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EDITORIALS

Coroners' verdicts and suicide statistics in England and Wales

Increasing use of narrative verdicts raises serious concerns

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Suicide is the most tragic consequence of mental illness, and it accounted for 4648 deaths in England and Wales in 2009.[1] Reliable suicide statistics are essential to inform and evaluate suicide prevention strategies,[2] highlight changes in rates (perhaps as a result of changing socioeconomic conditions), and detect emergence of new methods of suicide.[3]

Suicide statistics in England and Wales are derived from death certificates issued after coroners' inquests into unnatural or unexpected deaths. Around 30 000 such inquests are held each year, and coroners usually give a "short form" verdict for the cause of death—the most commonly recorded verdicts are accident, natural causes, suicide, industrial disease, and "open."[4] Most deaths given open verdicts are likely to be suicides.[5] However, the legal requirements for identifying suicide (beyond reasonable doubt) differ from the less stringent criteria used by health professionals.[6] Furthermore, some coroners may give open or accidental verdicts in the belief that this avoids adding to a family's distress.[7] For these reasons official suicide statistics produced by the Office for National Statistics (ONS) combine suicide and open verdict deaths.[8]

Suicide statistics have long been recognised as imperfect.[9] Suicides may be especially difficult to identify when methods such as drowning and overdose are used and intent is unclear.[10] Suicide rates are therefore likely to be underestimated, but recent research by the ONS signals a new and growing problem with the accuracy of national data.[11]

Since 2001 a growing number of coroners have summarised their inquest findings with a "narrative verdict"—which records, in several sentences, how, and in what circumstances, the death occurred—rather than giving a short form verdict. The numbers of narrative verdicts increased from 111 in 2001 to 3012 (>10% of all inquests) in 2009[11]; figures for 2010 indicate that numbers are continuing to rise.[4] This growth is thought to be fuelled by recent case law, in particular the Middleton judgment (see box) in relation to deaths in custody and other deaths at the hands of "state agents." Narrative verdicts are intended for use when the coroner wishes to raise matters of public concern. For example, at the inquest into the death by jumping of a young woman while she was in hospital after an overdose it has been suggested that without a narrative verdict "it is doubtful whether any of the inadequacies in procedure, and in the system itself, would have come to light."[12]

However, the use of narrative verdicts now extends beyond circumstances leading to the Middleton judgment—for example, they are being used in cases where the decision is difficult (as an alternative to an open verdict) or where coroners wish to give more detail about a death. This increased use of narrative verdicts has important effects on the estimation of national suicide rates because these verdicts present coding difficulties for the ONS—when suicide intent is unclear such deaths are coded as accidents.[11] The ONS gave the following example in its recent analysis: "Mr x, after being found hanging in his cell at x youth offenders institution on [date], died on [date] at x infirmary. It was a serious omission by x young offenders' institute not to have informed x's parents on each occasion that x had self-harmed. The jury's verdict is that x died from hanging."[11] Because intent was not mentioned, the death was classified as accidental, but suicide is strongly implied.[11] Likewise, in our own research, we have encountered several examples of narrative verdicts that would be difficult for ONS to code. For example, one narrative records that the "Deceased took his own life with an accidental overdose of opiates and paroxetine." Motivation in this case seems to be suicide, but because the possibility of an accident is also suggested, it may be coded as such in the absence of a short form verdict.

The ONS estimates that if all deaths from hanging and poisoning given narrative verdicts by coroners and coded as accidents by ONS were, in fact, suicides, the 2009 suicide rate would have been underestimated by 6%—a difference equivalent to almost a third of the National Suicide Prevention Strategy's 20% reduction target.[2] This may be a conservative assessment because

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Middleton judgment

The Middleton judgment (March 2004) was a House of Lords ruling made after its review of the inquest into the death of Colin Middleton, a 31 year old man who hanged himself in his prison cell in 1999. The original coroner's inquest verdict was quashed because it was found not to be based on a thorough inquiry. At a second inquest in 2000, the jury's concerns that the prison service had failed in its duty of care to the deceased were given to the coroner as a written note, but he did not make the content of the note public. It was judged that, for the state to comply with article 2 of the European Convention on Human Rights, where an inquest was the means by which the state discharged its obligation to initiate an effective public investigation by an independent official body into a death, the inquest ordinarily had to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case. (In the Middleton case itself, the jury had not been given an opportunity to do this, and if it had, there would have been no need for the jurors to submit a note. The use of such private notes was viewed as anathema to the public nature of the proceedings.) The House of Lords' ruling further clarified that under the requirements of the Coroners Act 1988, in some cases coroners should extend their duty to describe "how" (interpreted as "by what means") a death came about, to specifying "by what means and in what circumstances" the death occurred, and this could be done using a narrative verdict. Although narrative verdicts were already used by coroners (albeit infrequently), this ruling is likely to have legitimised an increase in their use. It should be noted, however, that the Middleton ruling post-dated the rise in use of narrative verdicts by three years.

Source: http://www.publications.parliament.uk/pa/ld200304/ldjudgmt/jd040311/midd-1.htm

the ONS's analysis did not include other common methods of suicide, such as drowning and jumping.

As the use of narrative verdicts rises, so too may the underestimation of suicide. The consequences of this could be incorrect rate estimates, misleading evaluations of national and local prevention activity, and masking of the effects of the current economic crisis on suicide. Furthermore, because coroners vary greatly in their use of narrative verdicts,[4] suicide rates may (falsely) seem to decline in areas served by coroners who make most use of such verdicts.

National suicide statistics are crucial to public health surveillance. So, what can be done to restore confidence in their reliability? The ONS is reviewing its coding of narrative verdicts,[11] and—on the basis of the ONS's concerns—the Coroners' Society of England and Wales is investigating how it can improve the current situation (personal communication, ONS). One approach that would ensure the future reliability of national suicide statistics would be for coroners to record both the short form verdict and, where appropriate, accompany this with a longer narrative account of the death. Even if this policy was introduced, suicide statistics for the years when narrative verdicts proliferated should be treated with caution. Changes are needed urgently, but the current government's proposed abolition of the post of chief coroner (created by the 2009 Coroners and Justice Act) is likely to delay the implementation of recommended improvements and the development of consistent practice across the country.

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