SUICIDE IN THE TIME OF COVID:
PREVALENCE, PREVENTION, PROBABILITY AND PROOF

An Article from the 2TG Life & Health Insurance Group

April 2021

Bob Moxon Browne QC and Lucas Fear-Segal examine the potential impact of the pandemic on life insurance policies covering death by suicide, in the light of current wordings, and the recent decision of the Supreme Court in *Maughan v. HM Senior Coroner for Oxfordshire* (2020) UKSC 46.

Bob Moxon Browne QC
rmb@2tg.co.uk
+44 (0)20 7822 1218

Lucas Fear-Segal
lfs@2tg.co.uk
+44 (0)20 7822 1280

Prevalence

There are roughly 6,000 deaths per year in the UK resulting from suicide. These deaths are predominantly amongst men, who are particularly at risk in the age group 40-60 – and for many years suicide has been the leading cause of death amongst men in this age bracket. However, more recently, the number of recorded suicides in younger age groups has increased, including amongst women[1].

Against this background, fears have been widespread that the Covid pandemic would be accompanied by a parallel pandemic of self-harm and suicide, created by a perfect storm of inter-relating factors: isolation, illness, depression, frustration, difficulty in accessing mental health services and money worries[2]. However, so far there has been a dearth of hard evidence that the prevalence of suicide has been significantly affected by the pandemic, at any rate in the UK. Most of the current literature on this topic (which is prolific) is based on the fact that the pandemic has certainly caused a peak in mental health disorders, on parallels to be drawn with the effects of previous pandemics on suicide figures (particularly Spanish flu, which was associated with a sharp rise in suicides)[3],

[1] See Office for National Statistics: *Suicide in England and Wales 2020*.
[2] See e.g. *Trends in Suicide During the Covid 19 Pandemic* BMJ (2020) 371 (12 November 2020).
[3] See Birmingham University: *Death and the Spanish Lady: Suicide in Pandemic Times* (16 November 2020).

and on the likelihood that these patterns will repeat themselves, even if the evidence for that is currently scanty[4].

One country which has reported a sharp rise in deaths from suicide in the course of the pandemic is Japan, which has for many years had the highest suicide rate per capita in the developed world, accompanied by very fast and accurate reporting methodologies for this cause of death.

As a result of major public health initiatives, suicide in Japan has decreased steadily year on year since 2009 – until 2020, when the trend reversed, with sharp increases in suicides presumed to be associated with the pandemic, especially amongst young women. It has been widely assumed that other countries would be well advised to keep an eye on this data[5].

Prevention

Japan's experience over the last ten years demonstrates that recognition that suicide is a major public health issue is the first step towards initiatives to reduce its incidence: and that such initiatives can be extremely effective. A well known example is the effect of a reduction of paracetamol pack sizes in both the UK and USA, which led to an immediate and dramatic fall in paracetamol self-poisoning[6]. Similarly, it has been shown that small increases in the size of barriers guarding the edges of motorway bridges in suicide hotspots have had a marked effect on suicides in these locations[7].

The life insurance industry has itself been active in liaising with suicide-prevention bodies in promoting discussion about and implementing preventative strategies, especially but not exclusively in relation to suicides on the railway network[8].

Any discussion about suicide prevention strategies will quickly lead to consideration of the issue whether the majority of suicides are the result of pre-meditation and planning, or of acting upon a more or less sudden impulse. Obviously it is easier to place obstacles in the path of a would-be suicide whose actions are the result of a recent and perhaps transient whim, than it is to dissuade someone from seeing through a carefully-made plan of long standing.

Perhaps surprisingly, there is abundant evidence that a very large percentage of attempted and actual suicides are the result of a recent impulse: perhaps as many as 50% of cases, or even more, depending on the methodology of assessment used[9]. It seems that for many suicides and would-be suicides, the act follows an impulsive decision made only short minutes or even seconds earlier, and may indeed by the product of a form of generalised pathological impulsivity which is quite separate from ordinary suicidal ideation[10].

The implications for the insurance industry are obvious, especially in the time of Covid, which may have produced, or be about to produce, a new cohort of candidates for suicide who lack any previous history of depression or suicidal ideation, and who may therefore have no previous medical history of the kind designed to be detected on a life insurance proposal. While it is still early days, statistics may soon emerge which will show

[4] See e.g. Manchester University: *Suicide in England since the Covid 19 pandemic: early figures from real-time surveillance* (2020).
[5] See *Covid and Suicide: Japan's rise a warning to the world?* BBC News, Tokyo, 18 February 2021.
[6] See *Long term effect of reduced pack sizes of paracetamol on poisoning deaths* BMJ 2013: 346. In the USA, where the laws about paracetamol pack sizes vary between States the incidence of paracetamol poisoning can be shown to track differentials in pack sizing from State to State very closely.
[7] See *Interventions to reduce suicides at suicide hotspots: a system review*, Cox et al, BMC Public Health 13, 214.
[8] See e.g. *Suicide Prevention Initiatives and Claims Challenges* RGA Global Claims Views September 2019 and the work published by *Action for Suicide Prevention in Insurance* (ASPiiN) in conjunction with the Samaritans.
[9] See "*Impulsive Suicide Attempts: What do we Really Mean?*" May et al *Personality Disorders: Theory Research and Treatment* 7(3) 293-302.
[10] See amongst numerous papers, *Differences between Impulsive and Non-Impulsive Suicide* Psychiatry Investigation 2016 July 389-396, and *Impulsivity and Suicide Risk: Review and Clinical Implications* Klonsky et al *Psychiatric Times* Vol. 32 No.8 Issue 8.

whether Covid itself, and/or its indirect effects on those who have lived through the pandemic, do significantly increase the risk of suicide, and if so what kind of inquiries (not necessarily strictly medical) may most effectively identify that risk. For example, post-Covid, the question "*have you ever received counselling about debt?*" might prove as relevant as the traditional question "*have you ever seen a doctor about depression?*"

Probability

It is trite to observe that the starting point for suicide prevention strategies is prompt and accurate reporting of relevant data about who is committing suicide and why. In the UK the main source of this kind of information is the Coroner's Inquest. Reporting is slow (the average time elapsing between death by suicide and a Coroner's verdict is 160 days) and the results are manifestly unreliable, given the propensity of Coroners to avoid a verdict of suicide whenever that can credibly be done (and sometimes regardless of credibility).

This unsatisfactory situation has been exacerbated by the increasing tendency for Coroners to produce narrative verdicts, in which the factors telling for and against suicide (as opposed to e.g. accidental death) are set out, with no formal conclusion stated[11].

The inclination of most Coroners to avoid a clear conclusion of suicide where possible has been facilitated by the long-standing rule that a Coroner (or their jury) cannot reach such a verdict unless satisfied of this conclusion *beyond all reasonable doubt*: i.e. applying the criminal standard of proof; as opposed to the civil standard, which looks for proof only on *the balance of probabilities*. Life insurers will be familiar with many cases where the issue has been between accidental death and suicide, in which Coroners have found that while death by accident appeared *improbable*, they could not be *sure* (i.e. to the criminal standard) that suicide was proved; and hence have entered an open verdict. This practice may have provided some consolation to the families of the deceased; but did little to enhance the reliability of suicide statistics.

There is no doubt that the rule that in Inquests, suicide needs to be proved to a criminal standard, has its roots in the fact that until 1961, the commission of suicide was a criminal offence. Since the abolition of the crime of suicide by the passage of the Suicide Act 1961, the rule applied in Inquests has appeared anomalous. This was very recently recognised by the Court of Appeal, and subsequently by the Supreme Court, in the case of *R (ex parte Maughan) v. HM Senior Coroner for Oxfordshire* (2020) UKSC 46, where it was held that henceforth conclusions of suicide in Inquests (whether delivered in short or narrative form) need only be based on a finding on *the balance of probabilities*, and no longer need to be proved *beyond all reasonable doubt*.

Surprisingly, the Supreme Court also found that a similar change in the law should apply to conclusions by Coroners or their juries in relation to *unlawful killing*. Surprising, because an unlawful killing, unlike a suicide, assumes the commission of a crime, and hence, logically, might require proof to a criminal standard; and because this further finding was unnecessary in the case of *Maughan*, which was a case concerned only with suicide.

Giving the leading speech of the Supreme Court in *Maughan*, Lady Arden emphasised that one of the major reasons for the Court's decision was the need to be able to rely on Inquest decisions for statistical purposes in relation to deaths by suicide, and to minimise the tendency to under-record such

[11] See *Open Verdict v Suicide: Importance to Research* Linsley at British Journal of Psychiatry (2001) 178: 465-468; *Impact of growing use of narrative verdicts by Coroners on geographic variations in suicide* Journal of Public Health (2012) 34: 447-453; and *Coroners' verdicts and suicide statistics in England and Wales* BMJ (2011) 343.

cases. In words very apt in the time of Covid, Lady Arden stressed that "*Society needs to understand the causes and to try to prevent suicides occurring. Statistics are the means whereby this can be done. If a criminal burden of proof is required, suicide is likely to be under-recorded. This is especially worrying in the case of state-related deaths. If there is an open verdict because the criminal standard of proof cannot be achieved, the circumstances of the case have to be analysed before it can be included in any statistics to show the true number of suicides. There is considerable public interest in accurate suicide statistics as they may reveal a need for social and medical care in areas not previously regarded as significant. Each suicide determination can help others by revealing how suicide risks may be managed in future*". While Lady Arden acknowledged that to some extent policymakers and researchers can seek to mitigate the under-recording of suicide by examining cases of open conclusions, they may not be able to do so accurately, and she concludes that "*lowering the standard of proof would be a more satisfactory way of getting accurate figures*".

Time will tell soon enough whether a new approach by Coroners to the recording of deaths by suicide will make a difference to the statistics, independently of any effects resulting from the Covid pandemic[12]. For the time being, the decision in *Maughan* is entitled to a qualified welcome by life insurers, especially in those cases where the facts show that the insured's deliberate actions led to their death, the only issue being whether death was the intended outcome of such actions.

We would add two notes of caution. In the first place, it has often been taken for granted that the more serious an allegation (whether or not imputing a crime) the more cogent the evidence needed to prove it. Suicide will never be presumed. Positive evidence will always be needed to prove it, including evidence of an intention to die, or from which an intent to die can be inferred[13].

Secondly, so long as Coroners applied a higher standard of proof to suicide than would be applied by an ordinary civil court, it was always open to life insurers to disregard a Coroner's verdict, on the grounds that following an insurance claim, a different result might be reached by a Court applying the civil standard of proof. This is a position which has frequently been asserted by insurers in suicide or potential suicide cases being considered by FOS (with, it must be said, varying degrees of success).

Following *Maughan* it will no longer be possible to deploy this reasoning. It remains the case that technically, the conclusions of a Coroner will always be inadmissible in a civil court, including in cases concerned with insurance issues[14]. However, it is easy to see that in practice this will be a difficult point to take, if the Coroner can be shown to have considered precisely the same question, and to have applied the same standard of proof, as would be considered by a civil court looking at the same question.

Proof

It is important to note that proof of suicide involves proving both that the deceased *caused* his own death, *and* that he did so *intending that result*. It is the second requirement that distinguishes various forms of extremely high-risk behaviour (in popular language, "suicidal" behaviour) from true suicide. The distinction may appear a fine one, but examples of the grey area between suicidal behaviour and actual suicide are common: dare devil risk-taking such as playing "chicken" on motor

[12] See the preliminary conclusions of the Office for National Statistics *Change in the standard of proof used by Coroners and the impact on suicide death registrations* (2020).
[13] See e.g. *Re Davis* (1968) 1 QB 72 per Sellers LJ at 82; and *R v. City of London coroner ex.p Barker* (1975) 1 WLR 1310 per Widgery LJ at 1313.

[14] See Jervis *On Coroners* 13th Edit. at 20-02, and the citation from Beldam LJ in *Re Shepherd* "*The opinion of the Coroner, as to the cause of death, is in my opinion irrelevant as between the parties to a claim under a policy of insurance*".

bikes; risks of asphyxia associated with sexual experiments; and different forms of "cries for help" (e.g. standing on bridge or window parapets in high winds) provide only a few examples where a Coroner would probably (and quite properly) decline to find suicide proved.

Although there is little or no legal authority on the topic, experience indicates that a good measure of true suicidal intent is the degree of likelihood or certainty of a lethal outcome consequent upon the deceased's behaviour. Suicidal intention may be inferred if a man is seen to jump off the cliffs at Beachy Head, or in front of an express train; but not necessarily if he jumps from a first floor window, or runs across a busy motorway.

Two recent Inquest cases in which we have been involved may illustrate this point. In the first, a man hung himself from a tree on the towpath by a river. The Coroner declined to find suicide, on the grounds that because the towpath was frequented by dog-walkers, the deceased might have had some expectation of being discovered and cut down before he died. In another case, a doctor stole some anaesthetic from her hospital, and administered it to herself via a drip inserted in her arm. She quickly lost consciousness and then died. Despite the fact that in both cases the deceased must have known that their conduct would quickly result in a situation which they had put it out of their power to reverse, the Coroner refused to find that suicide was proved beyond reasonable doubt.

Both these Inquests were concluded before the decision in *Maughan*. Following *Maughan* it is hard to believe that in either case the conclusion that death was *probably* the result of suicide could have been avoided.

Almost all modern life insurance wordings dealing with suicide exclusions refer simply to death as a result of suicide or similar words incorporating a reference to suicide, leaving it to the parties (and if necessary the Courts) to decide whether or not the circumstances of death meet that definition. However at least one UK life office is currently excluding a policy response "*if within X years of the policy, the life insured dies as a result of suicide, intentional and serious self injury or an event where* ***in the Insurer's reasonable opinion*** *the life insured took their own life*". The words in bold are novel in stipulating that in an appropriate case it will be the *opinion of the insurer* which determines whether or not the insured took their own life. In our view, following *Maughan*, this wording could be further reinforced by inserting the word "*probably*" before the words "*took their own life*".

So far as we are aware no life insurance company has yet attempted to exclude liability to meet death claims arising from the deliberate conduct of the insured *in circumstances likely to cause his death*, i.e. independently of any proven suicidal intention. Whether or not such a wide exclusion could be justified on public policy grounds, a wording in that form would go further than an ordinary suicide exclusion, as that concept is currently understood.

Conclusion

Our conclusion is that it is very likely that it will soon be shown that the continuing effects of the pandemic are causing increases in suicides, probably preferentially affecting younger people, and females, more than has been the case in the past. The lowering of the standard of proof in Inquests into deaths by suicide is also very likely to lead to an increase in recorded deaths from this cause: it will be a task for the statisticians to determine whether increases in the numbers of suicide are associated with Covid, or with the new standard of proof; or both[15].

[15] See Office for National Statistics *Changes in the Standard of Proof used by Coroners, and the Impact on Suicide Death Registrations* (2020).

Strategies for the prevention of suicide depend upon accurate assessments of who is taking their own lives, why they do so, and what means are used. It is likely that more accurate reporting of suicide by Coroners will assist research into these areas.

If the continuing effects of the pandemic do result in significant increases in cases of suicide, life insurers may want to consider reviewing the scope of the information requested by proposal forms, perhaps with a view to shifting the emphasis away from a clinical history indicating elevated risk, towards the identification of underlying stress factors known to increase risk.

Disclaimer

ABOUT THE AUTHORS

Bob Moxon Browne QC
rmb@2tg.co.uk
+44 (0)20 7822 1218

Bob Moxon Browne QC

Described by Chambers UK as "*a warhorse of the Insurance Bar*" and by Legal 500 as having "*vast experience in insurance work ..... he is held in very high regard across the industry*". Bob has long had a niche practice in life insurance issues, and his expertise in this area is widely recognised by insurers and reinsurers interested in these risks. Bob has unrivalled experience of coverage disputes following apparent suicide by the life insured, with a long-standing special interest in the role of impulsivity in suicides by younger people. He is a frequent author and speaker on these and related topics.

Lucas Fear-Segal
lfs@2tg.co.uk
+44 (0)20 7822 1280

Lucas Fear-Segal

Named by Legal 500 (2021) as a *Rising Star of the Insurance and Reinsurance Bar*, combining "*formidable intellect*" with "*absolutely ferocious cross examination skills*", Lucas is a specialist in insurance work, with numerous appearances on behalf of insurers and their reinsurers in cases where the cause of death of a life insured has been in doubt. These include *Re Perepilichnny* (sudden death of Russian oligarch in uncertain circumstances) and *Re Naviede* (death of prominent businessman in unexplained crash of light aircraft).

CONTACT US

Lee Tyler
Senior Clerk
ltyler@2tg.co.uk
+44 (0)20 7822 1203

Paul Cray
Deputy Senior Clerk
pcray@2tg.co.uk
+44 (0)20 7822 1208

"Outstanding service" (Legal 500)

"On the ball, courteous and efficient" (Chambers UK)

"Approachable, modern and commercial in their outlook" (Chambers UK)

FIND US

Address
2 Temple Gardens
London EC4Y 9AY

Telephone
+44 (0)207 822 1200

Fax
+44 (0)207 822 1300

Tube
Temple (Circle & District
Blackfriars (Circle & District and Thameslink rail)

DX
134 Chancery Lane

Rail
Blackfriars
City Thameslink