Problems with the coronial determination of 'suicide'

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Keywords: suicide, coroners, sociology, governance, definitions, Wittgenstein

Mortality

(7089 words)

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Abstract

After over 100 years of constant dissatisfaction with the accuracy of suicide data, this paper suggests that the problem may actually lie with the category of suicide itself. In almost all previous research, 'suicide' is taken to be a self-evidently valid category of death, not an object of study in its own right. Instead, the focus in this paper is upon the presupposition that how a social fact like suicide is counted depends upon norms for its governmental regulation, leading to a reciprocal relationship between social norms and statistical norms. Since this relationship is centred almost entirely in the coroner's office, this paper examines governmental, definitional, and categorisational issues relating to how coroners reach findings of suicide. The intention of this paper is to contribute to international debates over how suicide can best be conceptualised and adjudged.

Introduction

'Suicide rates' are rightly deemed to be of profound significance. At an individual level, they are an aggregated numeric reminder of personal and family tragedy; at a suicidological level, they are the dominant currency though which the discipline largely operates; and at a broader social level, they continue to be used as 'objective measures' of the health of the social body, and more usually, given cohorts within that social body (Georgatos 2013).

Given the governmental and academic importance of these statistics, logic would suggest that, as far as social statistics go, these should be considered reliable. However, the best evidence suggests that this is not the case, with suicide rates being heavily questioned by almost all involved in the field. Researchers generally point to ongoing systemic underestimations of anywhere between 15% to 50% (De Leo 2007; Walker, Chen and Madden 2008; Crepeau-Hobson 2010; Chapple,

Ziebland and Hawton 2012; Tait and Carpenter 2013a)—making such rates 'not only unreliable but useless for the purpose to which they are put in sociological research' (Green 1992). Given the ongoing 'problems' with suicide data, there have been numerous attempts to address the issue of coronial underestimation of suicide (Harrison, Abou Elnour and Pointer 2009; De Leo et al. 2010)—to the extent that, for example, the Australia Bureau of Statistics now attempts to compensate for such 'underestimation' issues, *post-facto.*

This poses the question: if so many are dissatisfied with existing calculations of suicide rates, why not do something about it? The answer here is that within almost all jurisdictions based upon English Common Law, an official finding of suicide can only be made by a coroner, and it is these coronial determinations alone which provide the data for suicide statistics. Historically, it is coroners who have decided how the notion of suicide is practically conceptualised, where it's 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, and for a complex set of historical, social, and pragmatic reasons, it is a conclusion they are often reluctant to reach (Tait and Carpenter 2013a).

This paper is not simply another attempt at improving the quality of coronial suicide data, and hence the 'accuracy' of suicide rates—instead it will be based upon the insight that after over 100 years of constant dissatisfaction with suicide data (Durkheim 1897), the problem may actually lie with the coronial construction of suicide itself. 'Suicide' is most frequently understood as a self-evident and valid category of death, and as a vehicle for addressing other social and personal issues, not an object of study in its own right (Fairburn 1995; Cholbi 2011). This paper does not share this presupposition, instead asking the question: *to what extent, and in what ways, are statistical calculations of suicide dependent upon its coronial determination*? This is of crucial importance because, as Rose (1991, 676) states, '… such numbers do not merely inscribe a pre-existing reality. They constitute it.' After all, how a social fact like suicide is counted depends on the norms and concepts that determine what counts as suicide in a given setting, or for certain purposes. That is,

suicide statistics do not measure the actual incidence of suicide, rather they only measure what is counted and labeled as such.

In the area of law and government, the determination of various measures of the 'social body' depends upon norms for its governmental regulation, leading to a reciprocal relation between social norms and statistical norms or measures of distribution of events in a population (Hacking 1982, 1991; Foucault 1984). In the specific area of suicide, this nexus of social norms and statistical measurement is centred in the coroner's office, which makes it the prime surface on which the social fact of suicide is measured—and hence the best location for any effective analysis of its conceptualisation and adjudgment. This paper will begin the process of staking out some of the central elements of that analysis.

Suicide Rates and Coronial Practice

Recent research into various aspects of coronial practice has pointed to three specific issues that affect the likelihood of coroners reaching a finding of suicide, and hence the formulation of suicide rates (Tait and Carpenter, 2013a; 2013b; 2014). These issues relate to the coronial governance of suicide, to how suicide is defined within the coronial system, and to how suicide can be practically categorised by coroners. By addressing these in turn, it becomes possible both to better understand the role played by the coroner's office in relation to the gatekeeping of suicide data, and also to raise some questions about the manner in which the notion of suicide is actually operationalised, with the aim of opening up some conceptual space for re-evaluating of how we approach self-inflicted deaths.

Governmental Issues

From the inception of the role in the 11th century, one of the central responsibilities of the coroner has been to investigate deaths 'considered worthy of inquiry' (Burney, 2000, p. 3). This included deaths such as those by accident, those where there is some suspicion of wrongdoing, and those by suicide. Though investigation

these deaths remain central to its function, the social and political contexts within which the coroner's role functioned was subject to considerable and continual change from feudal times onwards, and by the end of the 18th century, it began to be seen as a largely administrative task, one that formed part of the effective administration of the populace. This should not come as a surprise since, around this time, new forms of social regulation and governance were in the process of fundamentally reshaping the social order, with the social body being transformed from an undifferentiated mob, into a workable and readily governable population (Foucault, 1977). While this process began in a fairly modest way, it enabled disparate organs of government to sketch out a preliminary map of some of the most important contours of community life. These contours included, for example, how many people lived in given locations, how they were employed, how they lived, how long they lived, and importantly for the purposes of this paper, how they died.

Over the ensuing two hundred years, mortality rates have proven to be one of the most important statistics within the management of populations, principally because the health of the population has rapidly become one of the central functions of the exercise of political power—that is, providing a social milieu that promises physical well-being, health, and optimal longevity. As Foucault (1984, p. 277) states: 'The imperative of health: at once the duty of each and the objective of all'. Consequently, as the nineteenth century progressed, characterized by what Hacking (1982) refers to as 'an avalanche of printed numbers', it became possible to know—and *important* to know—when people died, how they died, where they died, and how many died by their own hand. After all, a healthy population is not a population with a high suicide rate. Following this logic, the issue of suicide became the focus of immense concern towards the end of the nineteenth century, culminating in the publication of Durkheim's seminal sociological text, *Suicide* (1897), amongst several others.

1) Suicide as pathology

The important issue here is that the concern for the health of the population did not stop with simply policing external manifestations of ill-health, leading to death. As

Rose (1985; 1990) contends, the health of the mind was now also to be subject to governmental intervention and regulation. The rise of the various psy-disciplines (psychology, psychiatry, psychoanalysis) denotes the emergence of a new rationale for government targeting human individuality. Just as the physically ill became sub-divided into more precise and workable categories, so too were the mental faculties of the population, and as such, more and more conduct became explained away as pathology. This has particularly been the case with the issue of self-inflicted death.

It is now the case that acts of intentional, fatal self-harm are most frequently immediately positioned as indicators of the pre-existence of particular pathological identities—'the manic depressive', 'the schizophrenic', 'post-traumatic stress disordered', 'the anorexic', and so on—in what Marsh (2010, 85) refers to as a 'compulsory ontology of pathology'. Moreover, such deaths are now most frequently located within simplistic modernist binaries: suicide/not suicide, sane/mentally ill—all neatly packaged for the effective administration of death. The converse of this assumption is that if someone was demonstrably *not* mentally ill, then it is far less likely that their death will be categorised as a suicide, irrespective of the actual circumstances of that death.

The central problem here lies in the fact that such positioning leads to very familiar scripts for coroners about what constitutes an acceptable, recognizable suicide—most notably pre-existing mental health issues, but also the presence of a suicide note, a history of previous attempts, the probably lethality of method choice—all of which are factored into the coronial decision-making process when deciding whether a particular death is to be counted as a suicide (Carpenter et al., 2009). The difficulty here is that these 'scripts' of suicide do not necessarily fit some social cohorts at all, such as with many Indigenous deaths, where traditional epistemologies of 'mental illness' often have little to contribute to post-facto explanations regarding the decision to end life (Tatz, 2004, 2005). The scripts for these deaths can be very different indeed, and under such circumstances these death may be far less likely to be adjudged as suicides, and hence remain missing from the official statistics.

2) Therapeutic jurisprudence

The second issue relating to the governance of suicide concerns the multiple roles Coroners now have with regard to suicide investigations. In addition to their principal role as fact finders for the states' record keepers, coroners are now also expected to generate policy suggestions for the purpose of social management and the prevention of future harm. More recently still, coroners have also been allocated, or perhaps more accurately, have allocated themselves a role in the process of giving closure to grieving families. These three distinct roles often sit uncomfortably alongside each other (Tait and Carpenter, 2014).

The concern for the feelings of bereaved families—often a highly visible and vocal presence within the process, with most lobbying against findings of suicide (Tait and Carpenter 2013a)—can lead to a reluctance by the coroner to reach such a finding, which in turn has a direct effect on suicide rates. While coroners have always been aware of the social stigma surrounding a finding of suicide, this ongoing reluctance may now constitute a component of what Freckleton (2008, 576) refers to as the rise of 'therapeutic jurisprudence', understood as 'the study of the role of the law as a therapeutic agent'. This sense of responsibility for the wellbeing of the family of the deceased has significant implications for the coroner's principal role: accurately informing the state as to cause of death. Within therapeutic jurisprudence, the law is not simply a set of codes to be followed without reflection; legal institutions, and those charged with making them work, are now deemed to have some responsibility for the mental and emotional wellbeing of all participants. King (2008, 4) has been quite explicit in his call for an increasingly therapeutic approach to Coronial practice:

> Coroners' work is intimately connected with well-being—a concern of therapeutic jurisprudence. Part of the Coroner's role is to determine whether there are public health or safety issues arising out of the death and whether any action needs to be taken to remedy any problems, particularly those that may cause future deaths … Moreover, the dead

person's family suffer grief and, depending upon circumstances of the death, significant trauma.

According to this logic, it would be insufficient for a Coroner to reach a finding within a suicide inquest, without considering how this finding might impact upon those left behind by the death. Coroners would no longer be regarded, or regard themselves, as mere functionaries in the process of recording death statistics, but rather they would have a therapeutic role to play in the emotional and psychological health of their wider communities. This is not to say that the trauma of losing a loved one cannot ever be exacerbated by being told the truth about it, but it does suggest that the Coroners responsibilities lie beyond simply determining the cause and circumstances of death.

In summary, while there is a wide range of possible governmental problems surrounding coronial determinations of suicide, two have been identified here as being of particular importance; first, recognizing that there appears to exist a 'compulsory ontology of pathology' within the coronial system. This pre-supposition that medical/psychological explanations of intentional, self-inflicted death necessarily supersede all others, results in a recurrent perceptual set among coroners about which deaths are unlikely to be suicides, as they do not fit the familiar script. Second, there is an ongoing governmental problem concerning a practical determination of the principal responsibilities of the coroner regarding suicide**.** If coroners are now deemed to have responsibilities as part of the social apparatus of 'therapeutic jurisprudence', these responsibilities often act in contradiction to their traditional role regarding the administration of death. Arguably, these two governmental problems significantly impact on suicide rates within systems of coronial death investigation.

The next issue relates not to the governance of intentional, self-inflicted death, but to how that needs to be conceptualised in order for it to be defined as suicide. Furthermore, it involves the degree to which various types of slippage occur when implementing those definitions.

Definitional Issues

Silverman (2006) argues that prior to the development of any kind of coherent approach to appropriate and consistent determinations of suicide, there needs to be a commonly agreed idea of what is actually meant by the term. He contends that there are currently at least fifteen commonly referenced definitions, beginning with Durkheim's seminal description, which is: 'all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result' (1897, 44). In addition to these fifteen, suicide is also defined differently by the Australian Bureau of Statistics (ABS 2011), by the World Health Organisation (OECD 2009), and within the Operational Criteria for the Determination of Suicide (Rosenberg et al. 1988); there are various re-workings of Durkheim (Douglas 1967), definitions which include self sacrifice and refusal of medical treatment (Beauchamp 1978), definitions founded in analytic philosophy (Hill 2011), and literally dozens of others (Schneidman, 1985). As Schneidman (1985, 15) states, 'All have wrestled with the topic of the definition of suicide without anyone (to be straightforward about it) pinning the idea to the conceptual mat for long enough for a suicidological referee to call a clear win.'

One of the key points made by Silverman is that how suicide is conceptualised is largely determined by the disciplinary affiliations, and the belief systems, of the people making the definition, and while there may be some similarities, definitions tend to cluster according to the domain, epistemological assumptions that support them:

> Most of these definitions are theoretically bound, representing perspectives from sociology, psychiatry, psychology, public health, and philosophy, amongst others. These definitions have essentially defined suicide in one of three ways: a deliberate act of self-destruction that results in death; a conscious self-directed act with the intent to die; or a

> willful self-inflicted life-threatening act resulting in death. (Silverman 2006, 521)

Not only do these three generalized definitions, to no little degree, have their origins within different disciplines, they have very different implications for what may, or may not, be classified as a suicide. The final definition—a willful self-inflicted life-threatening act resulting in death—can encompass as far greater range of deaths than can the other two. For example, it could be argued that base-jumping from a tall building, or overdosing on narcotics, are both covered by this definition.

The point here is that the indeterminacy regarding conceptualisations of suicide is of more than abstract importance when dealing with the production of suicide statistics. Goldney (2009) also notes that while issues of family sensitivity about recordings of suicide, insurance considerations, and state or religious sanctions against suicide have all been significant in shaping coronial findings, differences in the types of definition employed are particularly important, and need to be factored into ensuing calculations. After all, while the final decision as to the circumstances of death lies with the coroner (who is most frequently legally trained, but in some instances may be a medical doctor) information from medical professionals also usually constitutes an important component of the eventual finding, as do 'common-sense' understandings of whether the deceased actually killed themselves. As Goldney points out, all three of these domains—legal, medical, common sense—operate according to very different principles. That is, legal definitions of suicide require sufficient evidence of intent in order to rise to the necessary standard, which itself varies according to jurisdiction; clinical definitions are solely on the 'balance of probabilities' and would include most deaths from poisoning, even though these would not rise to a legal standard; and while the notion of 'common sense' structures much of the context within which these deliberations occur, this will still 'get short judicial shrift' when it comes to actual legal processes (Chamber 1989, 181).

In addition to the various different operational definitions of suicide, and to the different approaches to these definitions that can function within the coronial system, there are other issues that affect how coroners reach their finding, as they pertain to suicide. The most significant of these involves a high degree of slippage between coroners as to precisely what constitutes a suicide. That is, agreement over which definition to use, and to the standards that should be applied to that definition, do not immediately translate into an objective, consistent, and valid system of assessment for intentional, self-inflicted deaths.

Tait and Carpenter (2014) address some of the issues surrounding coronial practice in England and Australia and they have found that inconsistency between coroners is endemic in both systems. These inconsistencies operate in a number of ways. First, there are inevitably differing levels of experience among coroners. These differences are then reflected in their ability to manage the complexities of procedure, evidence and family bereavement, and translate these complexities in relation to particular definitions of suicide. In addition to this, there are differing levels of ability, types of training, and levels of resourcing, especially within the English coronial system. All these factors militate against uniformity of coronial judgment.

Second, and relating directly to the notion of 'therapeutic jurisprudence' discussed in the previous section, some coroners understand their primary roles through the lens of this judicial philosophy; others regard themselves to a far greater extent as simple functionaries in the process of garnering accurate death statistics. These two divergent approaches to the job necessitate a different relationship with dominant conceptualisations of suicide, with the former adopting a seemingly less rigorous application of those conceptualisations than the latter. That is, two separate coroners may share the same conceptualisation of suicide, but if they are not prepared to apply that definition in the same way, for jurisprudential reasons, then, further slippage necessarily occurs.

Finally, even where agreement over a definition of suicide exists, as well as a common jurisprudential philosophy, there is still a lot of inconsistency between coroners as to how that definition is applied. For example, though often clearly defined, 'intent' can be taken as central to any given definition, peripheral to it, or even ignored altogether. As one Australian coroner stated: 'If someone dies falling from a roof, and they didn't slip, and weren't pushed, then as far as I'm concerned, it's suicide.' (Tait and Carpenter 2013b, 10). In terms of articulating a particular definition of suicide, this statement would garner only limited support from other coroners.

In summary, conceptualisations of suicide vary according to the knowledges that seek to explain it, as well as with the norms and purposes informing the institutions designed to know and regulate it. After all, there is no such thing as a 'true' definition of suicide. The task of social research then is instead to map its operational conceptualisation, which in countries like England and Australia directly equates to its coronial conceptualisation. The complexity of this process is then compounded by the differential ways in which coroners filter the circumstances of any particular death through the prism of any chosen definition.

Categorising Issues

The final issue is perhaps the most fundamental and far-reaching. Difficulties with the notion of suicide extend beyond its effective governance, and issues relating to its definition, into the ways in which self-inflicted death can most effectively be categorised. In Australia, the governmental task of differentiating suicide from other forms of death is managed by coroners according to a civil standard of proof—'on the balance of probabilities'—as opposed to the United Kingdom, which still operates on the criminal standard of 'beyond a reasonable doubt'. However, precisely what any of this means is open to interpretation by different coroners, in different jurisdictions, as applied to different groups, in different contexts. Thus, the central issue becomes, not simply one of definition, but rather one of setting the

administrative boundaries of the category. It will be argued now that there are three possible routes forward from here:

1) Categories of certainty

One of the central elements of all definitions of suicide is the concept of *intention.* The three generalized definitions discussed earlier all involve intent, whether it is the actual term itself, as in 'intent to die', or some corollary of the term, such as 'deliberate', or 'willful'. The issue is of fundamental importance because it is the notion of 'intent' that separates a death by 'suicide' from one categorized as 'accident'.

The problem here is that 'intention' remains an elusive and much-contested component of coronial investigations into possible suicides, with De Leo et al (2004, 29) referring to it as 'the most contentious aspect of the definitional debate on suicide and non-fatal suicidal behaviours'. Andriessen (2006) points to a range of problems with the issue, including the assertion that it is too vague a notion to be included in any valid definition, that suicidal people can have a range of intentions at the same time, that intentions can shift throughout the course of a suicidal event, and that suicidal people can be ambivalent as to the outcome of an act where death is a significant possibility.

Given these inherent difficulties, it is perhaps not surprising that coroners often find themselves unable to reach a finding of suicide with the prerequisite standard of certainty—that is, 'beyond a reasonable doubt' in the United Kingdom, or 'on the balance of probabilities' in Australia. The suggestion here is that rather than continue to accept a single binary—suicide/not suicide—a graded determination of suicide could be more effective (De Leo et al. 2010). That is, the category of 'suicide' should be replaced by three alternative categories, based upon probability: 'possible suicide', 'probable suicide', and 'suicide, beyond reasonable doubt'. By adopting a system such as this, not only might the thorny issue of 'intent' be significantly reduced as an ongoing conceptual limitation within the fabric of suicidology, it might also allow the processes of coronial suicide determinations to be more nuanced and,

following the logic of 'therapeutic jurisprudence', somewhat less confronting for bereaved families.

2) Additional categories of self-inflicted death

The ongoing problems over the nexus between intent and suicide have led to a second set of proposals, ones that do not focus on levels of certainty *per se,* but rather upon the likelihood of death as an outcome of particular conduct. To put it another way, rather than retaining suicide as the only category of intentional, self-inflicted death, and grading the likelihood of this being the case, such proposals introduce various preliminary categories of self-inflicted death, one where intent may be uncertain, but death still a highly probable outcome of a given act.

A number of suggestions have been made regarding this preliminary category of self-inflicted death. Farberow (1980) introduced the concept of 'indirect suicide' as a way of explaining a wide range of different types of conduct, none of which would rise to the level of suicide as used in dominant discourse, let alone to the levels required by the coroner's office. These forms of behaviour include activities as diverse as those involved becoming morbidly obese and smoking, dangerous criminal and deviant conduct, and participation in very high-risk sports. These arguments were extended by Schneidman (1981; 1985), who used the term 'subintentional deaths', which encompasses 'perhaps a majority of all deaths in which the deceased played a covert, partial, latent, unconscious role in hastening his own death' (1985, 21). In placing these deaths within the same conceptual terrain as more traditional notions of suicide, Schneidman is not trying to downplay the significance of the differences—such as in comparing an emphysemic person who continued to smoke, with someone who chooses to hang themselves—rather he is simply pointing to the existence of a continuum of self-destructive behaviours.

While staying within the same problematic, Cholbi (2007) looks more specifically at actions that could result directly in death. In the same way that intentional killing of someone else, murder, correlates to the intentional killing of oneself, suicide, Cholbi advocates for the development of a new category that correlates with

manslaughter—the *accidental* killing of someone else; he calls this new category 'self-manslaughter'. These deaths might include those where intentions are unclear, though death is a very likely outcome, or where the person engaged in the act is indifferent to its consequences—a possible example might be driving at high speed down the wrong side of the road. In advocating for this change, Cholbi's suggestion is that this provides a viable classification for what would otherwise most likely be categorised by coroners—in the absence of additional evidence—as an accident.

> Suicide is a painful and enigmatic phenomenon no matter what, but classificatory schemes that force self-inflicted deaths into the binary of suicide or accidental death (or leave hard cases 'undetermined') do little to lift the veil on the complex intentions and rationales that lie behind suicidal behaviour. (Cholbi 2007, 157)

The point here is that if death can be regarded as a highly probable outcome from a given high-risk action—be that lethally dangerous driving, falls from height, or various forms of self-poisoning—coroners may be more willing to reach a finding of 'self-manslaughter', and families accept this finding, than simply one of 'suicide'. These deaths could then be factored in to suicide statistics in ways that at least do not find them omitted in their entirety.

3) Suicide, language games, and family resemblances

In addition to the possible introduction of categories of certainty, as well as the option of a second, subordinate category of suicide, one final alternative is to problematize the category of suicide, as it currently stands, in its entirety. That is, rather than continually seeking ways of improving the administrative clarity of suicide as a type of death—enhancing its coronial governance, clarifying and standardizing its definition, sharpening its legal boundaries—perhaps the best way forward is to accept that the notion of 'suicide', as it is popularly conceptualised, is fundamentally incapable of operating in the ways required of it: an exclusive signifier for an unproblematic signified.

The ‘ordinary language’ philosophy of Wittgenstein offers a framework for expanding upon this contention. According to Wittgenstein (1953), words such as ‘suicide’ are not to be examined in isolation, but only as components of sentences, deployed within given contexts. Language is best understood as a collection of activities that operate in the same way as a game; the rules of the game do not have inherent meaning, but rather are there simply to make the game work. Furthermore, each game has different rules. Lycan (2000) makes the comparison with a game of chess. Just as rooks or bishops are defined by the rules that both regulate where they start on the board, and how they are allowed to move, so too are linguistic expressions, such as ‘Hello’, ‘Excuse me’, and ‘Thanks’. These are conventional devices associated with greeting, apologising and thanking respectively; they are specific sounds with functional roles, such that there are appropriate and inappropriate times to use them, combined with appropriate and inappropriate responses. Therefore, in the final analysis, meaning is simply the function an expression performs within a given social context.

By the same reasoning, a particular meaning does not reside within the term ‘suicide’ that allows it to be hooked onto a correlating natural essence, rather its meaning emerges from its use within a given sentence. When the term suicide is used within clinical practice, this does not necessarily operate according to the same rules of the game as when the term is used by a coroner, or when it is spoken by a lay-person in general conversation. The meaning of the term ‘suicide’ is not to be found by looking for some essence of meaning within the word itself, instead Wittgenstein proposes it is to be found by understanding the rules of the game regarding its specific deployment, in these cases, most usually charting the boundary between the medical and the legal, the normal and the pathological, and the governmental and the colloquial.

Wittgenstein extends this logic to other parts of his philosophy on language and meaning, and in particular, his work on ‘family resemblances’. This refers to an understanding of language that connects particular uses of the same word, so that rather than seeking a single essence that defines the meaning of a word, the meaning

is shaped within a series of overlapping similarities, with no necessity that any single similarity is common to all. He uses the example of the fibres of a tread, in that 'the strength of the thread does not reside in the fact that one fibre runs through its whole length, but in the overlapping of many fibres' (Wittgenstein 1953, 66). Notions such as 'suicide' can also have inherently fuzzy boundaries and lack specific defining features. What they contain is an animating mental prototype that contains all the crucial elements of the category, and correlates fairly directly with the notion of the thread, comprised of various fibres—for fibres, read; 'uses of the term suicide, within the various language games which employ it'—none of which are singularly essential to the integrity of the whole.

Accordingly, 'suicide' should best be understood within the context of particular language-games. Their associated meanings are assembled, fibre by fibre, into a polythetic thread, a fuzzy cluster of family resemblances, lacking an essential core, but still permitting a generalised conception to emerge. 'Suicide' does not have neat hermeneutic boundaries, with a corresponding essence in nature, it is rather a term that only gains a meaning when placed in context, and which can be applied comfortably to phenomena that share a sufficient number of the fibres of the nominal thread, less well so to those that do not.

This is precisely the argument employed by Windt (1981), who contends that, ultimately, suicide is an 'open textured' concept, one that cannot simply be reduced to an analysis of necessary and sufficient conditions. As such, 'suicide' is simply a term that represents, in a Wittgensteinian sense, a set of loose family resemblances, one that may not fit well with the neatly-bounded classifications expected within contemporary governance. Windt's studies of suicide led him to conclude that:

> Cases of suicide may be found which are definitional, in the sense that they really are the characteristics by virtue of which an event is a suicide, but which are neither necessary nor sufficient conditions for an event's being a case of suicide—that is, for each characteristic, cases of suicide may be found which do not have the characteristic, and cases may be

> found of the event which have the characteristic but are not cases of suicide. (Windt 1981, 39-40)

All that can be expected then is a set of usages of the word 'suicide', that through numerous family resemblances, allow us to assemble a thread capable of holding itself together effectively. However, as Durkheim (1897, 41) already observed on this issue, when it comes to trying to understand what a 'suicide' is: 'we risk distinguishing what should be combined, or combining what should be distinguished, mistaking the real affinity of things.'

Marusic (2004) is raising exactly this concern when he asks whether suicidologists are prone to Fregoli's illusion—the delusional belief that a number of different people, all different in appearance, are actually the same person. In asking this question, Marusic is suggesting that perhaps the term suicide has never been broad enough to cover the almost boundlessly diverse circumstances of death that it is required to encompass. As he states: 'Can one's definition of suicidality be sent in a letter across the Pacific and be really understood as written when mailed, or does the message in the bottle somehow get lost?' (Marusic 2004, 145). Or perhaps more pertinently, can a single message ever be sufficient?

The point here is that the recurrent 'problem' of suicide research may actually lie with the concept of suicide itself, how the category is constituted, what actions the word 'suicide' can appropriately be applied to, and what we expect of it. Consequently, what may be required is an acceptance of greater indeterminacy for the category of suicide than is currently the case. Within coronial practice in England, there is a growing use of narrative verdicts. This gives the circumstances of death, without locating that death in a single explanatory category, such as suicide. This type of verdict is popular with coroners, as it means that they do not have to reach a formal finding in the traditional sense; it is popular with the families of the deceased, as there is no formal adjudgment of suicide, with its associated stigma and guilt. In one sense, the narrative verdict is a practical recognition of the often-inherent indeterminacy and 'open-textured' nature of suicide as a category of death.

It is perhaps an acceptance of the Wittgensteinian argument that notions such as 'suicide' necessarily have no discernable central essence, and very fuzzy boundaries. Unfortunately, the flip side of this argument is that narrative verdict add yet further to existing systemic underestimation of suicide within national statistics (Carroll et al., 2011)—one of the driving rationales for writing this paper in the first place.

Conclusion

The argument here is that three factors—governmental issues, definitional issues, categorising issues—provide a vocabulary of ways of beginning the process of rethinking the notion of suicide, specifically within coronial systems. Rather than simply restructuring some of the peripheral issues of suicide determination—consistency of death report forms, coding protocols—this paper seeks to find ways of first problematising, and then reshaping, the existing parameters of the category itself.

Few would dispute that we need to take some significant steps towards the development of suicide statistics more capable of withstanding comprehensive scrutiny. The first step towards this goal would be a better understanding of how pathologising scripts of suicide dominate all other coronial explanations of suicidal behaviour, determining what should, and what should not count as suicide. In addition, it is necessary to clarify the role of the coroner with regard to reaching a finding of suicide, given the contradictory governmental imperatives operating within the office. Few would also dispute the need for coherent and consistent benchmarks within the discipline of suicidology for operationalising the notion of suicide. Currently, even within a single National jurisdiction such as Australia, suicide is largely operationalised according to piecemeal local protocols and practices (De Leo et al. 2010; Tatz, 2005). Finally, it is hoped that this paper can contribute to the debates over how suicide can best be conceptualised and adjudged. After all, few within the field are satisfied with the reductionist modernist binary of suicide/not suicide that currently appears to provide the only option. Of late, such debates

appear to have stalled, and arguably what is required is some fresh impetus in what is one of the most crucial of all areas within the discipline of suicidology.

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