>14</sup>

Everyone in this debate has aimed to be on the side of families, but there is no single family viewpoint, except on one thing. Families agree that inquests, whatever they conclude, should be more supportive, less legalistic, with fewer delays.<sup>13</sup> The standard of proof is only one part of a system that needs reform.

We thank Sharon McDonnell and Stephen Habgood, who have been bereaved by suicide, for helpful comments on this editorial.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

- Maughan, R (On the Application Of) v Her Majesty's Senior Coroner for Oxfordshire [2019] EWCA Civ 809.
- Maughan, R v HM Senior Coroner Oxfordshire and others [2018] EWHC 1955 (Admin)
  Papyrus UK. Campaign to change the law. 2019. https://papyrus-uk.org/campaign-to-
- change-the-law/
- House of Commons Health Committee. Suicide prevention. Sixth report of session 2016-17: HC1087. https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/1087.pdf
   National Confidential Inquiry into Suicide and Safety in Mental Health. Annual report:
- England, Northern Ireland, Scotland, Wales. University of Manchester, 2018. Gunnell D, Bennewith O, Simkin S, etal . Time trends in coroners' use of different verdicts
- Gurneir D, Bernrewin O, Simkin S, etal. Time trends in corone's use of oninerent verdices for possible suicides and their impact on officially reported incidence of suicide in England: 1990-2005. *Psychol Med* 2013;43:1415-22. 10.1017/S0033291712002401 23113986
   Office for National Statistics. Statistical bulletin. Suicides in the UK: 2017 registrations.
- 2018.
  Gosney H, Hawton K. Inquest verdicts: youth suicides lost. *Psychiatr Bull* 2007;31:203-510.1192/bb.bb.105.007773.
- 2007, 91 2007, 07 10 2017, 07 2017,
- 11 Bould H, Mars B, Moran P, Biddle L, Gunnell D. Rising suicide rates among adolescents in England and Wales. *Lancet* 2019;394:116-7. 10.1016/S0140-6736(19)31102-X. 31227370
- Carroll R, Hawton K, Kapur N, Bennewith O, Gunnell D. Impact of the growing use of narrative verdicts by coroners on geographic variations in suicide: analysis of coroners' inquest data. J Public Health (Oxf) 2012;34:447-53. 10.1093/pubmed//dr091 22085685
- 13 Biddle L. Public hazards or private tragedies? An exploratory study of the effect of coroners' procedures on those bereaved by suicide. Soc Sci Med 2003;56:1033-45. 10.1016/S0277-9536(02)00097-7 12593876
- 14 Chapple A, Ziebland S, Hawton K. A proper, fitting explanation? Suicide bereavement and perceptions of the coroner's verdict. *Crisis* 2012;33:230-8. 10.1027/0227-5910/a000139 22562861

Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to http://group.bmj.com/group/rights-licensing/ permissions