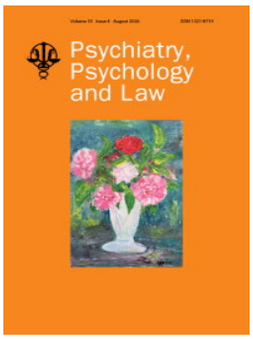

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Suicide in the Australian and Aotearoa New Zealand legal professions: distilling lessons from the coronial jurisdiction

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This article analyses coroners' cases involving suicide by members of the legal profession in Aotearoa New Zealand and Australia. Little research has been undertaken on coronial recommendations, and few studies have investigated coronial cases about suicide. The article suggests that wellbeing in the legal profession is significantly impacted by structural and organisation failings that can, in the worst circumstances, lead to suicide. Coroners in both jurisdictions have a statutory public health purpose. Through their recommendations, coroners can play a powerful role in preventing suicide and improving wellbeing. Although the cases clearly illustrated the structural issues faced by legal practitioners, many of the coroners' comments focused on their individual characteristics and life factors. The coroners did not make recommendations in any of the cases. We argue that this is a missed opportunity to utilise the coronial preventive power to enhance wellbeing in the legal profession and prevent suicides.

Keywords: coroners; coronial recommendations; legal profession; legal workplace; public health; suicide; wellbeing.

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Introduction

This article analyses coronial cases in which there has been a suicide by members of the legal profession in Aotearoa New Zealand (Aotearoa) and Australia. The article distils lessons from the cases, with a particular focus on the coronial preventive function. Little research has been undertaken on coronial recommendations in Australasia generally, and few studies have investigated coronial recommendations in cases of suicide.[1] The article suggests that wellbeing in the legal profession is significantly impacted by structural and organisation failings that can, in the worst circumstances, lead to suicide.

Coroners in Aotearoa and Australia have a statutory public health purpose.[2] They are tasked with preventing deaths and promoting justice. Through their recommendations, coroners can play a powerful role in preventing suicide and improving wellbeing.[3] Prior research demonstrated that coronial recommendations have prevented deaths in a range of contexts such as road accidents and farming injuries.[4] In Aotearoa, the suicide data web tool (which draws from coronial and *Te Whatu Ora* (Health New Zealand) data) releases annual information about suicides. In the 2023–24 financial year, there were 617 suspected self-inflicted deaths.[5] This data is organised by ethnicity, sex, age group, district

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and deprivation quintile, but not occupational group. In the United States, 10%–12% of lawyers have contemplated suicide.[6] Similarly, in Australia, about 11% of lawyers have suicidal ideation.[7]

To analyse coroners' preventive potential to decrease workplace distress and prevent suicide in the legal profession, we searched for relevant cases from 2013 to 2023 on the coronial websites in Aotearoa, Victoria, New South Wales and Queensland. We selected these three jurisdictions in Australia because they are populous states, and Victoria is recognised in the literature as a gold standard coronial system. We identified five Australasian coronial cases involving suicide of legal professionals. Two of the cases (Case A and Case B) were not available on the coronial services website or the New Zealand Legal Information Institute. We obtained these cases from the Aotearoa Coronial Services Unit in November 2023. We were aware of these cases because of media reports. The first two cases involved Aotearoa legal professionals, including a criminal defence lawyer (Case A)[8] and a District Court Judge (Case B).[9] The remaining cases were from Australia, including two magistrates at the Magistrates' Court of Victoria (Case C)[10] and (Case D)[11] and a principal in-house solicitor in Victoria (Case E).[12]

Although there were only five cases, they provided rich insight into the culture of legal workplaces and the circumstances in which the suicides occurred. Several structural workplace features were common across the five cases. All the deceased had: enormous workloads; complex cases; unmanageable deadlines; high personal and public performance expectations; and reported professional isolation with limited management support.[13] Although the cases clearly illustrated the structural issues they all faced, many of the coroners' comments focused on their individual characteristics and life factors. The coroners did not make recommendations in any of the cases. We argue that this is a missed opportunity to utilise the coronial preventive power to enhance wellbeing in the legal profession and prevent suicides.

The next section provides a brief overview of coronial jurisdictions in Aotearoa and Australia, focusing on their statutory public health purpose, including in relation to suicide. The article then defines wellbeing and explores how its absence manifests in legal workplaces, drawing on the five cases. The next section explores the structural and organisational causes of stress leading to suicide, with integration of factors from the cases. The analysis reveals that despite the ability of coroners to provide recommendations to address the *structural* failings, they declined to do so. Finally, the article suggests how coroners could much more proactively utilise their powers to inform future preventive strategies. The analysis contributes to a growing body of scholarship advocating for lawyers' and judges' wellbeing.[14]

A brief overview of coronial jurisdictions in Aotearoa and Australia

Coronership is an ancient judicial office, established in 1194 in England.[15] The English coronial system was imported into other jurisdictions 'in recognisable form over much of the English-speaking world, notably in the United States, Canada, Australia and New Zealand'.[16]

Coronial law scholars and practitioners have frequently remarked about the jurisdiction's ability to 'shape-shift' over the centuries.[17] For example, former Aotearoa Coroner McDowell observed that 'a characteristic of the office of coroner has been its ability to evolve in response to political, social and cultural demands'.[18] In particular, four conceptualisations have emerged[19] to describe the current scope of coronial practice:[20] (1) within multidisciplinary investigation teams; (2) with a preventive public health and safety purpose; (3) infused with human rights; and (4) as therapeutic jurisprudence.[21] More recently, former

New South Wales Coroner Dillon argued that the principle and theory of 'recognition' is a more suitable conceptual framework, to inform the jurisdiction's practices with the deceased, their loved ones, and everyone who encounters the coronial system.[22]

The coronial system in Aotearoa

The New Zealand Law Commission's 2000 report about the coronial jurisdiction recommended an 'urgent overhaul of current system and practices'.[23] Their report prompted major legal reform, culminating in the *Coroners Act* 2006 (NZ), which reflected many of the Commission's recommendations.

From 2012 to 2014, there was a government review of the coronial jurisdiction. An important term of reference was to 'clarify the role coroners have in making recommendations to prevent future deaths and the relationship to agencies that have policy and operational responsibilities in those areas'.[24] The review and research resulted in amendments to the coronial law, with the *Coroners Amendment Act* 2016 (NZ) receiving Royal Assent on 20 June 2016.

The Aotearoa Coroners Court has 38 coroners including a Chief Coroner who must be a District Court Judge or a coroner immediately before being appointed.[25] The Chief Coroner's main function is 'to contribute to the integrity and effectiveness of the coronial system'.[26] All coroners in Aotearoa must be legally qualified and have held a legal practicing certificate for at least five years.[27] The Aotearoa coronial system (which is called the Coronial Services of New Zealand) is centralised and sits within the Ministry of Justice.[28] A vital aspect of coronial services in Aotearoa is the incorporation of *tikanga* Māori (practices, customary law, and values) in the legislation and coronial practice requiring that *matauranga* Māori (Māori knowledge), concepts and practices are infused throughout the coronial legal system.

The coroner's main purpose is to help prevent deaths and to promote justice through 'investigations, and the identification of the causes and circumstances, of sudden or unexplained deaths, or deaths in special circumstances'.[29] Importantly, coroners are also tasked with the 'making of recommendations or comments that, if drawn to public attention, may reduce the chances of further deaths occurring in circumstances similar to those in which the deaths occurred'.[30] Deaths are reported to the coroner for numerous reasons, including a death that appears to have been without known cause, or self-inflicted, unnatural or violent.[31]

Upon receiving a reportable death, coroners have several statutory functions, which include deciding whether to direct postmortems, authorising release of the body, deciding whether to open an inquiry or an inquest and giving family notice of significant matters.[32] An inquiry is the broad investigation. Section 60 identifies deaths which require inquiries including deaths that appear to be self-inflicted.[33] Inquiries and inquests are inquisitorial. The purposes of coronial inquiries are to establish that a person has died, the person's identity, when and where the person died, the causes of the death and the circumstances of the death.[34]

Coroners are not permitted to determine civil, criminal or disciplinary liability.[35] Judges and the New Zealand Law Commission have stated that inquiries and inquests should be of social and statistical significance in the community. The coronial focus is to 'get at the truth' and 'to try and learn lessons that can be identified from the circumstances of the death'.[36] The Act requires coroners to consider whether other authorities (such as commissioners or government agencies) should investigate the death and to identify any interested parties.[37]

The principal way that coroners fulfil their duty to 'prevent deaths'[38] is through the formulation of public health and safety recommendations.[39] While coroners are not legally *required* to make recommendations, they may be directed at specific agencies to minimise the likelihood of future suicides. Families who have lost loved ones, and who encounter the

coronial jurisdiction, frequently report that coronial recommendations give their loved ones' lives meaning and may prevent others from enduring the same pain.[40] Indeed, the importance of the coronial prophylactic function is well-recognised, and detailed analysis about their recommendations has been published.[41] A large mixed-methods study of coronial recommendations in Aotearoa identified their shortcomings, but also their lifesaving potential.[42]

There were several important outcomes of this research. First, in response to research findings that some recommendations were not evidence-based, a new section (s 57A(3)) provides that recommendations must be linked to factors related to the death and based on evidence. Second, the legislative reform requires coroners to consult with agencies in their formulation of recommendations.[43] Finally, the statute now provides for joint inquests,[44] enabling coroners to focus on identifying patterns and trends in certain categories or causes of death. Previously, coroners focused on a single death, without systematic application of public health principles. These reforms were intended to harness the preventive potential of coronial recommendations.

The coronial system in Australia

Like Aotearoa, the Australian coronial system was inherited from England at the time of settlement. Unlike Aotearoa, Australia, since federation in 1901, has no national coronial system. Rather, each state or territory has its own legislation and system for administering coronial processes and making recommendations to prevent deaths. From the early 1970s, all states and territories appointed court registrars or magistrates as coroners to facilitate professionalism.

In recent decades, the Australian coronial jurisdictions have undergone reform. For example, Victoria (recognised as a world leader in coronial law) introduced the *Coroners Act 1985* (Vic),[45] providing a 'blueprint for a new generation of coronial law reform'.[46]

All Australian coroners must be legally qualified. The structure of coronial systems varies across the jurisdictions. In Victoria, South Australia and Western Australia, there are stand-alone coroners' courts. By contrast, in Queensland, New South Wales, Tasmania, the Australian Capital Territory and the Northern Territory, coroners are linked to the local magistrates' courts. The purposes and functions of coroners are similar throughout Australia. For example, in Victoria, where the cases in the dataset are situated, the main purpose is to 'contribute to the reduction of the number of preventable deaths and fires through the findings of investigation of deaths and fires, and the making of recommendations, by coroners'.[47]

To achieve the death investigation function, deaths must be reported to the coroner, including 'a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury'.[48] Victorian coroners investigate approximately 6500 deaths and fires annually.[49] Similar to Aotearoa, Australian coroners' main functions include release of the body, deciding whether to direct postmortems, providing relevant persons with information, holding inquests and making recommendations. Victorian coroners must also establish the identity of the person who died, the cause of death and how the death occurred. In Victoria, inquests are held for a small number of investigations, typically around 5% per year.[50] There are, however, certain types of death that require an inquest. The Victorian coronial investigation and inquest processes are inquisitorial. Coroners are not bound by the rules of evidence during an inquest.[51] Inquests should be conducted with minimal formality, and coroners must identify interested parties.[52]

A core function of Victorian coroners is to 'contribute to the reduction of the number of preventable deaths'.[53] Pursuant to s 72 of the

Coroners Act 2008 (Vic), coroners 'may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice'. Victorian coroners are not, therefore, *required* to make preventive recommendations, but a public statutory authority or entity that receives coroners' recommendations 'must provide a written response, not later than 3 months after the date of receipt of the recommendations'.[54]

Victorian coroners also fulfil their preventive function in several other ways. For example, the Victorian Coroners Court has an in-house preventive research unit, with close links to researchers at Monash University and the Victorian Institute of Forensic Medicine. The Coronial Council of Victoria provides research and strategic advice to the court, as provided for by the legislation.[55] Melbourne is also home to the National Coronial Information System (NCIS), which is a coronial data repository that can be used by coroners, epidemiologists and other researchers.[56] The stated vision of the NCIS is 'saving lives through the power of data'.[57] The NCIS also has a searchable database dedicated to coronial recommendations which is called 'Fatal Facts'.[58]

Understanding Wellbeing in the Legal Profession

Wellbeing in relation to legal professionals can be defined as:[59]

> multidimensional, comprising positive facets such as work engagement, motivation, job satisfaction, personal growth, purpose and meaningfulness, as well as negative facets such as psychological strain, anxiety, depression, burn-out and work-related trauma.

The literature reveals that 'lawyers' wellbeing is conceptualised primarily as *ill-being*, despite wellbeing's positive facets'.[60] Another scholar noted that discussions of legal professionals' wellbeing do not argue that individuals are 'somehow genetically predisposed to poor wellbeing or depression'.[61] Accordingly, there has been a call for understanding the wider context that contributes to legal professionals' poor wellbeing, including structural factors, in the spirit of prevention (discussed later in this article).

Soon, McDowall and Teoh's study of the research on the concept of lawyers' wellbeing and the relevance of work context provide a broad understanding of existing research.[62] This is the first study to systematically review the past 50 years of global literature on lawyers' wellbeing. The dominant research priorities and gaps in the literature were reported, with recommendations for theory development and concrete reforms in the workplace. The article provided critical perspectives on the positive elements of wellbeing, which have received meagre scholarly attention, and demonstrated the value of research within specific work environments. In addition, the study investigated empirical evidence of *contextual* influences upon lawyers' wellbeing.[63] In brief, lawyers' wellbeing was portrayed as a combination of negative outcomes, with stress, anxiety and depression prominently featured.

Research has indicated that a lack of wellbeing in the legal profession has manifested in high rates of depression and psychological distress such as anxiety and social alienation.[64] More specifically, research has reported high levels of psychological distress experienced by Australian lawyers.[65] A survey of 7551 Australian professionals found that legal practitioners experienced the highest incidence of depressive symptoms compared with nine other professions, with 15.2% reporting moderate to severe symptoms of depression, compared with an average of 10.5% across all participants.[66] More recently, an Australian study on the psychological effect of judicial work stress upon wellbeing was published.[67] Similarly, a recent statistical study from the United States of America found that stress, overcommitment and loneliness are predictors

of lawyer suicide risk.[68] The authors recommended individual and organisational interventions to reduce stress and overcommitment.

The findings of these international and Australian studies resonate with the content of the five coroners' cases. The lawyer from Aotearoa (Case A), was described as 'exhausted, unwell, disillusioned, depressed'.[69] The Coroner observed: '(A) says that his heart and soul were always to be a defence lawyer, but after nearly 20 years he is "completely over it. Totally burnt out"'. Furthermore, '(A) says his experiences with criminals have dulled his human senses and that victims of serious crime have affected him profoundly'.[70] Regarding the District Court Judge from Aotearoa, the coroner documented that Judge B's colleagues reported his 'elevated levels of stress'[71] and 'for some time prior to his death they had been suggesting to him that he seek professional help'.[72] According to those colleagues, Judge B viewed support services as unnecessary and their use could be seen 'as a sign of weakness that might count against him personally and professionally'.[73] The Australian magistrate in case C reportedly struggled with feeling overwhelmed and being out of her depth.[74] Stressors included 'exhaustion from travelling to and from outlying courts, the constant workloads, and the pressure to get through long lists and long sitting times'.[75] The in-house lawyer in Case E suffered from a '*work related* major depressive disorder'.[76]

Substance abuse,[77] including harmful or hazardous drinking,[78] is common among legal professionals according to a number of studies,[79] although there was no reference to this in the five cases. Sleep difficulties are also a commonly reported sign of poor wellbeing in legal professionals. Magistrate C 'had sleep disturbances' and was generally struggling,[80] lawyer E suffered from 'severe insomnia'[81] and A was 'haunted'[82] and had 'trouble sleeping'.[83] Research has demonstrated the importance of sleep for legal practitioners' wellbeing and performance.[84]

Suicidal ideation has been identified in numerous studies, with findings that legal professionals were significantly more likely to report suicidal ideation 'several days' and 'more than half the days' as compared with the general working population.[85] Judge B had talked about suicide prior to his death, A had commented that 'there was no light at the end of the tunnel'[86] and lawyer E believed 'she would never get better'.[87]

The synthesis review did not locate any organisational-level interventions to beneficially redesign lawyers' jobs.[88] However, the authors reflected upon studies with distressed *health* professionals where effective organisational reforms included streamlining administrative processes and improving team relationships, among other interventions.[89] The authors propose that legal environments could better promote wellbeing through alternative job design models and upskilling supervisors and managers on behavioural competencies.[90]

The legal professions in Aotearoa and Australia have introduced wellbeing initiatives focused on individuals taking responsibility for their mental health. For example, the Law Society provides resources to support lawyers via the 'Practising Well' programme.[91] The website offers general information to promote health and mentoring.[92] Up to six free, confidential counselling sessions are available. Similarly, in Australia, the Victoria Legal Services Board and Commissioner's Lawyer Wellbeing Report offered a spectrum of strategies.[93] These included: increased promotion of counselling and debriefing programmes; reforms to court practices; improved management training; the incorporation of a wellbeing focus with the continuing professional development requirements; and increased collaboration with researchers. In addition, the Victorian Legal Services Board and Commissioner's website reports on their survey about how workplace culture impacts lawyers' wellbeing.[94] However, the wellbeing initiatives in Australasia focus on

individualised approaches, rather than addressing the structural factors which contribute to distress and suicide within the profession.

Structural context of law firms and courtrooms: organisational failures

Legal professionals, as discussed above, often do not enjoy wellbeing in the workplace. While many of the coroners' comments focused on the *individual* characteristics and life factors of the five deceased, the comments did not focus on other major contributing factors – namely the broader culture, structure and environment of law firms and courtrooms.[95]

From within scholarship on wellbeing in the profession, Collier argued that the dominant discourses focus on individual responsibility, rather than locating accountability within the law firm, partnership, managers and teams.[96] Similarly, others have called for a broader focus on systemic factors for promotion of legal professionals' wellbeing. The Honourable Chief Justice Ferguson's keynote address to the National Wellness for Law Forum 2024 in Melbourne identified the need for empirical research and observed that 'while each of us is responsible for prioritising our wellbeing, the culture, systems and structures in our organisations must support us in order to do so'.[97]

Manifold structural factors impact legal professionals' mental health. Research has found that legal practice is competitive, adversarial and involves extended work hours.[98] Courtrooms, although a different setting to law firms, are characterised by many of the same structural issues. The work of judges, magistrates and lawyers often involves enormous workloads, complex cases, deadlines, difficulty accessing leave, professional isolation, limited management support, a cultural expectation of high performance and pressure to perform.[99] All these structural factors were exposed in the coronial findings.[100]

Law firms and courts often have hierarchical structures and rigid organisational cultures that may not be conducive to work-life balance or employee wellbeing. Junior lawyers or new appointments to the courts may feel pressure to prove themselves to more senior colleagues or partners.[101] There may be significant power imbalances between senior colleagues and junior or new staff.[102] Legal workplaces are often competitive, and lawyers and judges may feel intense pressure to outperform their colleagues to advance their careers or secure partnerships within the firms with a win-at-all-costs mentality. The structure endorses a notion of the 'ideal worker' who surrenders their own needs to that of the firm or the court process.[103]

Both law firms and the judiciary typically demand long working hours and tight deadlines in which to complete large volumes of work that may contribute to lack of work-life balance, high turnover levels[104] and burnout.[105] As a result, lawyers often operate with an expectation of 24/7 availability, simultaneously managing multiple cases while under time pressure.[106] Many law firms operate on a billable hours model, where lawyers are required to track the amount of time spent on each client's case, often recorded in 6-minute blocks.[107] Billable hours often involve unrealistic time frames that do not acknowledge unbillable components of legal tasks such as research, consulting, self-care and training. Research conducted in Melbourne law firms found rigid and demanding schedules tied to the system of billable hours, with rewards (pay rises, bonuses and promotion) for good performance and sanctions for any failures.[108]

The demanding workloads of the five deceased were evident in the findings. Although A had his own practice as a criminal defence lawyer, his workload was immense. On the day of his suicide, he had just finished a manslaughter trial in Wellington High Court, had a trial starting in Rotorua the following week, but had to be back in Wellington by Wednesday afternoon to appear as an amicus curiae in the Wellington High Court.[109] His

wife stated after A's death that 'there was no light at the end of the tunnel from the relentless pressure he was under'.[110]

Judge B had a 'high workload, long hours and high expectations of himself with regard to the quality of his judicial decisions'.[111] Similarly, Magistrate D was described by witnesses in the coronial investigation as having an exceptional work ethic; he reportedly had accrued 90 days of leave and more than 70 days of long service leave. Similarly, he had complained of being 'smashed' with up to 90 cases per day,[112] and expressed to colleagues and family his exhaustion and frustration at the ever-increasing workload. E worked long hours into the evening and on weekends.[113] Magistrate C told colleagues that she was exhausted from travelling to and from outlying courts, the constant workloads and the pressure to get through large lists and sitting times.[114] Importantly, her doctor reported that the anxiety appeared to be triggered by the 'high stress situation rather than any underlying psychological disorder'.[115]

For both lawyers and judges, legal cases often involve complex issues and high stakes for those subject to proceedings. Lawyers may be distressed about the potential consequences of their decisions and the impact on their clients' lives, especially in cases involving sensitive issues such as family law, criminal defence or personal injury. Indeed, all five of the deceased expressed to friends and colleagues the stress caused by the cases and parties. Magistrate C had 'difficulty leaving cases at work and dwelled on them afterwards'.[116] Also, she felt under-resourced, under-trained[117] and pressured by expectations, including a fear that she would make 'incorrect decisions that would later be challenged'.[118] Lawyer A stated in his suicide note that his experiences with criminals had 'dulled his human senses and that victims of serious crime have affected him profoundly'.[119] He had enough of 'being exposed to this kind of death and immersed in such terrible things on a daily basis' and saw the 'appalling gaps we now have in our society getting worse, not better'.[120] Magistrate D expressed to colleagues and family his frustration at his inability to do justice to those who appeared before him.[121] Lawyer E was responsible for highly challenging, complex cases and unsolved homicides and told friends and family of the resulting emotional toll.[122] Judge B had high expectations of himself with regard to the quality of his judicial decisions.[123]

Enormous emotional pressure results from the long-hours culture, the desire to provide high-quality legal advice and representation or to make appropriate judgments, while maintaining professionalism and integrity. These occupational factors are not conducive to work-life balance or employee wellbeing. For law firms, stress related to 'poor management practices, an over-emphasis on profit and targets, erosion of professional collegiality and fear of failure may thwart social connectedness at work and propagate a culture of incivility, bullying and discrimination among lawyers'.[124]

Evidently, none of the five deceased had a reasonable work-life balance. Given that lawyers and judges have reported hierarchical and unsupportive environments,[125] and research indicates feeling unsupported in the workplace leads to stress,[126] it is unsurprising that they all reported lack of support, workplace toxicity and long leave balances.

A's typewritten note stated that although he was exhausted, he continued 'to work 12-hour days at least six days a week' and 'had not had a break in several years and had nothing longer than four days off in probably over five years'.[127] Lawyer E had a large leave balance at the time of her suicide. Although she was offered assistance with her workload, she declined it, partially because of her 'desire to maintain her reputation in the eyes of the Court and not be seen to have failed in the role'.[128] She had constant thoughts of failure and reputational damage.[129] Also, after she went on sick leave, she received virtually no contact or support from the court.[130] Judge B

was 'isolated'[131] and viewed seeking professional help 'as a sign of weakness that might count against him personally and professionally'.[132] Magistrate C felt unable to perform but also unable to resign because of 'financial and professional repercussions'.[133]

Another structural factor that impacts lawyering and judging is exposure to secondary trauma.[134] Legal professionals may be significantly disturbed by exposure to the trauma of others. Research has revealed the deleterious effects of exposure to traumatic material for legal professionals in fields such as criminal, family, immigration, refugee[135] and personal injury law.[136] In Aotearoa, research funded by the New Zealand Law Foundation is underway with legal professionals to design risk-mitigation strategies.[137] Of relevance in Australia, the plaintiffs in *Kozarov v The State of Victoria*[138] were judicial officers who argued they were harmed through exposure to traumatic material,[139] and the case has inspired recent commentary.[140] Secondary trauma was suggested in all five cases in our dataset, with no institutional safeguards in place to protect the deceased. Lawyer E suffered 'vicarious trauma',[141] Magistrate D was 'passionate about social justice issues'[142] while 'overwhelmed by the work they did',[143] A was profoundly affected by 'victims of serious crimes'[144] and Judge B was, according to his counsellor, at 'risk of post-traumatic stress disorder due to the exposure to distressing material'.[145] Thus, the cases abundantly document how structural influences contributed to the five deaths.

Coroners' recommendations about suicide in the Australasian legal profession

Coronial statutory public health function

As outlined previously, Australasian coroners have a statutory public health function. One of the main ways that coroners fulfil this statutory purpose is by making public health and safety recommendations to minimise the likelihood that similar deaths will occur.[146] Of relevance to the five cases, coroners are judicial officers with a statutory public health function and have a potentially potent role in suicide prevention.

Leading coronial law scholars have described coroners as 'public health officials'[147] who have the opportunity to make significant contributions to public health outcomes, and quality and safety in healthcare. In contrast to medicine (which focuses on the individual health practitioner and individual patient), public health is concerned with populations, systems and structures. Concepts such as the 'social determinants of health'[148] highlight that public health is focused on how structures are associated with health outcomes. The World Health Organization, and the scholarly literature, recognise workplaces as a social determinant of health which can impact our health outcomes.[149] In addition, there is growing focus on the legal obligation of workplaces to protect the psychosocial safety of staff as part of their occupational health and safety duties.[150]

This section examines whether the coroners in the five cases utilised their statutory public health role to address structural factors and thereby improve mental health outcomes for Australasian legal professionals and judges.

Coroners' approaches to recommendations in this study's cases

Despite having the statutory power to issue public health recommendations, in the five cases, the coroners did not make any statutory recommendations. In four cases,[151] the coroners explained why they did not issue public health recommendations. For example, in the Judge B findings, the coroner justified his decision not to issue recommendations as follows:[152]

> I have considered whether there are any recommendations that could be made in this case however it is difficult to clearly

> link any of the specific recommendations made by Ms Maguire (clinical psychologist) to the factors that contributed to Judge B's death. … It is difficult to identify one or more actions that would have prevented (his) death.

In the other three cases, the coroners explained that they did not make recommendations because they considered that the changes undertaken by the workplaces were adequate. For example, in the Magistrate D case, the coroner stated that no recommendations were issued because:[153]

> the changes made and those to be made to improve judicial wellbeing by the Magistrates' Court of Victoria in consultation with the JCV following the death of Magistrate D are both timely and significant. I do not consider any meaningful recommendations under the Act can be made.

Similarly, in the Magistrate C findings, the coroner also expressed the view that coronial recommendations were not necessary because, in his view, the changes concerning wellbeing that were undertaken by the court were sufficient. The coroner stated that the:[154]

> changes made to the induction and training of new appointees to the Court and more generally changes to enhance the wellbeing of all magistrates are both timely and significant. I do not consider meaningful recommendations under the Act can be made.

Although none of the coroners made preventive recommendations in these five cases, there are multiple reasons why coroners could, and should, consider this strategy. First, coroners have the capacity to contribute to prevention efforts through their statutory public health function. These coroners *could* make recommendations; whether coroners *should* make recommendations is linked to the broader scholarly and policy debate about the appropriate statutory functions, and conceptualisation, of coronership.[155]

Formulating recommendations is a discretionary matter, and some scholars argue that the coroners' investigative and/or therapeutic functions have primacy over their preventive role. Two coronial jurisdiction scholars have argued that there is a tension between the preventive, therapeutic and investigative roles of the coroner.[156] However, there is empirical evidence that, for families of the deceased, these roles are intertwined, not in tension.[157] Specifically, when coroners investigate a death (including a suicide) and issue recommendations, this is therapeutic for families who have lost loved ones.[158] Families prefer coroners to issue recommendations, but on the basis that those recommendations will minimise the chance of other families experiencing similar pain. There is a growing literature about how coroners can strengthen their recommendations by, for example, using public health principles to frame them.[159]

Second, there are empirical and policy reasons why coroners *should* issue evidence-based recommendations relating to wellbeing and suicide in the profession. It is well-documented in the Australasian literature on the coronial jurisdiction that 'coroners have an important role in identifying factors that may prevent death and injury'.[160] Researchers in Aotearoa found that coronial investigations into suicide are a 'key foundation of information for the design and implementation of suicide prevention initiatives'.[161] Likewise, in the international literature, scholars have highlighted that coroners (particularly in relation to suicide) are 'an important element of the process by which the State accumulates social data which are used to identify problems and shape policy'.[162] Given the powerful preventive potential of coronial recommendations, their absence with regards to suicide in the Australasian legal profession is a missed opportunity. Much of the data, policy and understandings about suicide comes from coronial findings.[163] If coroners routinely decide not to 'contribute to the production of consistent and useful social data regarding suicide,

[this will] arguably render comparative suicide statistics relatively worthless'.[164]

Third, the expert evidence gathered by coroners should be utilised to formulate evidence-based recommendations. For example, in four cases, the coroners obtained expert reports from clinical psychologists and/or occupational health and safety professionals.[165] In the case of Magistrate D, the Coroner's Court obtained a report entitled *Investigation, Analysis, Risk Assessment and Report on the Work Occupational Health and Safety Operations of the Magistrates' Court of Victoria*. This report contained information about how the structure and culture of the occupational environment can adversely impact practitioners. The coroner acknowledged that 'work was [the practitioner's] main stressor',[166] but did not formulate any statutory recommendations.

In the future, coroners could be supported through additional professional expertise. For example, organisational psychologists' evidence was not proffered in the cases. This domain-specific expertise regarding organisational practice may be underutilised by coroners and could have informed the recommendations.

To further support coroners, the NCIS coronial data depository in Melbourne is described above. Potentially, Aotearoa could develop a similar repository. Also, Aotearoa could utilise its Integrated Data Infrastructure to enable data linkage for suicide prevention and coroners' recommendations by analysing information regarding: legal occupation; demographics; medical interventions; substance use; hospital care after suicide attempts; and death by suicide.[167]

Unfortunately, the expert reports were not converted into evidence-based recommendations to inform structural, organisational and occupational changes. Instead, coroners primarily commented on individual factors that may have led to the suicides and individualised approaches for suicide prevention. For example, all the cases recommended individual-focused changes such as wellbeing workshops,[168] 'judicial wellness programs',[169] a 'Wellbeing Steering Committee'[170] and 'mental health and wellbeing awareness and conversations'.[171] However, it is well documented that these individualistic approaches are inadequate and fail to solve structural problems leading to poor mental and physical health and suicidal ideation. Robust evidence from the WHO, CDC and public health research identified that social determinants, such as workplaces, are significantly linked to health outcomes; structures and systems determine health outcomes more than 'individual risk factors'.[172] The new model regulations obligating workplaces to protect the psychosocial safety of staff, as part of their occupational health and safety duties, provide another indication of the structural causes of workplace stress. Furthermore, research demonstrates that suicide, suicidal ideation and self-harm among Australian *health* practitioners can be partly attributed to work stressors and workplace structures.[173]

Similarly, there is growing recognition of structural factors upon wellbeing in the literature regarding the legal professions. For instance, researchers argued that:[174]

> Until the structural issues within law and legal education that impact negatively on lawyer wellbeing are acknowledged, these issues will continue. While individual techniques of self-management may help the individual to endure the issues that lead to their distress, no amount of antidepressants, time management workshops or resilience training will ultimately solve the problem of the profession as a whole.

In two cases, the coroners identified that workplace structures may contribute to stress. For example, Magistrate C's case noted that her workplace had no 'structural support'.[175] Similarly, in E's case, the coroner found that E had no prior mental health issues. While she was working in three roles concurrently within her legal workplace,[176] she developed, and was diagnosed with, 'work related major depressive disorder'.[177] In the coroner's findings, E's

workplace was described as 'toxic'.[178] This suggests that the coroner recognised that structural contexts can create an environment which harms practitioners' wellbeing and may lead to suicidal ideation and/or suicide. Despite that, the coroner did not make recommendations because he considered that the changes implemented by the court were satisfactory. However, those implemented changes focused on individualistic, not structural, approaches to addressing wellbeing and suicide in the profession. Even the changes which the coroners' courts identified as 'structural changes' to address suicide within the profession (such as the 'creation of role of director, and a risk management committee')[179] are arguably aimed at individual health, rather than addressing the broader, recurring structural issues within the culture of the legal workplace.

Practical implications

As noted above, workplace structures are recognised as a main contributor to stress, poor health outcomes and suicidal ideation in the legal profession. This article, therefore, argues for a shift away from the dominant individualising narratives, which are apparent in the coronial cases. Instead, it argues that coroners could, and should, optimise their role in facilitating positive health outcomes for legal practitioners. The main way that coroners could harness this potential is to use their statutory power to formulate evidence-based recommendations which highlight that workplace structures (not individuals) must change.

Another way to enhance the preventive function of the coronial jurisdiction is to have a statutory requirement for agencies to *respond* to coronial recommendations. This does not require that agencies implement the coroners' recommendations. Rather, it promotes the practices from jurisdictions (such as Victoria, Australia) which have mandatory response regimes that require agencies to provide a written response about what, if anything, they have done to address coroners' recommendations. However, Aotearoa did not adopt a mandatory response regime, despite it being recommended by researchers.[180]

Holding joint inquests is another option for enhancing the preventive function of the coronial jurisdiction. Joint inquests have been undertaken by coroners in Aotearoa and Australia for certain types of sudden death such as pill use at music festivals. However, this option may not be appropriate for suicide cases given their sensitivity and the needs of grieving families.

Some coroners may be discouraged from making recommendations in suicide cases because of psychiatric advice that it is not possible to predict suicide in people who have been diagnosed with mental illnesses.[181] However, this article does not ask coroners to engage in such predictions. Instead, it argues that coroners should use their statutory power to formulate evidence-based recommendations which highlight the major role that workplace structures play in causing stress and creating conditions whereby practitioners die by suicide. The expertise of organisational psychologists, for example, may aid coroners to craft recommendations; greater awareness of the potential role of psychologists as expert witnesses would aid this type of initiative.[182] In this way, coroners may be able to encourage a shift in focus away from individuals and towards workplace structures, with the aim of contributing to a reduction in suicide rates in the legal profession.

Finally, including coronial training modules on how structural psychosocial factors impact judicial and lawyer wellbeing might increase coroners' knowledge and understanding. It could better prepare them for making evidence-based recommendations which highlight the major role that workplace structures play in causing stress and creating conditions whereby practitioners die by suicide.

Conclusion

Suicide is a complicated phenomenon with tragic outcomes. This analysis examined the

circumstances of five Australasian legal professionals, to reflect on how coroners may use their influence to prevent, or minimise, death by suicide. Increasingly, research is revealing the detrimental impacts of structural factors such as workloads, isolation and secondary trauma upon legal professionals. The first step in prevention is acknowledgement of these structural factors, which were identified in our cases. The second is action. Coroners have statutory responsibilities for public health promotion and for examination of the circumstances surrounding preventable deaths. They also have a unique power to make case-based recommendations, with the corresponding opportunity to activate positive change. Given their intimate knowledge of the structural factors, coroners may use insights to prevent future suicides of our valued lawyers and judges.

Ethical standards

Declaration of conflicts of interest

Jennifer Schulz has declared no conflicts of interest.
Kate Diesfeld has declared no conflicts of interest.
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Ethical approval

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