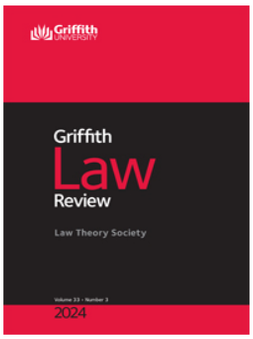

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Mapping coronial discretion in suicide death investigation

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ABSTRACT

This article examines coronial investigations into the suicide deaths of people voluntarily admitted to a psychiatric facility. It focuses on this context of suicide – death following or during voluntary mental health treatment – to unpack how discretionary coronial decision-making around suicide developed in the historical governmentality of death. The evolution of the coronial role following suicide is also situated in broader policy changes around mental health that narrowed the mandated focus of coroners as the mental health sector expanded beyond asylum walls, reordering mandatory scrutiny along the lines of patient status as opposed to institutional site. Considering this history, the article traces how contemporary discretionary coronial decision-making around suicide can therefore disassociate a death from questions of institutional treatment. The article argues that thinking 'institutionally' about psychiatric facilities, whether private or public, as 'sites of state confinement' directs attention to how these sites operate as investigatory vacuums, and how the limited coronial acknowledgement of these institutional sites of 'care and control' supports individualistic views of suicide. By identifying a gap in understanding the social and legal impact of this dimension of discretionary coronial work in Australia, the article contributes to literature on coronial decision-making following suicide.

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Coroner; discretion; suicide; inquest; death investigation; voluntary patient

1. Introduction: coronership and suicide

In Australia, sudden, unexpected, violent and accidental deaths are reportable to coroners, who are legal death investigators responsible for determining the facts of death including cause and circumstances, or manner, of death. To do this, coroners are empowered to hold inquests – inquisitorial, public hearings – and can issue recommendations aimed at preventing avoidable deaths in similar circumstances. Suicide deaths are reportable deaths, however the context of a specific death is relevant to whether an inquest is held. For example, an inquest into the death of a person held 'in care' is statutorily mandated by Coroners Acts and there exists no coronial discretion around holding an

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inquest. In the context of a suicide death, a person admitted as an *involuntary patient* to a facility, detained under the provisions of a Mental Health Care Act, is understood to be the death of a person held in care, and their death is followed by a mandatory inquest. On the other hand, coroners have discretion as to whether they will hold an inquest into a suicide death of a person voluntarily admitted to a psychiatric facility.

This article maps key issues arising from discretionary decision-making following the suicide deaths of people *voluntarily admitted* to a psychiatric facility. Our approach differs from previous scholarship, which has focused on discretionary decision-making and coronial determinations of suicide. We instead centre the use of discretion around whether to proceed with an inquest. Our analysis was precipitated by the appeal judgement in *Childs v Coroners Court of Victoria* (*Childs*).[1] *Childs* concerned the suicide death of a voluntary psychiatric patient – 24-year-old Sean Florrimell – who was being treated at a private psychiatric facility in Melbourne, Victoria when he left the facility and took his own life. In investigating the death, the coroner found no reason to hold an inquest into the cause and circumstances of Sean's death and so exercised his discretion to not hold an inquest and to finalise the investigation. Sean's family appealed this decision, raising concerns around his treatment, including his status as a voluntary patient and mental health services obligations in voluntary contexts. Ultimately, however, the appeal was denied. The judgment in *Childs* gave us pause to consider not only the factors that underwrite discretionary decision-making around suicide deaths in voluntary contexts, but how this discretionary decision-making speaks volumes about coronial power vis-à-vis community interests in contributing to social and legal epistemologies of suicide. Central to this exercise is appraising the wider context of suicide that informs coronial decision-making.

Correspondingly, the article contextualises contemporary coronial discretionary decision-making around suicide in the historical governmentality of death, which positioned the inquest as a crucial forum for scrutinising death and transformed the coroner into an agent of death prevention. This social and legal funnelling saw coroners afforded increased discretion at the same time that death investigation was standardised, such that coronial law and policy both enabled and constrained coronial discretionary decision-making. The significance of these developments for suicide death investigations is further situated in broader policy changes around mental health that narrowed the mandated focus of coroners as the mental health sector expanded. The move from large psychiatric institutions – 'asylums' – to dispersed systems of mental health under deinstitutionalisation[2] reorganised coronial scrutiny of suicide deaths. Crucially, it reordered this scrutiny along the lines of patient status as opposed to institutional site, a distinction galvanised under neoliberal governance and the 'mixed economy' of mental health care.[3] This article examines how, in light of this history, and cases such as *Childs,* coronial investigation can disassociate death from questions of institutional care and treatment when families' seek to centre these concerns. We argue that thinking 'institutionally' about psychiatric facilities, whether private or public, as 'sites of state confinement' directs attention to how these sites operate as investigatory vacuums, and how the limited coronial

[1] *Childs v Coroners Court of Victoria* [2020] VSC 755.
[2] Piers Gooding, 'From Deinstitutionalisation to Consumer Empowerment: Mental Health Policy, Neoliberal Restructuring and the Closure of the 'Big Bins' in Victoria' (2016) 25(1) *Health Sociology Review* 33.
[3] Ibid 40.

acknowledgement of these broader sites of institutional 'care and control' supports individualistic views of suicide, with the corollary that some deaths are diagnosed as 'tragic' but nevertheless 'inevitable' and thus unavoidable. The article first outlines the role of the coroner in Australia when investigating death following suicide. It then outlines the historical significance of the inquest in exposing failures of governance, and the impact of deinstitutionalisation, before unpacking the exercise of discretion in coronial decision-making around inquest following suicide. A discussion section argues for greater scrutiny of death in or proximate to voluntary psychiatric admissions before a brief conclusion.

2. Coronial investigation of suicide

Coroners in Australia are judicial officers who investigate sudden, unexpected, violent and accidental deaths and make statutorily prescribed findings, including the identity of the deceased, time and place of death, cause of death and manner – otherwise known as circumstances – of death: the *who, when, where, what, how*. The types of deaths that coroners investigate are termed 'reportable deaths', and are defined in Coroners Acts throughout Australian states and territories.[4] As part of their investigation, coroners may hold inquests, which are inquisitorial public court hearings, that call and hear evidence. Thereafter, coroners make statutory findings and are empowered to issue recommendations aimed at preventing avoidable death. In specific circumstances, inquests are mandatory, such as following deaths in custody.[5]

Compared to other coronial jurisdictions such as England and Wales, inquests in Australia follow a smaller proportion of reportable deaths.[6] As discussed in the following section, Australian coronial practice has steadily whittled down the number of inquests and their frequency. This is reflected across different categories of cases, with the majority of inquests held being legislatively mandated. In terms of suicide deaths in Australia, this means that matters that commonly proceed to inquest are, as stated, those of a person who before they died, was a person 'held in care' under definitions outlined in Coroners Acts.[7] Significantly, the term 'in care' refers in the context of suicide to *involuntary detention* under relevant mental health legislation. For such deaths, there is no coronial discretion to hold an inquest, and an inquest is mandatory. For example, in Victoria the *Coroners Act 2008* (Vic) defines a reportable death as including 'the death of a person

[4] *Coroners Act 1993* (NT) s 12(1); *Coroners Act 2003* (Qld) s 8; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 3; *Coroners Act 1996* (WA) s 3, *Coroners Act 1997* (ACT) s 13; *Coroners Act 2009* (NSW) s 6; *Coroners Act* (SA) s 3.

[5] The exception is in Victoria, where an inquest following a death in custody is not mandatory if the person died of natural causes: see *Coroners Act 2008* (Vic) s 52(3A). This is not an uncontroversial provision, see, eg, Sarah Schwartz, 'Veronica Nelson's death was cruel and disturbing. So too was the government cover-up', *The Guardian* (online, 20 February 2023) <https://www.theguardian.com/commentisfree/2023/feb/20/veronica-nelsons-death-was-cruel-and-disturbing-so-too-was-the-governments-cover-up>.

[6] See, eg, Hugh Dillon where he writes: 'Most deaths reported to coroners do not result in an inquest. In NSW, about 6,500 deaths are reported annually to coroners (out of a total number of deaths in this State of about 50,000). Between 2012 and 2015, an average of 145 inquests were conducted annually by NSW coroners (about 2 per cent of reported cases). In 2016, only 120 were conducted. In 2017, it fell to only 84 (1.2 per cent). Of those, 26 were mandatory inquests into deaths in custody or police operations', Hugh Dillon, 'A Probe in the System: Medical Inquests in NSW' (2019) January/February 150 *Precedent* 9.

[7] See *Coroners Act 1996* (WA) s 3; *Coroners Act 1997* (ACT) s 3BB; *Coroners Act 2009* (NSW) s 24A(2); *Coroners Act 1993* (NT) s 12(1)(b); *Coroners Act 2008* (Vic) s 3; *Coroners Act 2003* Qld s 9(1)(aa)-(b); *Coroners Act 1995* (Tas) s 3; *Coroners Act 2003* (SA) s 3.

who immediately before death was a person placed in custody or care',[8] or 'the death of a person who immediately before death was a patient within the meaning of the *Mental Health and Wellbeing Act 2022*'.[9] Recognising the vulnerability of persons held in the care of the state, a coroner must hold an inquest into a death if the person was, immediately before their death, a person placed in custody or care.[10] Despite legislative differences across the eight coronial jurisdictions in Australia, this statutory provision is similar, highlighting the significance of scrutinising death that occurs in or immediately after involuntary detention. This scrutiny reflects the importance of coronial investigations following deaths in the context of exercises of state power, and in confinement, such as deaths in custody or following police operations.[11] For deaths where there is no mandated inquest, the coroner holds a discretion to initiate an inquest.

In surveying the current coronial investigatory framework around mental health related deaths, it is clear that some suicide deaths are subject to mandatory coronial inquest scrutiny, while others are subject to the discretion of the investigating coroner. This differential approach to investigating mental-health related deaths needs to be appreciated in the context of the structure and framework of coronial investigations following 'in care' deaths and the significance of what coronial scrutiny brings to meaning-making around death. Specifically, and arguably, coronial case sequalae involves investigation, inquest, findings, recommendations and responses to those recommendations. In some Australian coronial jurisdictions, such as New South Wales (NSW), coroners are not empowered to make preventive recommendations without holding an inquest, meaning that inquests become the central forum for exploring issues of preventability around avoidable deaths, with recommendations formulated and expressed in inquest findings and not in the absence of an inquest.[12]

Suicide death investigations can therefore take radically different forms throughout Australia. There may be an inquest with findings and preventive recommendations; an inquest with findings but no recommendations; and a non-inquest finding – otherwise known as a 'chambers finding' or a finding 'on the papers' – without recommendations or, in some jurisdictions, with recommendations. This latter category is only available as a discretionary option in certain Australian jurisdictions such as Victoria, revealing discrepancies in the exercise of coronial scrutiny of suicide deaths. In Victoria and Queensland, the emergence of detailed non-inquest findings with or without recommendations means that, for some suicide investigations, coronial findings occupy a curious coronial

[8] *Coroners Act 2008* (Vic) s 4(2)(c). The Act stipulates (s 3) that a person placed in custody or care includes 'a patient detained in a designated mental health service within the meaning of the *Mental Health and Wellbeing Act 2022*'. Under s 3 *Mental Health and Wellbeing Act 2022* (Vic) a 'patient' refers to an individual who is subject to a compulsory order for assessment or treatment, or who is a security or forensic patient.

[9] *Coroners Act 2008* (Vic) s 4(2)(d).

[10] *Coroners Act 2008* (Vic) s 52(2)(b). However, it should be noted that in Victoria, the *Coroners Act 2008* (Vic) s 52(3A) provides that if the investigating coroner considers that the death was due to natural causes, they do not have to hold an inquest. See for example Coroners Court of Victoria, *Finding Without Inquest, Cindy Jane Martin*, COR 2020 003618 (Deputy State Coroner Jacqui Hawkins).

[11] *Coroners Act 2003* (Qld) ss 8(3)(g), 10; *Coroners Act 1995* (Tas) s 3; *Coroners Act* (NT) ss 12(1), 12(1A); *Coroners Act 2003* (SA) s 3; *Coroners Act 1996* (WA) s 3; *Coroners Act 2008* (Vic) ss 4, 3; *Coroners Act 1997* (ACT) s 3C; *Coroners Act 2009* (NSW) s 23. See Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press 2006) 224.

[12] An exception is Victoria, where recommendations can be made without inquest: *Coroners Act 2008* (Vic) s 72(2).

terrain. They are often discursive in their consideration of evidence, appearing more akin to findings following an inquest than chambers consideration, and adopt the findings and/or recommendations of other inquiry processes, such as root cause analyses (RCA).[13] In such hybrid processes, evidence is not tested in open court, families' interests potentially remain underexplored, and other review processes (such as RCA) are adopted without additional or contextual scrutiny of contributory matters. These emergent fora are further discussed in section 5.

In terms of meaning-making, at their best coronial inquests are described as sites of accountability, quelling rumour and suspicion, and revealing the truth of a death.[14] For bereaved families, the inquest can be a site for justice and understanding what happened, where lessons are learnt so that no other family suffers what they have.[15] However, research has discussed the problematic dimensions of investigation and inquest, including in suicide cases, and their impact on the bereaved, highlighting how suicide – and its investigative aftermath – is complex.[16] Research has documented concerns with the timing and delay of inquests, poor communication and lack of consultation, lack of cultural sensitivity, the legalistic and formal nature of inquests, their public nature that reveals private details to strangers, media attention, the graphic nature of evidence, the demeanour of coroners and other officials in the conduct of matters, and the finding.[17] Collectively, this research highlights how the coronial inquest can re-traumatise families and communities, producing a range of emotional responses, including apprehension, fear, frustration, guilt, blame, shame, distress, pain, stress and nervousness. When inquests

[13]See, eg, *Non-Inquest Findings into the Death of Mitchell James Follent*, Coroners Court of Queensland 2016/3441 [6 November 2019] (Deputy State Coroner John Lock); *Non-Inquest Findings into the Death of JJKD*, Coroners Court of Queensland 2016/8 [17 August 2017] (Coroner James McDougall).

[14]Marc Trabsky, *Law and the Dead: Technology, Relations and Institutions* (Routledge 2019).

[15]Ed Kirton-Darling, *Death, Family and the Law: The Contemporary Inquest in Context* (Bristol University Press 2022).

[16]Pat Dudgeon and others, *Coronial Responses to Aboriginal and Torres Strait Islander Suicides: Research Report*, University of Western Australia (Research Report, October 2023) 22 <https://cbpatsisp.com.au/wp-content/uploads/2023/10/Coronial-responses-report.pdf>. See also Sarouche Razi, '"Speaking for the Dead to Protect the Living": On Audre Lorde's Biomythography, Law, Love, and Epistemic Violence in the Coronial Jurisdiction in the Kimberley' (2023) 36(3) *Law & Literature* 523. There have been a number of prominent Australian inquests into multiple First Nations suicide deaths, including *Inquest into the Deaths of Thirteen Children and Young Persons in the Kimberley Region*, Western Australia, Coroner's Court of Western Australia 25/2017 [7 February 2019] (State Coroner Rosalinda Fogliani); *Inquest into the deaths of EJ Riley, R Henry, C Atkins, T Beharral, M Brown, J Dick, L Dawson, B Dickens, IB Gepp, OGJ Hale, EJ Laurel, J Middleton, WR Miller, G Oscar, CA Shaw, S Surprise, DK Edwards, NM Cox, D Sampi, L Sampi, TJ O'Sullivan & Z Yamera*, WA Coroner's Court, Western Australia 37/07 [25 February 2008] (State Coroner Alastair Hope). See also Belinda Carpenter and others, 'Coronial Inquests, Indigenous Suicide and the Colonial Narrative' (2020) 29 *Critical Criminology* 527.

[17]See, eg, B.M. Barraclough and D.M. Shepherd, 'Public Interest: Private Grief' (1976) 129(2) *The British Journal of Psychiatry* 109; B.M. Barraclough and D.M. Shepherd, 'The Immediate and Enduring Effects of the Inquest on Relatives of Suicides' (1977) 131(4) *The British Journal of Psychiatry* 400; Daniel Harwood and others, 'The Grief Experiences and Needs of Bereaved Relatives and Friends of Older People Dying Through Suicide: A Descriptive and Case-Control Study' (2002) 72(2) *Journal of Affective Disorders* 185; Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effects of Coroners' Procedures on those Bereaved by Suicide' (2003) 56 *Social Science & Medicine* 1033; Janette M. McKinnon and Jill Chonody, 'Exploring the Formal Supports Used By People Bereaved Through Suicide: A Qualitative Study' (2014) 12(3) *Social Work in Mental Health* 231; Ailbhe Spillane and others, 'How Suicide-Bereaved Family Members Experience the Inquest Process: A Qualitative Study Using Thematic Analysis' (2019) 14(1) *International Journal of Qualitative Studies on Health and Well-Being* 1563430; George Newhouse, Daniel Ghezelbash, and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections From the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76; Dudgeon and others (n 16); KPMG, *Shining a Light on Whānau Experiences of Coroners' Investigations of Suspected Self-Inflicted Deaths: Coronial Investigations Review*, New Zealand Ministry of Health (2023) <https://www.health.govt.nz/publication/shining-light-whanau-experiences-coroners-investigations-suspected-self-inflicted-deaths>. See also Carly Speed, 'As Little Regard in Life as in Death: A Critical Analysis of Subjugation and Accountability Following Deaths in Psychiatric Detention' (2017) 25(1) *Illness, Crisis & Loss* 27.

have been described as enabling clarity and an opportunity for meaning-making,[18] it is because coroners, and medico-legal staff, have been perceived as compassionate, consultative, and informative, where bereaved people are prepared and know what to expect, when inquests are less formal, culturally responsive, and there is a sensitive use of coronial discretionary powers around, for instance, the hearing of evidence.[19] The research therefore consistently highlights the significance of a more 'therapeutic' coronial approach to positive outcomes in suicide inquests.

The research on bereaved experiences of coronial investigations into suicide provides valuable insights into the lived experiences of families, but has seldom considered a family's preference for an inquest where the coroner holds the discretion, or the impact of coronial discretionary decision-making on families for matters that do not proceed to inquest. There exists little academic research into coronial investigations following the suicide of 'voluntary' patients admitted to a psychiatric facility, highlighting a gap in understanding the social and legal impact of this dimension of discretionary coronial work in Australia. To appreciate the coronial function, the next section outlines the role that coroners and the inquest have occupied in transformations of the governmentality of death.

3. Coroners, the inquest and the governmentality of death

The coronial inquest into reportable deaths historically occupied a central role in the administration of justice in a society, even if this history reveals a 'tangled and contradictory' politics around the inquest's ability to account for those responsible for causing death.[20] The modern inquest evolved during the Industrial Revolution as a legal process for holding governments and owners of capital accountable for causing accidental or industrial deaths. Families of the deceased, and communities in general, in the eighteenth and nineteenth centuries, and particularly in England, sought out coroners to expose failures of governance, patterns of negligence and lack of care as the primary cause of a death. The inquest thus came to prominence in the mid nineteenth century in light of increasing industrial deaths due to unsafe work practices, railway accidents caused by faulty trains and hospital deaths linked to unsanitary conditions. It is in this context that the coroner became colloquially known as the 'magistrate of the poor'.[21]

While regard for the coronial role was not only confined to England, and was shared through empire building by settlers in the British colonies, it is important to emphasise the coroner's role in disavowing the investigatory rituals of Indigenous cultures and the insufficiencies of inquests into the deaths of Indigenous people at the hands of colonists in Australia and elsewhere.[22] Coroners were complicit through British colonisation in

[18]Spillane and others (n 17).
[19]Clive Aspin and others, 'Engaging with Whānau to Improve Coronial Investigations into Rangatahi Suicide' (2023) 19(3) *Kōtuitui: New Zealand Journal of Social Sciences Online* 315; Biddle (n 17); Dudgeon and others (n 16); KPMG (n 17); Newhouse, Ghezelbash and Whittaker (n 17).
[20]Joe Sim and Tony Ward, 'The Magistrate of the Poor? Coroners and Deaths in Custody in 19th Century England' in Michael Clark and Catherine Crawford (eds), *Legal Medicine in History* (Cambridge University Press 1994) 262; Edward Kirton-Darling, 'Searching for Pigeons in the Belfry: The Inquest, the Abolition of the Deodand and the Rise of the Family (2014) 14(3) *Law, Culture and the Humanities* 439; Trabsky (n 14).
[21]Sim and Ward (n 20) 245.
[22]Amanda Nettelbeck and Robert Foster, 'Colonial Judiciaries, Aboriginal Protection and South Australia's Policy of Punishing "with Exemplary Severity"' (2010) 41(3) *Australian Historical Studies* 319, 331; Mark Finnane and Jonathan

legitimating the dispossession of Indigenous lands and the violation of Indigenous bodies; inquests were conducted on stolen land and produced little accountability for Indigenous deaths.[23] This history reveals how not all subjects of British colonisation experienced the coroner as a 'magistrate of the poor', a legacy that underscores the profoundly contested nature of accountability in contemporary settler-colonial coroner's courts.[24]

The positioning of the inquest as central to the public scrutiny of governments and corporations took place alongside a shift in the eighteenth and nineteenth centuries from the sovereign's 'right to decide life and death' towards a 'power of life and death'.[25] Transformations of the coronial inquest emerged during a period where governmentality turned its attention away from 'letting live' and 'making death' to creating conditions for fostering a living workforce. In other words, attention moved away from ignoring industrial deaths to improving workplace conditions that make workers more productive. Marc Trabsky has written about how the inquest became part of a new arrangement of *thanato-politics* (politics of death), which aimed at caring for both populations of the dead as well as the living.[26] It was in this period that governments invested in coroners holding inquests to take account of the different ways a person could die, manage fluctuations in mortality rates and bureaucratise the relationships between the living and dead.

It is in this broader context of *thanato-politics* that the inquest functions as a site, as Ian Burney writes, for investigating deaths of societal concern, that is, deaths that have a 'public interest'.[27] On the one hand, these may be the industrial deaths that we discussed above, or deaths that are caused by the abuse of state power, for example, deaths in prison or police custody. But they are also deaths that take place in medical institutions conceived broadly, particularly where there is an unequal power-knowledge relation between the deceased and the medical expert. Gordon Tait and Belinda Carpenter note that this is why the public inquest is 'not just a matter of social and administrative interest' but central to ideas about 'justice and democracy'.[28]

Mandatory public inquests into accidental, industrial and violent deaths evolved in the nineteenth and twentieth centuries as an important legal process in the governmentality of death. However, since the late twentieth century legislation has integrated discretionary decision-making into the role of the coroner. This has partly emerged due to changing attitudes towards death in society, which has resulted in an increase in the number of deaths reported to the coroner, and a decrease in the number of inquests conducted by coroners. First, the rise in reportable deaths, due to changes in medical institutions, such as a reluctance on hospitals or doctors to sign death certificates for people who die of multiple co-morbidities, as well as registration practices, such as the modernisation of procedures for recording a clear cause of death, has substantially increased the caseload

Richards, '"You'll Get Nothing Out of It"? The Inquest, Police and Aboriginal Deaths in Colonial Queensland' (2004) 35(123) *Australian Historical Studies* 84, 91.

[23]Nettelbeck and Foster (n 22); Finnane and Richards (n 22); Trabsky (n 14) 71–73; Helen MacDonald, *Possessing the Dead: The Artful Science of Anatomy* (Melbourne University Press 2010).

[24]Newhouse, Ghezelbash and Whittaker (n 17); Razi (n 16).

[25]Michel Foucault, *The History of Sexuality, Volume 1: The Will to Knowledge*, trans Robert Hurley (Penguin Books 1998) 136.

[26]Trabsky (n 14). See also on thanato-politics, Marc Trabsky, *Death: New Trajectories of Law* (Routledge 2024).

[27]Ian Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest* (John Hopkins University Press 2000).

[28]Gordon Tait and Belinda Carpenter, 'The Continuing Implications of the "Crime" of Suicide: A Brief History of the Present' (2016) 12(2) *International Journal of Law in Context* 210, 214.

for coroners investigating a death. However, rather than increasing funding for coronial jurisdictions, most governments have sought to limit the number of investigations that proceed to inquest through legislative reform.[29] While this has also been justified as states responding to the desires of families for curtailed investigations, resourcing limitations have been a central concern. Second, the transformation of the role of coroner from investigator into public health officer, has affected the number of investigations that proceed to inquest. Indeed, most coronial Acts emphasise the role of the coroner in promoting public health and safety through the making of recommendations for preventing future deaths.[30]

These changes are further contextualised by broader social and legal policy developments concerning mental health in the era of deinstitutionalisation, which had the effect of statutorily narrowing the mandated focus of the coroner in relation to suicide deaths during or following psychiatric admissions, a move that restructured mandatory coronial scrutiny according to patient status as opposed to institutional site. This change represented a departure from early coronial law in the Australian colony, when the consolidation of common law into the *Coroners Act 1865* (Vic) required coroners to hold inquests into prison and asylum deaths.[31] Mandatory scrutiny of asylum deaths persisted until the 1950s, when social and legislative language began to shift from 'asylums' and 'lunatics' to 'mental hospitals' and 'patients'.[32] Scholars have charted distinct periods of mental health policy and legislative reform, including the notable post-war welfare state initiative of deinstitutionalisation which sought to destigmatise mental illness and reimagine mental health patients as 'consumers', delineating those capable of seeking temporary treatment via 'voluntary' admission.[33] This era heralded a greater distinction between the notion and status of voluntary and involuntary patients which was correspondingly reflected in legislation, including the Coroners Act.[34]

Deinstitutionalisation and the consequent community dispersal of mental health care was hastened under neoliberalism, with economic rationalism driving privatisation and deregulation of the mental health sector at the same time that governments advanced the language of rights.[35] Amid the push in the 1990s to mainstream psychiatric services, further legislative changes repealed Mental Health Act provisions for voluntary admissions.[36] These changes confirmed the 'individualisation' of mental health consumers in a human rights era,[37] who paradoxically confronted a lack of choice and access to

[29]See for example the *Coroners Act 1996* (WA) ss 19A and 25(1A), which limit the number of cases that could proceed to an inquest.

[30]*Coroners Act 2008* (Vic) ss 8, 72(2); *Coroners Act 1997* (ACT) s 52(4); *Coroners Act 1993* (NT) s 26(1)(b), 34(2); *Coroners Act 1996* (WA) s 25(2); *Coroners Act 2009* (NSW) s 82(1)-(2); *Coroners Act 2003* (Qld) s 46(1)(a)–(c); *Coroners Act 2003* (SA) s 25(2); *Coroners Act 1995* (Tas) s 28(2), (3).

[31]This provision was not uncontroversial, including in England, see Sim and Ward (n 20); Burney (n 27).

[32]See e.g., *Coroners Act 1865* (Vic) s 4 compared to *Coroners Act 1958* (Vic) s 6(1)(a).

[33]Mark Finnane, 'From Dangerous Lunatic to Human Rights? The Law and Mental Illness in Australian History' in Catharine Coleborne and Dolly MacKinnon (eds), *'Madness' in Australia: Histories, Heritage and the Asylum* (University of Queensland Press 2003) 30.

[34]See, e.g., *Mental Health Hygiene Act 1958* (Vic) which differed from the *Mental Health Hygiene Act 1953* (Vic) in distinguishing between 'patients' and 'voluntary boarders'. This change flowed through to coroners by consolidating coronial scrutiny on people compulsorily detained. The *Coroners Act 1958* (Vic) refers to people 'detained in any mental hospital within the meaning of the *Mental Hygiene Act 1958*' s 6(1)(a), which the *Mental Hygiene Act 1958* s 3(1) defined as 'any house building or place provided by the State for the reception of insane persons'.

[35]Gooding (n 2).

[36]E.g., *Mental Health (Amendment) Act 1995* (Vic) s 10.

[37]Finnane (n 33) 30.

services, and inadequate support.[38] Together, these social and political changes finally confirmed the coroner's focus on involuntary patient deaths, decentring the significance of institutions, and consolidating patient status as the organising principle of mandatory scrutiny, where the deaths of voluntary patients were consigned to coronial discretion. The next section unpacks the contemporary exercise of discretion in coronial decision-making around inquest following suicide.

4. Coronial discretion and suicide inquests

The discretion to hold an inquest is open where the coroner does not 'suspect the death was the result of homicide' or where the deceased was not 'immediately before death, a person placed in custody or care'.[39] This effectively empowers coroners with absolute discretion for holding or dispensing with an inquest where they suspect the death was the result of suicide, which is the opposite to England, where public inquests are mandatory for all suicide deaths. The powers of discretion have undermined the nineteenth century concept of the coroner as the 'magistrate of the poor' and they have further integrated the coroner as both a conduit and an instrument in bureaucratising relations between the living and the dead. The coroner actively decides what kind of deaths matter for public scrutiny, and thus manage in the context of *thanato-politics* how investigations into causes of death can be exploited to foster a living workforce.

The issue of coronial discretion is significant when considering the preventive potential of coronial insight following suicide. The exercise of coronial power is underwritten by statutes that prescribe coroners to complete certain tasks and findings and yet at the same time those statutes confer considerable discretion in the decision-making process. Of course, coronial decisions have their fullest effect in the lives of the bereaved, including decision-making around post-mortem examinations, scope of inquest and inquest management. But as Hugh Dillon reflects, the coronial decision which has ostensibly the 'greatest impact' on the bereaved is the decision to hold, or not hold, an inquest.[40] It also has a bearing on how society understands deaths in its midst. This is echoed in coronial research on the specific issue of discretionary inquest decision-making. As Simon Walter et al note in a study of factors predicting coroners' decisions to hold discretionary inquests, while the 'vetting process for determining which cases are subject to a discretionary inquest is invisible', coronial decisions 'may influence the public's understanding of risks, fatal injuries and untimely death'.[41] They add that 'because the investigations and recommendations generated by inquests are the centerpiece of the coroner's role in preventing untimely deaths, the vetting process can shape their contribution to public health and safety'.[42] How and on what deaths coroners choose to focus their attention clearly and undoubtedly shapes the inquest's role in the governmentality of death.

[38]Gooding (n 2).
[39]See, eg, *Coroners Act 2008* (Vic) ss 52(2)(a) and (b).
[40]Hugh Dillon, 'A Three-Cavity Autopsy of the NSW Coronial System: What's Going on Inside?' (2019) Autumn *Bar News: The Journal of the NSW Bar Association* 9, 11. See also Shannon Chapman, 'The Coroner's Exercise of Discretion: Are Guidelines Needed?' (2008) 12 *Australian Indigenous Law Review* 103.
[41]Simon J. Walter and others, 'Factors Predicting Coroners' Decisions to Hold Discretionary Inquests' (2012) 184(5) *CMAJ* 521, 521.
[42]Ibid.

The modern paradox of coronial discretion around inquests is that it is 'virtually unfettered'[43] but nonetheless, in practice, restricted. While restrictions are reflected in the evolution of early Australian coronial bureaucracy as outlined by Trabsky, who notes that 'discretion was limited by standardised procedures',[44] the contemporary context sees issues such as mandatory inquest caseloads and resourcing impact on discretionary inquest decision-making. Coroners have expressed frustration that their caseloads are being dominated by mandatory inquests, which curtails their capacity to conduct discretionary inquests.[45] This is borne out in the number and type of inquests held, including delay and backlog issues with mandated matters and under-resourcing of the coronial jurisdiction, as outlined in parliamentary inquiries.[46] Of significance too is the inconsistent practice of guiding coroners around discretionary decision-making. Some jurisdictions provide guidance to coroners concerning the exercise of their discretion, while others do not.[47]

Simon Walter et al's research into the factors involved in coroners' decision to hold discretionary inquests across five Australian jurisdictions between 2000 and 2007 revealed that the odds for conducting an inquest were lowest for suicide deaths.[48] Of 6822 suicides there were 61 discretionary inquests held,[49] with coroners disproportionately unlikely to hold suicide death inquests.[50] While a focus on the number of discretionary inquests and the causes of death they investigate are useful statistical indicia of coronial practice, recent research has addressed additional troubling issues contextualising suicide deaths and the corollary of such low odds. One issue is the predominance of Aboriginal and Torres Strait Islander peoples in suicide statistics. Those figures indicate that the rate of First Nations suicide deaths is approximately two and a half times higher than for non-Indigenous Australians.[51] Citing Walter et al's research in their report into the coronial investigation of Indigenous suicide, Pat Dudgeon et al note that where coroners make discretionary decisions to not hold inquests, 'opportunities for prevention of Indigenous suicides are overlooked in public coronial processes'.[52] Moreover, coroners 'may be unable to publicly explore systemic factors that may contribute to Indigenous suicides'.[53] This is a critical gap given research details the contribution of colonisation, intergenerational trauma and contemporary disadvantage and discrimination to suicide among First Nations people.[54]

[43]Dillon (n 6) 12.
[44]Marc Trabsky, 'The Coronial Manual and the Bureaucratic Logic of the Coroner's Office' (2016) 12(2) *International Journal of Law in Context* 195, 206.
[45]Dudgeon and others (n 16) 22.
[46]See submissions and oral evidence to the Joint Committee on Children and Young People, Parliament of New South Wales, *Prevention of Youth Suicide in New South Wales* (Report 5/56, October 2018); Legislative Council, Parliament of New South Wales, *Select Committee on the Coronial Jurisdiction in New South Wales* (Report, April 2022).
[47]For example, Queensland provides express legislative guidance to coroners in regard to exercising their discretion whether or not to hold an inquest into a death: *Coroners Act 2003* (Qld) s 28.
[48]Walter and others (n 41) 521.
[49]Ibid 525.
[50]Ibid 526.
[51]Australian Institute for Health and Welfare, *Suicide and Self-Harm Monitoring: Deaths by Suicide Among First Nations People*, (13 March 2024) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>.
[52]Dudgeon and others (n 16) 22.
[53]Ibid.
[54]Pat Dudgeon, Tom Calma, and Christopher Holland, 'The Context and Causes of the Suicide of Indigenous People in Australia' (2017) 2(2) *Journal of Indigenous Wellbeing* 5.

The reference here is also to discretionary decision-making around the scope of coronial investigations. With respect to First Nations people, issues of scope are receiving greater attention both outside and inside coronial courts.[55] Central is the recognition that inquest scope following the deaths of First Nations people has hitherto been limited, and excluded deeper consideration of colonisation and its effects, and that this is now rightfully changing.[56] Correspondingly, submissions to the *Select Committee on the Coronial Jurisdiction in New South Wales* (NSW Select Committee), such as that of legal advocacy organisation the National Justice Project, specifically voiced concerns over the coronial gap in knowledge around Indigenous suicide deaths, and characterised the corresponding coronial failure to address systemic issues as an inability that 'prevents the entire jurisdiction from being able to respond to the needs of systemically oppressed groups'.[57] The National Justice Project pointed out the need to avoid presumptions that 'a person died by suicide and that is all we need to know'.[58] Such an approach 'sends the message that systemic discrimination and the intergenerational trauma felt by First Nations people is not suspicious – that nothing is wrong'.[59] These observations should also be appreciated in the context of community and government recognition that Indigenous suicide is a public health priority.[60]

Notwithstanding the issues raised above, the use of discretion for holding or dispensing with an inquest in the situation of the suicides of voluntary patients in a mental health facility also produces inconsistency in family's experiences of coronial investigations. Stephanie Jowett, Belinda Carpenter and Gordon Tait have focused on discretionary decision-making on coronial determinations of suicide[61] and they have shown that a finding of suicide has not been approached in a consistent manner. This is significant due to both the relationship between coronial determinations of suicide and how they feed into suicide statistics, but also the relationships between coroners and families, and their complex emotions for both resolution and revelation. Carpenter and Tait have shown how suicide has moved from being a sin against God – and thus illegal – to an

[55]Rebecca Scott Bray, 'Contested Death and the Coronial Jurisdiction' in Marc Trabsky and Imogen Jones (eds), *The Routledge Handbook of Law and Death* (Routledge 2025) 209–25; Fiona Allison and others, 'Coroners Courts and Death Investigations' in Marg Camilleri and Alistair Harkness (eds), *Australian Courts: Controversies, Challenges and Change* (Springer International Publishing 2023) 247, 254; Dudgeon and others (n 16) 22–24.

[56]*Inquest into the Death of Naomi* Williams, Coroners Court of NSW 2016/2569 [29 July 2019] (Deputy State Coroner Harriet Grahame); *Finding into Death with Inquest, Tanya Louise Day*, Coroners Court of Victoria COR 2017 6424 [9 April 2020] (Deputy State Coroner Caitlin English); Northern Territory Government, Department of the Attorney-General and Justice, Kumanjayi Walker coronial inquest (Web Page) <https://justice.nt.gov.au/attorney-general-and-justice/courts/inquests-findings/kumanjayi-walker>.

[57]National Justice Project, Submission No 27 to Select Committee, Legislative Council, *Select Committee on the Coronial Jurisdiction in New South Wales* (12 July 2021) 10, 12, 25–26. See also Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission No 31 to Select Committee, Legislative Council, *Select Committee on the Coronial Jurisdiction in New South Wales* (12 July 2021) 5; Legislative Council, Parliament of New South Wales (n 46) 79.

[58]National Justice Project (n 57) 26.

[59]Ibid.

[60]See Australian Institute for Health and Welfare, *Suicide and Self-Harm Monitoring: Deaths by Suicide Among First Nations People* (13 March 2024) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>. See also the establishment of the Australian Institute for Health and Welfare, Indigenous Mental Health and Suicide Prevention Clearinghouse <https://www.indigenousmhspc.gov.au/>.

[61]Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *University of New South Wales Law Journal* 355; Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law: A Comparative Study of Coronial Practice' (2019) 42(2) *University of New South Wales Law Journal* 534; Gordon Tait, Stephanie Jowett and Belinda Carpenter, 'Coronial Decision-Making and the Management, Classification and Conceptualisation of the Finding of "Suicide"' (2020) 25(3) *Mortality* 297; Belinda Carpenter and others, 'Coronial Determination of Suicide: Insights from Inquests' (2024) 29(1) *Mortality* 108.

indicator of the 'health and well-being of the population'.[62] Discretionary decision-making has therefore been informed by coroners interpreting familial desires, transformations in laws, norms and public health and their own understanding and responses to cultures of suicide.[63] What in fact counts as a suicide is subject to the discretionary powers that coroners have in making a determination.

As outlined above, the decision as to whether to proceed with an inquest when investigating a suicide death is an important exercise of coronial discretion. Families seek coronial inquests to investigate how unequal power-knowledge relations between medical institutions and voluntary patients can exert subtle forms of control.[64] Research has revealed that families have extensive knowledge of their loved one's mental ill health circumstances, are actively involved in advocating for them, and often collect information about trajectories of illness and treatment for the coroner.[65] Their lived experience means families witness how medical institutions both exercise control, but may neglect their duties as people travel between voluntary and involuntary patient categories with their attendant differences in treatment and monitoring. Such issues are revealed through appellate jurisprudence around coronial discretionary decision-making following suicide – such as in the matter of *Childs* – which, notably, constitutes one of the few sites where familial frustration at coroners' decisions to not hold an inquest is publicly revealed and documented. With the economic (and emotional) costs of legal action precluding abundant litigation on such issues, many families suffer in silence and their concerns can be edged out of view. These matters have implications for understanding how coroners and inquests operate in the governmentality of death in the twenty-first century, and the epistemic injustice that potentially flows from the form and outcome of coronial death investigations following suicide.[66]

5. Discussion: meeting the threshold for coronial scrutiny

This discussion section identifies key issues that flow from coronial discretion to not scrutinise suicide deaths of voluntary patients. One issue is that, in placing voluntary patients 'out of care' – even when voluntary patients suicide during treatment or immediately after discharge – the coroner decentres families' experiences of psychiatric work and the mental health supervision of their relative. As noted above, families often possess extensive information about their loved one's health and treatment history, are often

[62]Tait and Carpenter (n 28) 213.

[63]Tait and Carpenter (n 28). Scholars have also outlined the tensions in historical legal discourse around suicide verdicts, examining the role – and influence – of medical professionals and family and friends of the person who died in inquests, see Robert Allen Houston, 'Explanations for Death by Suicide in Northern Britain During the Long Eighteenth Century' (2012) 23(1) *History of Psychiatry* 52; Georgina Laragy, '"A Peculiar Species of Felony": Suicide, Medicine, and the Law in Victorian Britain and Ireland' (2013) 46(3) *Journal of Social History* 732. It is also worth noting that it is unlawful for NSW coronial findings of suicide to be published unless a coroner considers publication is in the public interest and makes a publication order: *Coroners Act 2009* (NSW) ss 75(5) and (6). This issue is addressed in the New South Wales Statutory Review of the *Coroners Act 2009* (NSW): NSW Department of Communities and Justice, *Statutory Review: Report of the Statutory Review of the Coroners Act 2009* (2023) 81. Recommendation 41 of the Statutory Review notes the s 75 provision perpetuates the stigma around suicide. See also John Abernethy and others, *Waller's Coronial Law and Practice in New South Wales* (4th ed, Lexis Nexis Butterworths 2010) 199 [75.1].

[64]See, eg, *Childs v Coroners Court of Victoria* [2020] VSC 755.

[65]Jennifer Manuel, 'Coroners' Recommendations and Suicide Prevention in Specialist Mental Health Services' (PhD Thesis, University of Otago 2016); Jenni Manuel and others, 'Suicide Prevention in Mental Health Services: A Qualitative Analysis of Coroners' Reports (2018) 27(2) *International Journal of Mental Health Nursing* 642.

[66]Razi (n 16).

actively involved in supporting and advocating for their relative throughout treatment, or picking up the pieces in between mental health admissions, and this is matched following death by the information they collate to assist the coroner in their decision-making.[67] In circumstances where families seek but are denied an inquest, the coronial deference is to statutory provisions, patient status and ideas of 'public interest'. In practical terms, this trajectory is further shored up by reference to specialist services that assist the coroner – such as the Victorian Coroners Prevention Unit – that assess cases and provide advice to the coroner about a range of matters, including clinical treatment history and family concerns.

Writing at the time of the Brodrick Committee report in England and Wales in the mid-1970s, and recognising the issues thrown up by a suicide inquest, such as causing 'gossip' and reinforcing 'stigma', Barraclough and Shepherd note that 'when death takes place in an institution, whether residence is enforced or not, a public enquiry may be the best way of clearing the air: it is important that a coroner's inquiry without inquest should not be suspected of hushing up inconvenient facts'.[68] How then might we reconceptualise institutional deaths in the context of suicide and coronial investigation? Specifically, how might we place the psychiatric facility along a continuum of institutional violence that warrants closer coronial scrutiny regardless of patient status? Bree Carlton and Joe Sim identify that the typical focus of critical research and activism on sites of state confinement is the prison or police custody.[69] They challenge this locus to advocate for capturing a range of satellite institutions as sites of state confinement, both public and private, including psychiatric facilities. 'Confinement' criteria include the deprivation of liberty, including in sites where *de facto* detention occurs, such as care homes, hospitals, low security units and supported living services.[70] While the focus turns on definitions around deprivation of liberty which appears at first glance to exclude voluntary patients, we argue a number of important issues emerge.

Firstly, we propose rethinking the effects of confinement and the nexus between confinement, treatment and death. As Carlton and Sim themselves argue, expanding what we understand to be sites of state confinement highlights the complexity of lived realities across different sites of detention, and requires attention to 'sectoral and organisational level practices and cultures' and the 'micro-exercises of power' across diverse sites.[71] Given evidence that contact with mental health services prior to suicide is common,[72] revising how we categorise and understand sites of confinement as opposed to

[67]Aspin and others (n 19); Manuel, 'Coroners' Recommendations and Suicide Prevention' (n 65); Manuel and others, 'Suicide Prevention in Mental Health Services' (n 65).
[68]Barraclough and Shepherd, 'Public Interest' (n 17) 112.
[69]Bree Carlton and Joe Sim, 'Deaths in Sites of State Confinement: A Continuum of Routine Violence and Terror' in Sue Read, Sotirios Santatzoglou and Anthony Wrigley (eds), *Loss, Dying and Bereavement in the Criminal Justice System* (Routledge 2018) 54, 57.
[70]Ibid 55.
[71]Ibid 57.
[72]Dasamal Tharanga Fernando, Angela Clapperton and Janneke Berecki-Gisolf, 'Suicide Following Hospital Admission for Mental Health Conditions, Physical Illness, Injury and Intentional Self-Harm in Victoria, Australia' (2022) 17(7) *Plos One* e0271341. Fredrik A. Walby, Martin Øverlien Myhre and Anine Therese Kildahl, 'Contact with Mental Health Services Prior to Suicide: A Systematic Review and Meta-Analysis' (2018) 69(7) *Psychiatric Services* 751; Janet Meehan and others, 'Suicide in Mental Health In-Patients and Within 3 Months of Discharge' (2006) 188 *The British Journal of Psychiatry*, 129; Carsten Rygaard Hjorthøj and others, 'Risk of Suicide According to Level of Psychiatric Treatment: A Nationwide Nested Case-Control Study' (2014) 49 *Social Psychiatry and Psychiatric Epidemiology* 1357; Trine Madsen and others, 'Predictors of Psychiatric Inpatient Suicide: A National Prospective Register-Based Study' (2012) 73 *Journal of*

patient status is crucial. These issues are also important to consider in light of the effects of death on clinical staff, and evidence from the literature that suicide causes bewilderment, anger, guilt, anxiety and lack of confidence in clinical staff.[73]

Instrumentally, confinement in mental health contexts needs to be understood as dynamic. For instance, patient status can change from voluntary to involuntary – with a corresponding shift in detention status and thus control. The significance of this can be appreciated in the context of a status change dramatically altering the coronial investigatory pathway from discretionary decision-making around inquest to mandatory inquest hearings.[74] Importantly, mental health services are charged with the ability to detain someone under the Mental Health Act, and in some cases, families are critical post-death that this decision was not taken to protect their relative. It is evident from coroners legislation throughout Australia that in the event of a suicide death, sites of state confinement are linked to patient status and also type of facility. We argue that thinking about psychiatric facilities as sites of state confinement more broadly has the dual effect of contemplating how deaths in or proximate to these sites might instigate coronial scrutiny – when, and under what circumstances? – and reconciling how currently, after death, they largely exist as investigatory vacuums, free from coronial scrutiny because of statutory provisions.

Alternatively, and conversely, what can we observe about the significance of deaths outside of detention – immediately after, or during voluntary admission – and the scrutiny these deaths receive? Literature on deaths outside of custodial settings is instructive. As Jake Phillips, Loraine Gelsthorpe and Nicola Padfield note, deaths outside of a secure custodial setting, whether deaths after release, under probation supervision, or after police custody, receive less attention and scrutiny than deaths in secure custody.[75] Deaths outside of custodial settings are typically subject to investigatory discretion,[76] however, as Phillips, Gelsthorpe and Padfield argue, such deaths should not be ignored.[77] Instead, greater knowledge about non-custodial deaths would 'allow for a more critical look at the effects of mass supervision on those being supervised as well as society more broadly'.[78] In attending to investigatory, research, legal, and policy neglect around these deaths, Phillips, Gelsthorpe and Padfield propose an 'ethic of care': '[w]hile criminal justice agencies have a duty of care to the people they supervise, an ethic of care goes further than this … which holds care or benevolence as central to moral action'.[79]

Clinical Psychiatry 144; Jason B. Luoma, Catherine E. Martin and Jane L. Pearson, 'Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence' (2002) 159(2) *American Journal of Psychiatry* 909.

[73] J. D. Little, 'Staff Response to Inpatient and Outpatient Suicide: What Happened and What Do We Do?' (1992) 26(2) *Australian and New Zealand Journal of Psychiatry* 162.

[74] Such was the case following the death of 34-year-old Melissa Gaultier, who was a voluntary patient when she absconded from Latrobe Regional Hospital. Melissa was then made subject to an Assessment Order, converting her patient status to involuntary and her coronial status to a 'person placed in custody or care' under s 3 of the *Coroners Act 2008* (Vic), mandating an inquest into her death pursuant to s 52(2)(b) of the Act: Coroners Court of Victoria, *Finding into Death with Inquest, Inquest into the Death of Melissa Gaultier*, COR 2017 1792 [29 June 2022] (Coroner Audrey Jamieson) 10 [26].

[75] Jake Phillips, Loraine Gelsthorpe and Nicola Padfield, 'Non-Custodial Deaths: Missing, Ignored or Unimportant?' (2019) 19(2) Criminology & Criminal Justice 160 <https://doi.org/10.1177/1748895817745939>. See also Equality and Human Rights Commission, *Non-Natural Deaths Following Prison and Police Custody: Data and Practice Issues* (Research Report 106, 2016) <https://www.equalityhumanrights.com/sites/default/files/non-natural_deaths_following_prison_and_police_custody_2.pdf>.

[76] Phillips, Gelsthorpe and Padfield (n 75) 166.

[77] Ibid 174.

[78] Ibid 171.

[79] Ibid 171–72.

Following this framework, an ethic of care proposes that lines of accountability are strengthened through a fuller understanding of deaths that occur during or following institutional contact. In the context of mental health related deaths, this means situated learning from deaths following institutional contact and treatment, rather than the assumption against inquest due to patient status.

Relatedly, we argue that the limited coronial acknowledgement of broader sites of institutional 'care and control' ultimately supports individualistic views of suicide. Ostensibly, focusing on the voluntary status of detention as opposed to *detention itself* shifts the onus away from mental health services to the patient, responsibilising the person who has died, and also to an extent, their family. If such deaths do not meet the threshold for inquest, we suggest coronial discretion reiterates a view that some deaths are 'inevitable'.[80] Reflecting specifically on the over-representation of Aboriginal and Torres Strait Islander peoples in suicide deaths, a view of the inevitability of certain deaths recalls Sherene Razack's work on Indigenous deaths in custody. Razack examines the coronial process following Aboriginal deaths in custody as one which focuses on pathologising Aboriginal peoples rather than scrutinising the fatal exercise of colonial power, a move which naturalises preventable death as inevitable.[81] The settler moves of the inquest subsequently render Aboriginal deaths as 'timely rather than untimely'.[82] Such ideas not only dispense with core coronial aspirations around public health and death prevention, but signify how, as we discussed earlier, death investigation has a key role in the governmentality of death. This governmentality continues to evolve, including in seemingly paradoxical ways, such as when suicide deaths are tracked via suicide registers with the aim of greater understanding coming from surveillance[83] but also pass into the coronial archive without substantive scrutiny. As outlined by the submission of the National Justice Project to the NSW Select Committee, '[s]uicides should be presumed to be preventable deaths where an inquest would be useful, even where a person has a history of suicidal ideation'.[84]

When positing an 'ethic of care' at an institutional site,[85] including the coroner's inquest with its preventive potential, Sherene Razack's analysis also reminds us that we need to be

[80]Carpenter and others (n 16); Belinda Carpenter, Gordon Tait and Stephanie Jowett, 'The Inevitability of Suicide for Aboriginal Australians' in Said Shahtahmasebi and Hatim A. Omar (eds), *The Broader View of Suicide* (Cambridge Scholars Publishing 2020) 316.

[81]Sherene H. Razack, 'Timely Deaths: Medicalizing the Deaths of Aboriginal People in Police Custody' (2013) 9(2) *Law, Culture and the Humanities* 352. See also Sherene Razack, *Dying From Improvement: Inquests and Inquiries into Indigenous Deaths in Custody* (University of Toronto Press 2015).

[82]Razack 'Timely Deaths' (n 81) 353. See also Mandi Gray, 'Pathologizing Indigenous Suicide: Examining the Inquest into the Deaths of CJ and CB at the Manitoba Youth Centre' (2016) 10(1) *Studies in Social Justice* 80; Travis Hay, 'Foreclosing Accountability' (2018) 78 *Canadian Review of Social Policy* 1; Alison Whittaker, "'Dragged Like a Dead Kangaroo': Why Language Matters for Deaths in Custody', The Guardian (online, 8 September 2018) <https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody>; Tracy Westerman, 'Why don't Indigenous suicides matter?', *Indigenous X* (online, 5 March 2019) <https://indigenousx.com.au/why-dont-indigenous-suicides-matter/>; Tracy Westerman, 'Indigenous Expert responds to WA Govt Indigenous Suicide Prevention Plan', *Indigenous X* (online, 23 March 2020) <https://indigenousx.com.au/enough-lip-service-where-is-the-accountability/>.

[83]See, eg, Australian Institute for Health and Welfare, *Indigenous Mental Health and Suicide Prevention Clearinghouse* (15 November 2023) <https://www.indigenousmhspc.gov.au/>; Australian Institute for Health and Welfare, *Suicide and Self-Harm Monitoring: Suicide Registers* (13 March 2024) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suspected-deaths-by-suicide>; Australian Institute for Health and Welfare, *Suicide and Self-Harm Monitoring: Data from Suicide Registers* (13 March 2024) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suspected-deaths-by-suicide/data-from-suicide-registers>.

[84]National Justice Project (n 57) 26.

[85]Phillips, Gelsthorpe and Padfield (n 75) 171–72.

attuned to the 'benevolent' settler state seeking sanctuary through illusory reparative coronial work.[86] As Razack surmises, the inquest showcases settler benevolence, and repair may well be the 'enduring colonial mode'.[87] Critically assessing the evolution of death investigation and its influence in understanding different genres of death therefore means examining the quality of coronial attention as much as decreases in inquest numbers and lapses in coronial scrutiny, not only statutory provisions around 'in care' deaths. Evaluating the contemporary coronial role around investigating suicide also needs to locate death investigation in its broader social and political landscape. Accordingly, we ask whether a perspective of 'inevitable' death accords with government policy and suicide prevention efforts, and whether it promotes a systemic and systematic absence of scrutiny and learning following particular deaths. If, as mentioned, clinical research demonstrates that contact with mental health services prior to suicide is common,[88] then the role of institutional settings in the circumstances of suicide deaths proximate to service use can yield preventive lessons.

In practice, the coronial investigation of suicide leads to radically different case sequalae. As outlined earlier in this article, suicide deaths can be subject to an inquest with findings and preventive recommendations, an inquest with findings and no recommendations, a non-inquest 'chambers' finding without recommendations, or, in select jurisdictions, a non-inquest finding with recommendations. In terms of non-inquest findings such as those produced by coroners in Victoria and Queensland, with their often substantive discursive narration of evidence and findings, it is worth asking whether this new coronial practice is edging out the relevance of the public inquest as traditionally conceived. This is not a trivial question; as stated earlier in this article, the public inquest is central to ideas of justice and democracy.[89] Questions then arise as to the purpose and function of inquests, and decisions to not hold inquests, in light of these emergent hybrid processes. Conversely, while the capacity of coroners to make preventive recommendations without inquest might be regarded a positive development, when nominal progress is not evaluated or reflected nationally such capacious coronial discretion signals a troubling inconsistency in an important area of contemporary death prevention. If the centrality of the public inquest is receding, the argument for alternative, restorative processes and conferences that embrace and consider the concerns of families seems ever more pressing, including in light of this article.[90] To do so potentially aligns coronial work with restorative practice, otherwise risking a contracting and diminishing role for the coroner in society.

Considering the above, appreciating the broader discussions about death investigation and coronial reform as it bears on the issue of suicide and coronial discretion is critical. The 2021 NSW Select Committee made a number of observations about discretionary coronial

[86]Sherene H. Razack, 'Both Sorry and Happy: Inquests into Indigenous Deaths in Custody' in Chris Cunneen and others (eds), *The Routledge International Handbook on Decolonizing Justice* (Routledge 2023) 251.
[87]Ibid 252–53. See also Razack, 'Dying from Improvement' (n 81).
[88]See Fernando, Clapperton and Berecki-Gisolf (n 72); Walby, Myhre and Kildahl (n 72); Meehan and others (n 72); Hjorthøj and others (n 72); Madsen and others (n 72); Luoma, Martin and Pearson (n 72).
[89]See Greg Martin and Rebecca Scott Bray, 'Discolouring Democracy? Policing, Sensitive Evidence, and Contentious Deaths in the United Kingdom' (2013) 40(4) *Journal of Law and Society* 624; Rebecca Scott Bray, 'Executive Impunity and Parallel Justice? The United Kingdom Debate on Secret Inquests and Inquiries' (2012) 19 *Journal of Law and Medicine* 569; Rebecca Scott Bray and Greg Martin, 'Closing Down Open Justice in the United Kingdom?' (2012) 37(2) *Alternative Law Journal* 126.
[90]Michael S. King, 'Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model' (2008) 16(3) *Journal of Law and Medicine* 442; Dudgeon and others (n 16) 31–32.

inquest powers. Without explicitly addressing the issue of discretionary inquests in its recommendations, the Select Committee did cite submissions from a range of organisations to note the deleterious effects of a lack of resources and funding for the coronial jurisdiction. Not only does this lack contribute to delays in finalising mandated inquest matters, but the knock-on effect of such 'backlogs' is that scarce coronial resources are funnelled into mandated matters leaving little room for discretionary matters which may otherwise receive coronial scrutiny.[91] This is a key implicit takeaway from the Select Committee's rehearsal of issues with an under resourced jurisdiction in its report. The committee correspondingly recommended increasing resources and funding, including establishing a standalone NSW coroner's court with specialist coroners; a reform that has the aim of maximising the jurisdiction's contribution to public health and safety via death prevention which necessarily includes, per the Select Committee's report, the issue of discretionary inquests. This view reflects the *thanato-political* role of the coroner for suicide, given 'it is coroners who historically have decided how the notion of suicide is practically conceptualized, where its boundaries lie, which deaths are to be adjudged a suicide, and how these deaths are actually recorded. In short, "the truth" of suicide lies with the coroner'.[92]

Coupled with historical considerations of the role of the inquest in the governmentality of death and contemporary discussions about discretionary elements of coronial decision-making outlined in section 4 of this article, which highlight how questions of resourcing underwrite the jurisdiction in the twenty-first century, it is apparent that discretionary coronial decision making around inquest is exercised in particular social, political and economic contexts. Coroners are watchdogs of public health and safety, jurisdictionally focused on death prevention, but they perform this role in climates of fiscal restraint and resource contraction with cascading implications for their time and attention. These considerations bring texture to the issue of coronial discretion following suicide, and demand greater attention to systemic issues in suicide death investigation as opposed to mere tweaks in statutory frameworks around patient status.

6. Conclusion

In this article we have examined how, for suicide deaths following voluntary patient status, the coronial investigation of suicide can disassociate the death event from questions of institutional care and control in not proceeding with inquest. In these circumstances, the death event can be perceived by families as clearly related to issues of lack of care and neglect in an institutional setting, yet the circumstances of death are interpreted differently by coroners. Thinking 'institutionally' about psychiatric facilities, whether private or public, as sites of state confinement asks us to extend our view of how these institutions operate as investigatory vacuums following voluntary patient suicide, and how the consequent limited coronial acknowledgement of these sites of 'care and control' buttresses individualistic views of suicide.

Given social and legal discourses of suicide are shaped by the institution of the coroner, we argue that the implications of resourcing and efficiency for the contemporary coronial

[91]Legislative Council, Parliament of New South Wales (n 46) 27, 37, 55, and 37–38 at [2.84].
[92]Gordon Tait and Belinda Carpenter, 'Suicide, Statistics and the Coroner: A Comparative Study of Death Investigations (2015) 51(3) *Journal of Sociology* 553, 555–56.

role around preventable death occurring in circumstances of 'care' are far-reaching. A diminution of coronial scrutiny enabled by resource contraction represents the continued incursion of neoliberalism into death investigation, once again rearranging *thanato-politics* for a new era. In this landscape, where privatised lives and selves are responsiblised rather than accountability prevailing around institutional practices of 'care and control', arguably we witness the emergence of a 'post-care society'.[93] Such a society may deem certain deaths, such as some suicide deaths, as 'tragic' events but nevertheless regard them as 'inevitable' and thus unavoidable. Considering the significance of suicide as a concern in society,[94] inconsistent or inadequate scrutiny of suicide deaths may further contribute to a twenty-first century governmentality of death meted out along lines of economic value, neo-liberal managerialism and temporal efficiency that contextualises and weighs the interests of justice and the public against the costs of coronial scrutiny. But at what cost?

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[93]The term 'post-care' is drawn from Greg Martin, *Social Movements and Protest Politics* (Taylor & Francis 2023) 5, 336.
[94]See, for example, Mental Health Commission of New South Wales, *Shifting the Landscape for Suicide Prevention in NSW* <https://www.nswmentalhealthcommission.com.au/shifting-the-landscape> including the updated *Strategic Framework for Suicide Prevention in NSW 2022-2027*, *Shifting the Landscape for Suicide Prevention in NSW: A Whole-of-Government Strategic Framework for a Whole-of-Community Response 2022-2027*.