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coroners' suicide files

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Abstract

In keeping with recent critiques of literature on the body and the life course, the argument of this paper is that social identities can, to a certain extent, be constructed post-mortem and in the absence of a living body. The authors make this case with reference to a sociological autopsy study of a hundred suicide case files in a coroners' office in a medium-sized British city. The research draws on ethnographic approaches to documents. There is discussion of some of the diverse data sources in the coroners' files: medical reports, witness statements and suicide notes. The identity work revealed in these sources is as much about the living as the dead and is especially bound up in the process of avoiding blame.

This paper argues that the files assembled by coroners in the course of an inquest provide insights into the creation of social identities in contemporary Britain.¹ Drawing on ethnographic studies of documents (Riles 2006) and on recent critiques of literature on the body and the life course (Hallam, Hockey and Howarth, 1999; Hockey and Draper, 2005) we suggest that the files contribute to the constitution of different kinds of persons. Our argument is based on the analysis of one hundred inquest files returning a verdict of suicide at a coroner's office in a medium-sized British city.

In England and Wales, inquests are held by coroners to establish the cause and category of a sudden or unexplained death and until completed no final certificate of death can be issued. This official inquiry into the causes and circumstances of the death creates a space in which social identities are scrutinized, redefined and challenged, and involves the acquisition of new identities beyond the life course (Hockey and Draper, 2005). A conception of personhood as beginning before birth and extending after death presupposes a relational approach, wherein personhood is not possessed, but is generated and performed through interactions with other agents, human and non-human, alive and dead (Strathern 1992). In relation to the deceased in the context of suicide inquests, such a distributive understanding of personhood raises a number of issues. Firstly, identities and agency have long been recognised as embodied, but how are they affected by death? Secondly, if the identities of the living are multiple and often contradictory, what happens to these identities when a person dies? Finally, if identities are situated in relations, what are the implications for the connections between the living and the dead? We will keep these questions in view while examining three different kinds of documents that are found in the suicide inquest files: reports by physicians, witness statements, and suicide notes.

The study of suicide has a long history in the social sciences, humanities and the medical sciences (e.g. Durkheim 2006 [1952]; Douglas 1967; Atkinson 1978; Hawton and Van Heeringen, 2002) and there are several thriving journals

dedicated to the topic. The work of coroners in the UK remains largely under-researched (though for notable exceptions see Atkinson, 1978; Prior, 1989 and Howarth 1997). Timmermans has recently published an important study of the work of medical examiners in the US (Timmermans 2006). Although medical examiners are the closest equivalent to coroners in England and Wales, the differences between these respective offices are sufficiently pronounced to make comparisons and generalisations difficult. Our focus in this paper is rather different anyway, insofar as we are paying particular attention to the evidence from various actors that is presented to coroners in suicide cases rather than on the judgements of coroners themselves. After introducing our theoretical framework, we will sketch the conditions in which we encountered the suicide records and proceed by focusing on three kinds of artefacts collated in the files: medical reports, witness statements, and suicide notes.

Drawing on ethnographic approaches to files and to the life course

Recently, Jenny Hockey and Janet Draper (2005) have argued for a reconfiguration of our understanding of the theoretical concept of the life course. They maintain that particularly through artefacts, identities extending before birth and beyond death are created, or in their words:

Around bones, photos and bootees, personal and military histories are built; and family lives are dreamed into being (Hockey and Draper, 2005, p. 54).

Hallam et al (1999) argue, in similar fashion and as a challenge to mainstream sociological theorising about the body, that the construction of social identities does not in fact require the presence of a living body. On the basis of our research on suicide, we agree with these arguments, up to a point. Suicide inquest files, we suggest, should be added to Hockey and Draper's list of artefacts through which social identities are able to continue well after death. Moreover, on the basis of our research, we want to make four comments that are pertinent to the arguments of Hallam et al and Hockey and Draper. First, through their death, the deceased can also acquire new identities, such as the official label of someone who has killed him or herself or the private one of

someone who was unable to cope. Secondly, the identities of the deceased are not any less tangled up or confusing than those of the living. In the suicide files, different identities of the deceased jostled with each other, for instance as patients, parents, spouses, and as individual men or women, as they try to present themselves through patient files, witness statements and suicide notes. Thirdly, because of the distributed nature of personhood, the identities assigned to the deceased simultaneously give account of the concerns of the living. This also entails that the movement of identities is not one-way, but rather that the living are implicated in the identities of the dead. Finally, in the absence of the body as agent, the question of how authentic the identities of the deceased are gains new significance. We propose that it is this constellation of absent bodies and multiple and contested identities, that opens the space for the debates surrounding a death by suicide to continue long after the inquest has closed.

The other body of work we are engaging with here is ethnographic approaches to the study of documents as recently developed by Annelise Riles and others (Riles 2006a). In her introduction to an edited collection of essays on documents, Riles (2006b) highlights their ubiquity in ethnographers' working lives and draws attention to the importance and the potential of the study of artefacts. Because of a shared emphasis on documentation, the knowledge practices of bureaucrats and of ethnographers are closely related, leading to an intricate web that connects the study of artefacts with the concerns of ethnography as a discipline. This affinity means that documents have the ability to be objects of study, analytical categories and a methodological orientation at the same time (Riles 2006b).

Riles' introduction outlines a programme of work and sets the scene for a selection of stimulating papers that demonstrate the importance of approaching, interrogating and analysing documents ethnographically. By directing the readers' attention to diverse documentary practices and local meanings, this collection serves as a reminder that the study of artefacts has so far focused on documents' strategic or instrumental character, thereby missing other aspects, such as their aesthetic dimensions (Reed 2006). Paying attention to aspects other than artefacts' disciplinary characteristics is rather novel for the study of

inquest files because the work of Michel Foucault has been so influential in the field since Lindsay Prior's pioneering studies on the organisation of death through the office of the coroner and the institution of the mortuary (Prior 1985; Prior 1987).

For Prior, the ordering of death was an extension of the discourse and technologies of modern biomedicine. In the case of the coroner, he asserted, what their profession claims to be a neutral – because technocratic and medicalised - language is actually a symbol of power as well as the instrument through which such power to observe, investigate and explain is wielded (Prior 1985). By siting death within a medical framework, Prior argued, it became possible to divide all deaths into either natural ones – those situated in a world of disease – or unnatural ones which could only be accounted for by chance. The categories have in common that they allow for the excision of human agency by situating death in a realm outside human control and disconnecting it from the sphere of the social, thereby permitting the inquest to focus on the medical and technology aspects of death investigation.

Prior's study and his emphasis on the language of bureaucratic objectivity as a mark of power, struck a chord with us and his insight that by medicalising certain kinds of death, death itself appears to be controllable, is a point that is germane to any attempt to understand the link between suicide and mental illness. Yet, based on our material, a more complex and contradictory relationship between the language of the inquest and power, knowledge and identities emerges. Firstly, Prior seems to assume that the medicalisation of death is always oppressive because it denies human agency (Prior 1985, p. 83). However, the ethnographic work of Josef Dumit has shown that in the case of schizophrenia the presence of a biomedical diagnosis was welcomed by the families of schizophrenics, because it allowed them to challenge aetiologies that identified social – especial familial – relationships as the illness's cause (Dumit 2004). We also found examples of bereaved families actively embracing diagnoses of mental illness in suicide cases. Perhaps the connections between biomedicine, mental health and identities warrant more careful consideration. Secondly, our research showed that human agency remained very much

discernable in the files. Hence, we argue that what made the inquest files so fascinating was not that they were devoid of human agency, but rather that they presented an opportunity to study the ways in which different actors' agency moved in and out of the picture. Finally, while disciplinary power in the Foucauldian sense certainly plays an important role in the management of death, including the inquest, we fear that too strong a focus on its totalising aspects ignores some evidence to the contrary. Our intention here is to draw out the distinctly human practices and concerns of some of the key agents involved in the creation of the suicide file: medical experts, witnesses, and the deceased. However, before we do so, we will introduce briefly the role of the coroner, our research site, and the material components of the inquest files.

The site of the research

Coroners in England and Wales are appointed by local authorities, but are independent from them and have their own offices and dedicated staff. Their professional background can be either medical or legal. The summary of their role that follows is based on Dorries' (2004) guide to procedure. Under certain circumstances a death has to be reported to the coroner and an inquest must be opened. These are cases where the deceased has died a sudden or unnatural death or where he or she has died a sudden death of which the cause is unknown, or where he or she has died in prison or in a place or under circumstances that require that an inquest is conducted under an Act other than the Coroner's Act 1988. The purpose of the inquest is to determine the identity of the deceased, and how, when and where he or she died. It concludes with a verdict, called an 'inquisition'. Unlike other legal investigations or court procedures, the inquest's remit lies not with the apportioning of blame or establishing whether a particular claim is proved, but only with establishing facts. It is a non-adversarial process and no-one is on trial. Inquests are open to the public and to the press, with the exception of cases that have implications for national security. The press are allowed to report whatever is said in court, except where this would prejudice the jury or interfere with the proceedings. After 'accident or misadventure' (40 per cent) and 'natural causes' (20 per cent),

'suicide' (13 per cent) was the third most common verdict returned at inquests in 2003 (Allen 2004, p. 2).

A verdict of suicide is never a default option and can never be presumed, but has to be positively established based on unambiguous evidence. In order for a verdict of suicide to be returned, two conditions must have been fulfilled beyond reasonable doubt. First, the death must have been the consequence of a deliberate act and second, the deceased must have had the intention of taking his or her life. If these conditions are not met by the evidence, the coroner will rule the death as due to Accident or Misadventure or pronounce an Open Verdict. The former applies if the death was unintentional, the latter is used for instances where there remains doubt whether the deceased had wanted to kill him or herself.

We conducted our research in the light and comfortable boxroom of the coroner's quarters. Most of the space there was taken up by several sturdy storage shelves stacked high with cardboard boxes full of inquest files of the last three years, but the room was big enough to also accommodate a table, several chairs and assorted items of office furniture.ⁱⁱ Once we had identified a file as a suicide with the help of a list we had been provided with by the coroner, we would move to the table and start our investigation, starting from the outside of the file and then working our way through the assembled documents from top to bottom.

Sometime we would find notes handwritten on the flaps, such as 'killed himself', lists of questions still to be clarified before the hearing could take place or stapled-in circulation slips indicating the kinds of test and statements that had been ordered and when. Topmost amongst all the documents was the coroner's copy of the Coroner's Certificate after Inquest (White Form 99A) stating the cause(s) of death.ⁱⁱⁱ Only after this form has been issued by the coroner can the Registrar of Births and Deaths register the death and issue the Order for Burial. This was followed by another form titled 'Inquisition' that recorded the details of the deceased, the verdict, and the cause of death. In complex inquests, an 'advice file' had been created consisting of the key documents, such as

summaries of the findings of the forensic investigations, the witness statements, and different expert accounts, all typed up, bound and preceded by a police officer's synopsis of the case. Next would be the autopsy report and the toxicological analysis in full.

These post-mortem analyses were followed by a different category of reports: the witness statements, usually in the form of photocopies. Police officers had taken statements from those who had found the deceased, from the emergency personnel and from other police officers who had been first at the scene, as well as from those who had had contact with the deceased shortly before his or her death, or who were in a position to comment on the deceased's recent circumstances or state of mind. Another set of reports by medical and health professionals, such as psychiatrists and GPs, would typically come next in the file if the deceased had had a history of contact with the health or social services. Then there would be suicide notes or other final messages, if present. The remaining file consisted of the original handwritten witness reports and the forms that had been filled in by the police before the case was handed over to the coroner, including the green form to be 'completed only in cases of suicide (suspected, apparent, or alleged)'. The file concluded with miscellaneous objects of evidence such as emergency services logs, booklets of photographs and, very rarely, letters to the coroner regarding the case.

Reports by physicians

The coroner would ask for reports from medico-scientific professionals to establish if there had been any indications that the death under investigation may have been a suicide. GPs and psychiatrists were not the only medico-scientific experts present in the file. In fact their reports were rarer than those of toxicologists and pathologists whose analyses could be found in virtually all of the files.^{iv} However, the latter had encountered the deceased as a corpse. While corpses are ambiguous entities - no longer living, breathing human beings, but neither ordinary objects - they are nonetheless more easily separated from their social relations (Joralemon 1995; Howarth 1996; Richardson 2000; Scheper-Hughes 2002). In contrast, GPs and psychiatrists

had known what was now 'the deceased' as 'the patient', that is when he or she was still alive and self-evidently entangled in relationships. Hence, their reports exposed the tensions surrounding the act of the suicide.

For the purpose of the inquest the manner of death, previous suicide attempts, a history of depression and mental illness, especially recent or acute episodes, could all support the coroner in his or her decision to return a verdict of suicide. However, we argue, the documents created by medical professionals in response to the coroner's request were not only about establishing the deceased's intention to take his or her life, but also about the creation of different identities. We will be using the statements written by GPs and psychiatrists to draw out two aspects in particular - the identity of the treating physician as a medical expert and the identity of the deceased as patient - and to show how they are connected to the search for a causative agent.

The statements provided by GPs and psychiatrists were not organised according to an externally imposed structure, but followed an inherent order that responded to the questions of how long the physician had known the patient for, why they had come to see them, what they had been treated for, drugs prescribed and interventions ordered, and whether these had been successful or not (Berg 1997). These documents were not mere copies of accumulated medical records, but had been written retrospectively and on request of the coroner. This meant not only that they concentrated on any indications that the deceased had intended to take his or her life, but they also gave evidence of the treatment that the deceased had received, as well as asserting that this treatment had been appropriate under the circumstances. These accounts focused on the medical and technical aspects of therapeutic interventions and were informed by a conception of the mind as an organ that was primarily responsive to pharmaceutical intervention.

Hence, the reports' emphasis lay on treating the patients' symptoms with suitable drugs, including selective serotonin reuptake inhibitors (SSRIs) and other anti-depressants, as well as other psychiatric medication. For instance, the report by the deceased Mr P's GP recounted in some detail how he had

prescribed the patient four different anti-depressants during the last month before his death. In each case, it also stated the motives Mr P had given for stopping a particular drug. Two reasons mentioned in the GP's letter are that Mr P felt that one drug was not working and that another one had made him feel unwell. The document also recounts how the GP had reminded his patient that it was not the drugs that were causing his - Mr P's - problems, but his depression. Hence the statement demonstrated how GP and patient identified different agents as the cause of Mr P's condition. Whereas Mr P saw the drugs as the issue, the GP pointed the finger at the illness, an agent that was amenable to medical intervention, provided the correct drug could be found. In the case of Mrs N, identifying a cause was less clear cut. Her GP stated in his letter that Mrs N had not suffered from any psychotic illness and that her multiple issues were due to 'personality problems rather than other active disease'. He continued by remarking on the interactions between Mrs N's 'psychological/psychiatric problems and her somatic symptoms' and concluded by expressing his regrets at being unable to provide the coroner with a more precise diagnosis.

Modern biomedicine proceeds by separating out causes (Foucault 1994 [1973]), but the report of Mrs N's GP shows the difficulties medical practitioners are confronted with when trying to disentangle the different causes they have identified. Here, 'the social' becomes a blanket term for that which is not under specialist control and whose agency lies with the patient and not with his or her physical body or biologically-situated mind. This focus on agents amenable to medical intervention also opens up the possibility that failure of such interventions lies with the patient, rather than with the treatments.

While Mrs N's physician refrained from naming the patient as the reason why medical intervention had failed, preferring instead to evoke unspecified interactions between different agents, that included Mrs N but were not restricted to her, Mr J's psychiatrist was more explicit. Mr J had been under psychiatric care to help him cope with post-traumatic stress disorder and depression. In his report, the psychiatrist identified non-compliance with the medication, an unwillingness to engage with different professionals, and a

refusal of other treatment options as the impetus for Mr J's suicide. Mr J's psychiatrist had little doubt when it came to identify a cause for Mr J's suicide. And yet, the 'social' crept back into the file. In this instance through the unexpected and unpredictable synergies arising between the psychiatrist's assessment and the witness statements.

In his report, the psychiatrist had remarked that Mr J's wife supported her husband's decisions. But in the file, the psychiatrist's professional distance – his objectivity - regarding his patient clashed to shocking effect with the primeval despair – her subjectivity - of Mr J's wife who was the first to discover the body. From the coroner's point of view these different aspects of Mr J, the person, were relevant only in so far as they related to the purpose of the inquest. Yet, in the context of an ethnographic study of the inquest files, they illustrated how professional expertise and bureaucratic technology combined in the files to define certain relationships, and even certain aspects of relationships, as more relevant than others. Approaching the files ethnographically means that a very different account of Mr J's life *and* death becomes possible: one that restores complexity, multi-dimensionality and contradictions to people's lives which the inquest itself aims to reduce in order to answer the questions of how someone died and whether they intended to.

In conclusion, the medical professionals' reports in the file created certain aspects of the person of the deceased. They were expressive of a modern medico-scientific epistemology that aimed to separate human states into distinct illnesses that were due to well-defined causes. In the case of GPs and psychiatrists, a focus on physically situated illnesses that could be treated by primarily pharmaceutical interventions was also discernable. Furthermore, for those medical professionals who had encountered the deceased as patient rather than as corpse, the need arose to demonstrate that they had acted appropriately and that their patient's death had been unpredictable and unavoidable. In doing so, the medical professionals created a very normative identity of the deceased as a patient, with the implication that their agency should be restricted to following the advice of the treating specialist. Yet, in the

file medical reports commingled with other documents, such as witness statements that had the potential to show the deceased in a very different light.

Witness statements

The witness statements in the inquest files had been taken by police officers from those present at the scene of death, those who had been in contact with the deceased before his or her death, and those who had been close to him or her. Their objective was to report observations, but not opinions. The statements were originally recorded by hand on standard police forms, which later were transferred into word-processed documents. They gave the name, age, and contact details of the witness, as well as the relationship in which the witness stood to the deceased. The remainder of the original form was lined, but otherwise unstructured, therefore allowing the witnesses to produce their own narrative of the event and give account of what they had observed and experienced first hand.

While statement takers aimed to document the narrative in the witnesses' own words, such statements were not verbatim records of the interview. Rather, the events recounted in them had been consecutively ordered and the narrative itself had been shaped by the need to be concise and to the point. In order to achieve this aim, statements were drafted first by a police officer using institutional conventions of language and content. These documents' hybrid production process and the need to fulfil institutional and legal requirements, lent the accounts a shared appearance. Such efforts to direct witnesses' agency did not, however, conceal each statement's unique character or the immediate impact of the event on the statement giver. Compared to the reports by medical professionals, witness statements tended to display a greater degree of involvement of their authors with the deceased. Officially, witness statements were about the deceased, but unlike medical professionals, witnesses were often inextricably embroiled with the person whose death constituted the subject of the inquest. Furthermore, unless they were police officers or members of the emergency services on duty, witnesses lacked professional distance. Because of the way the identities of the deceased and the witnesses were entangled,

testimonies regarding the former could only be generated in relation to the latter.

Witnesses in suicide cases are a motley assortment and include the very close, such as kin, as well as those whose only connection with the deceased is the death itself. However, the witnesses were united in their unfamiliarity with death and in facing it without the protection granted by professionalism. While some of the witnesses avoided a close encounter with death, instead calling on other bystanders, the emergency services or the police to approach the body, other rushed to the scene. Accounts of the latter cases in particular - where the witnesses had handled the body - were often distinguished by the minute details recounted. The unflinching eye with which the witnesses had observed how the deceased had looked and felt, the kind of aids they had used to kill themselves, and how the witnesses' had tried to save their lives, lent these statements a particular clarity and almost a cinematic quality which could be distressing for researchers reading them (see *self-citation*).

The witnesses' confrontation with death could elicit powerful reactions and intense emotions that were sometimes discernable from the statement. In some cases, the witnesses' distress was implicit in the document's history as when there were two witness statements by the same person in the file. The first would be incoherent or it would be incomplete, for instance closing with a remark by the statement taker that the interview had been postponed because the witness was too distraught to continue. At other times, a statement dating from several days after the discovery of the death suggested that the witness had needed time to calm down. Another way to learn how the encounter with death had affected a witness was through the accounts of other witnesses. For instance, the police officer at the scene described the father who had discovered his son's body and was now cradling him in his arms as 'hysterical with grief' and repeating over and over again: 'He's my son, my only son'. At other times, the effect the death had on the witnesses was explicitly acknowledged in the statement. In a particularly gruesome suicide the key witness was a neighbour who had attempted to dissuade the deceased from jumping off a bridge. He had leapt as she turned her back. In her testimony this

witness stated that she had been unable to sleep and had to take time off work. Her doctor had prescribed sleeping tablets and had offered her antidepressants. She also suffered from terrible regrets and blamed herself for the death (see also Wertheimer 1990). She still found it difficult to cross the bridge and was considering selling her house and moving to a different neighbourhood.

For those witnesses who had known the deceased before their death, making a statement always implicated them. On the one hand this was because their own identity was intertwined with the deceased and on the other, because they had to re-evaluate their past in the light of the death. The inquest is non-adversarial and not concerned with guilt, and suicide is not a criminal offence. Yet the whole investigative process is thoroughly entangled with the criminal and legal system. Considered in conjunction with the desire to have acted beyond reproach, it is not surprising that the witnesses try to present their own conduct as favourably as possible. We are not suggesting that their performance was entirely under the witnesses' control, but only that they were trying to manage it (Goffman 1971). This objective can find rather bizarre expression in the statements. In one case, a mother asserted that she had no idea why her son had taken his life as he was generally in good health. The only exception had been two hospitalisations. The first was for an overdose and the second had been an incident involving the mother and a glass that had smashed next to the son's head, making the reader wonder if the mother had actually thrown it at him. The suspicion that the young man's life had been more chaotic than his mother's statement suggested was corroborated by other documents in the files. Similarly, the girlfriend of a young man who had taken his life pointed out that he had had significant debts and had recently been made redundant from his job, though none of these details had been mentioned by the deceased's family. The statements by family members instead highlighted that the young man and his girlfriend had had a stormy relationship that was frequently 'on-off'. These two examples illustrate again how the documents in the file act together to generate different and often contradictory aspects of the deceased.

In their statements the witnesses were working through their connections with the dead and as well as with the living and in the process were generating themselves, the deceased and others living as persons. Hence, they were maintaining connections with the deceased. Yet at the same time, many of the bereaved were also extricating themselves from relationships with the deceased by playing down their own agency in the act. They often did so by arguing that the suicide could not have been foreseen ('he seemed happy'), even when other evidence suggested otherwise. As a result, the bereaved – like the physicians and as we will see, the deceased – tried to transfer the reasons for the suicide into a sphere outside their area of responsibility and control. In the case of medical professionals, this external realm included 'the social', but the witnesses and the deceased transferred the act into the sphere of naturally, rather than socially, occurring incidences and events; that is, events and actions that were somehow unavoidable (as opposed to those that could potentially have resulted in a different outcome). However, such separation can never be total and hence the tensions that were generated by the question about a cause of the suicide continued.

Suicide notes

The final category of documents we will turn to is the suicide notes that were present in almost half of our sample. Suicide notes are important in the inquest, because they are evidence of the deceased's intent to take his or her life and thereby help to support a verdict of suicide.^v They vary greatly in their form and content and are the only documents in the file that have been written by the hand of the deceased. Coroners should usually release the note to the original addressee as soon as possible after the inquest, although they may retain a photocopy of it. Not having a suicide note is considered to interfere with the grieving process (Biddle 2003).

The notes varied widely in appearance, style and content, and reflected their varied authors. Thus, the documents were very much a continuation of the lives the deceased had lead and a snapshot of the kinds of persons they had been. Materially, the notes came in a variety of forms and not all of them were written

on paper. Instead, we encountered a handful of SMS text messages that had been recovered from mobile phones. The notes also differed in terms of their coherence. Some consisted only of a few garbled lines; others seemed entirely coherent and yet offered only bizarre seeming explanations of why the author was about to take his or her life. Examples of this kind were the young man who insisted he had to kill himself to give his brother a reprieve so he could remove his possessions before the bailiffs arrived to repossess their house. Another one was by a woman who had been deeply affected by the attacks on the World Trade Centre, as to her the Twin Towers had been like old friends. Then there were those notes that contained detailed instructions for the bereaved, as in the case of an accountant who left behind 22 pages of handwritten notes, mostly outlining what should happen to his investments. Many of the notes had been produced in a state of urgency, distress or confusion and had been hastily scribbled on torn out notebook pages or on the back of instruction manuals. They also showed smudges and stains and were frequently full of crossed out sections and spelling mistakes.

Suicide notes were the only documents compiled in the file that had been produced before the death occurred. They were also the only artefact in the file that has been created by the deceased. The notes can be read as an assertion of individual agency and personal autonomy - as certificates of an irreversible rupture - an interpretation that is reinforced by their sparsely contextualised presentation in the surprise bestseller *Let me finish* (Grashoff 2006), a collection of suicide notes from the German Democratic Republic. However, the notes are equally a means of connection, because they are performative and like signatures stand in a metonymic relationship to the deceased (Austin 1976). Because the notes were not only documents of separation, but also of connection with the deceased, the bereaved often felt ambiguous about them (see also Wertheimer 1990).

The suicide notes were also an attempt by the deceased to influence how they would be remembered in the future. To this end, they named causes and envisioned consequences, such as the man who left behind two notes: one to his mother in which he apologised for his act, and the other one to his wife in

which he congratulated her on winning; or another one who evoked the negative impact his death would have on the development of the son he had had with an ex-girlfriend, threatening that his memory would always stay with her, and with it her liability for his death. Admittedly, no guarantees existed that such evocations would become reality, and this also applied to the instructions to the bereaved not to be sad about the death, but instead to get on with their lives. An example of how incapable the deceased were to affect the reception of his or her suicide note concerned a young man who had mentioned feelings of loneliness and emptiness as causes for the act, while his file contained a memo inquiring about the state of an investigation regarding sexual offences the deceased had been accused of in an adjacent jurisdiction. Thus similarly to the witness statements, in the file the self-presentation of the authors often encountered other documents which cast doubt over the trustworthiness of their explanations.

Only a minority of the suicide notes we came across were as spiteful as the ones referred to above and many were full of expressions of regret, sorrow and desperation. The note a young man who took his life after his relationship with the mother of his baby daughter had come to an end provides an illustration, here. In the document written to his family he repeatedly told them how much he loved them and how sorry he was for the hurt he was causing them as well as for lacking the courage to continue. He ended by apologising for this selfishness.

Irrespective of their length, their eloquence or the sentiments they expressed, the notes shared the basic premise that the only course of action available to their authors was to take their own life. They had been forced into a situation where they had been 'in pain for too long now and [...] can't take no more', where 'enough is enough', and where '[t]here was no other way'. At the same time, they had been brought to this realisation, by circumstances lying outside their control.

Thus, the person about to commit suicide constructed a scenario where forces outside their command were acting on them. Under these circumstances, taking

one's life became an act of self-assertion, a way to exert power over forces otherwise too powerful to control. Yet such an act also implied the exclusion of other people, because the knowledge on which the decision to end his or her life was based could only be possessed by the person about to die. This is possible because of a conception of persons as individuals who are independent of and unlike each other. Each individual is by definition different and it follows that if no-one is like anyone else, then it is impossible to know what other individuals are going through. The question that follows then is: how to become an individual? And the answer is to impose one's own agency on other agents, such as other people, but also on other-than-human agents, such as drugs or illnesses (Strathern 1987). Yet while a precondition of agency is the existence of relationships, the performance of individuality with its focus on autonomy requires that relationships be muted. To paraphrase, the very relationships that make human beings persons are the ones that need to be subdued in order make persons individuals.

In relation to the suicide notes this meant that if 'the situation' had become 'too much', individual agency could be imposed on it by taking (control of) one's life. However, 'the situation' and 'the individual' who aims to differentiate himself or herself from it are generated through a tangle of relationships, that also includes 'loved ones'. By severing the relationships that tied 'the individual' to 'the situation' the deceased also cut the relationships that connected them to family and friends. The implications of this particular conception of personhood is that the performance of the individual - i.e. of a particular kind of person that exists in and of themselves, unencumbered by and independent of other agents - inevitably cuts out others. While this effect may be intended in the case of some kinds of relationships, such as with an ex-partner, in other cases the act's consequences for parents and children (for example) may be unintended. Thus, a completed suicide can be seen as the performance of individuality taken to the extreme and this changes not only the personhood of the one taking his or her life, but also that of their 'families and friends' by transforming them into 'the bereaved'. Yet, as we have argued, identities do not end with death, and the connections that are necessary for their existence persist even after the suicide has been completed.

Conclusion

At the beginning of this paper we noted the argument that identities can potentially be maintained in death. Our research on inquest files returning a verdict of suicide supports this argument – at least to an extent. One example of the process is the suicide notes, which are attempts by the deceased to exert agency from beyond the grave. Yet we can also conclude that such attempts to influence their legacy are hampered by the absence of a functioning body. Without an ability to act, the deceased cannot confront any challenges to their version of what has happened and why, unless the living respond on the deceased's behalf. We also found that the dead can acquire new identities in the course of an inquest, such as those of a suicide victim. Furthermore, the files showed that the identities of the deceased – like those of the living – can be multiple and contradictory, as in the conflicting demands of patient and spouse. However, our material equally demonstrated that while relational social identities continue after death, there is also evidence of all the actors in the files cutting others out of their relationships. This included medical professionals, who argued that the act was due to factors outside their control, and witnesses close to the deceased who tended to insist that the death could not possibly have been foreseen. Finally, the deceased themselves asserted that they had no choice but to commit suicide. In other words, everyone in the file was concerned with playing down their own agency and demonstrating that they themselves were not at fault. This was happening even though inquests are not officially meant to be about apportioning blame - that is, about finding the 'social' causes of death and identifying agency - thereby suggesting that the process of allocating blame was nonetheless a matter of great importance to the actors. This is perhaps unsurprising in the light of the discourses of morality that tend to surround discussion of suicide (see, for example, Fullagar, 2003).

By taking an ethnographic approach to the study of documents, we have been able to draw attention to the ways in which different actors in the suicide files were engaged in a process of separating out the social and the natural; that is, separating what was seen to be potentially avoidable from what was not. Thus,

the study of inquest files of suicide also provided an opportunity to analyse the ways in which culturally specific notions of relationships and of personhood infused the bureaucratic processes of the coroner's investigation.

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ⁱ Following Jenkins (2004), we will use the terms social identity and personhood interchangeably throughout the paper.

ⁱⁱ After this time, the files will go into deep storage and become very difficult to retrieve.

ⁱⁱⁱ It is possible for there to exist more than one cause of death. For instance, if the death had been the result of a lethal overdose of several different drugs, each represents a different cause of death. For the sake of convenience we will use the singular, unless otherwise required.

^{iv} In England and Wales in 2002 a post-mortem took place in 95% of inquests (Allen 2004).

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