Transition and Innovation in the Singapore Coronial System

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State Coroner, Singapore

At the Asia-Pacific Coroners Society Conference 2016

Perth, Australia

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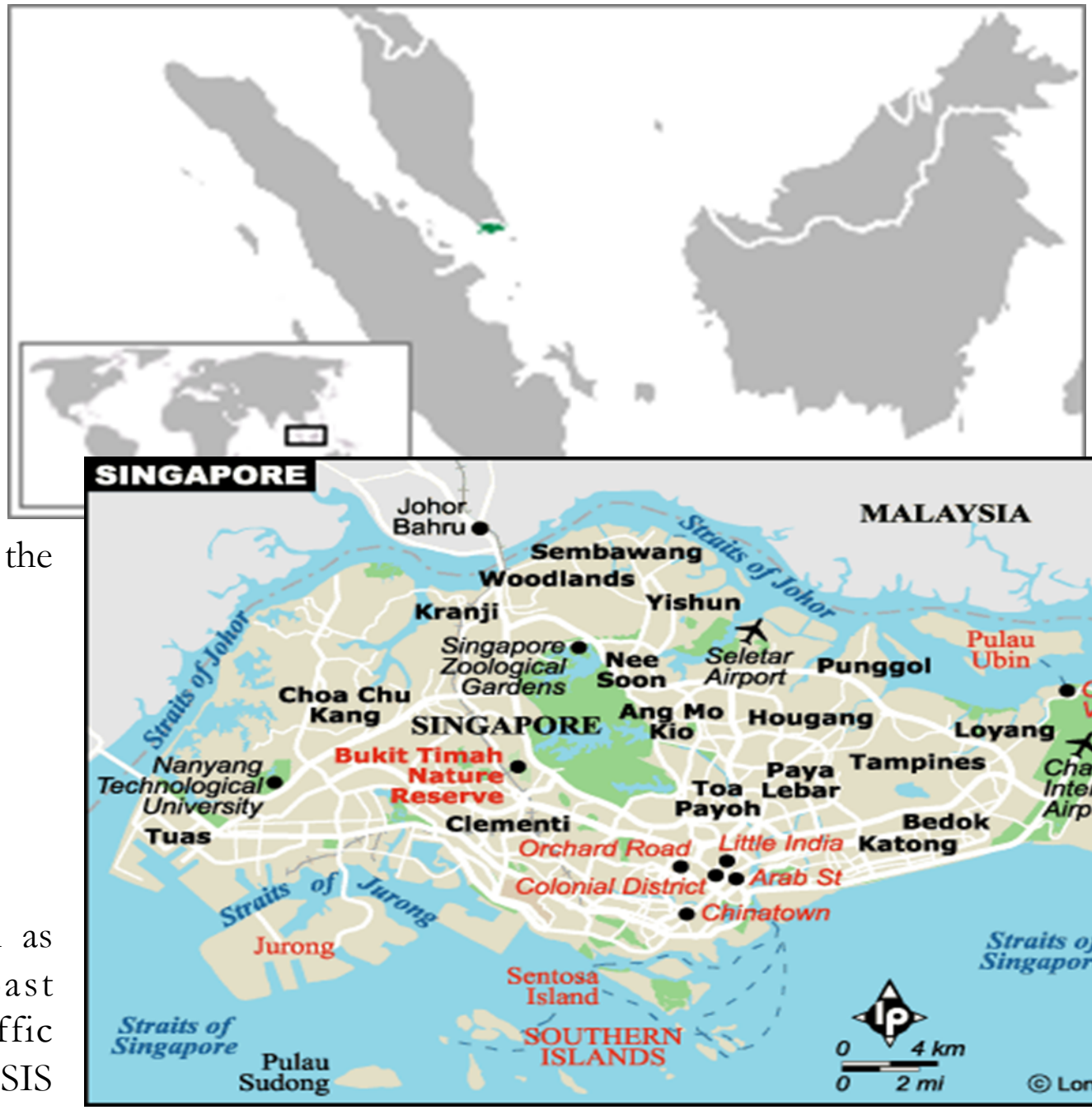
To put things in perspective

"According to most studies, people's number one fear is public speaking. Number two is death. Death is number two. Does that sound right? This means to the average person, if you go to a funeral, you're better off in the casket than doing the eulogy." *Jerry Seinfeld*

Obviously fear of public speaking is an immediate fear from an actual event , the prospect of death is usually an abstract thought except for Coroners, of course, who see, study and inveigh on death on a daily basis.

'The fear of death is what keeps us alive' Should that be a maxim of prevention;



Cases come from the Singapore Police's nine divisions A (Central), D (Clementi), E (Tanglin), F (Ang Mo Kio), G (Bedok), J (Jurong), as well as PCG (Police Coast Guard), TP (Traffic Police) and CID SIS (Homicides)

Singapore: Key statistics

Gross Domestic Product:
S$402.457 billion
Population: **5.69 million**
Ethnic groups: **Chinese 74.1%, Malay 13.4%, Indian 9.2%, and other races**
Religions: **Buddhism, Christianity/Catholicism, Islam, Taoism, Hinduism**
Official Languages: **English, Malay, Mandarin, Tamil.**
English is the key language of business and general communication.
Most Singaporeans speak and write a second language, usually Mandarin, Tamil or Malay. Several Chinese (Hokkien, Teochew, Cantonese, Hainanese, Hakka) and Indian (Hindi, Urdu. Punjabi, Malayalee, Telegu) dialects are also spoken.
Large foreign/ permanent resident population: Australians, Filipinos, Indonesians, Koreans, Japanese, Vietnamese.

The Singapore Judiciary

- The Judiciary is made up of the Supreme Court and the State Courts. The State Courts handle about 95 per cent of the Judiciary's caseload. Four divisions: criminal justice, civil justice, community justice and the court dispute resolution divisions. The Justice Family Court (FJC) is separate.
- The Presiding Judge oversees the District Judges and Magistrates and administrators of the State Courts.

State Courts' Judicial Officers

All Judicial Officer at the State Courts are appointed principally as District Judge or Magistrate, but hold concurrent appointment as Coroner, Deputy Registrar and Referee of the Small Claims Tribunal

The State Coroner is appointed by the President on recommendation of the Chief Justice

Medico legal death investigation

- The Coroner is the *nexus* or *node* of the medico-legal death investigation, an inquisitorial process integrating investigative facts of police investigation with forensic findings of pathologists.
- Coroner's BFFs (principal collaborators)

Police *Investigation officers* **and** *Forensic Pathologists* **from Forensic Medicine Division, with assistance in developing, processing and presentation of the case by** *State Counsel* **from the Attorney General's Chambers.**

- Frequent collaborators

Ministry of Manpower (industrial deaths) Singapore Civil Defense Fore (fire deaths), Academy of Medicine (iatrogenic-medical cases), Energy Market Authority (electrocutions), Maritime Ports Authority (deaths of seamen or persons in vessel) and Sports Council (public pool deaths).

The Coroner's Act

- The Coroners Act incepted in 2010 supplants the previous provisions in the Criminal Procedure Code

- Separate the fact-finding process from civil/ criminal/disciplinary sanctions

- Facilitate investigations into deaths where medical treatment or care is the suspected/potential cause or a contributory cause

- Allowing inquiries to be discretionary in certain circumstances

Beginning of the process: Coronal viewing

- The process begins by a **viewing** to confirm identity at the mortuary.
- Former practice: NOK would identify in from of coroner.
- Traumatic; frequent emotional break downs, banging of glass panel separating deceased from NOK, refusing to leave the viewing room, also long waits for NOK to be ready.
- Possibility that NOK were acting under a **social or cultural expectation** for demonstrative grieving against private grieving, especially if they were all clustered together.
- Solution was to implement identification viewing by investigation officers.

Simplified viewing process for Coronial Viewing

-Next of Kin no longer required to be present at the viewing
Before the viewing, IO use the photo-ID forms to confirm the identity of the deceased consult with NOK to confirm the identity. Forms will be *triple confirmed* by hospital tag, mortuary tag and IO's written certification at side of the form.

-If there is any concern, the IO and mortuary will sort out the matter before the formal viewing. Any disputes or queries on the identity of the person must be immediately made known to the duty Forensic Pathologist and Coroner.

-The viewing will be conducted between the IOs and the State Coroner. No NOKs will be involved. Where the body is not decomposed, the physical body will be presented, with the IO showing the Photo-ID form to the Coroner.
-Where the body is decomposed, the physical body will not be presented. If there are distinguishing marks (eg tattoos, scars..etc) on the body, additional photo ID form detailing the identifying feature will also be presented.

-Exceptions for personal viewing- Foreign domestic workers, where Embassy Representatives are present or where NOK have just flown in and specially request to do so
-IOs will upload into the ICMS system.

Triage of cases

- Sources of forensic examination
- Case notes/ evidence at scene (eg: medication, mobile devices, items for self harm)
- Post Mortem Computed Tomography/LODOX- to see body in its 'packed' state
- External examination
- Discussion between Pathologist and Coroner on whether to proceed.

Post Mortem cases

- Except for homicide or complex post-op cases, body will be returned on the same day of PM, usually between 12-1 pm.
- Respect for religious and ethnic traditions for the body to be cremated or interred on day of demise (certain schools of Islam, Judaism or Hinduism.
- Hence the 'window' is very short. PM will start at 10 am and usually conclude before 12 pm.
- Short retention time is exceptional.

Innovations on the Organ Harvest process

- **Human Organ Transplant Act (HOTA)- an opt out process for major organs**
- **Medical Treatment, Education and Research Act (MTERA) a voluntary donation process**
- **Formal application by transplant coordinator and attached discharge summary.**
- **Consultation between Coroner and Pathologist to ensure that organs needed for medico –legal death investigation are not inadvertently removed.**
- **Also a filter to caveat to prompt transplant team (eg using kidneys from person with *rhabdomyolysis*, or heart valves from patient with cardiac *arrhythmia*.**

Disaster Victim Identification (DVI) Protocol

Inter agency collaboration with AGC, SPF, MHA and Health Sciences Authority's Forensic Medicine Division

A Disaster Victim Identification (DVI) Protocol has been developed to put in place a *systematic and effective* means of forensic investigations for various types of anticipated disasters.

These would include airliner crashes, acts of terrorism ('*not if but when*') and natural disasters.

Consequential emphasis from fault-finding to fact-finding

- **Coroner at an inquiry does not frame a finding in such a way as to determine any question of criminal, civil or disciplinary liability.**

- **Shift the focus of a Coroner's Inquiry away from any determination of *criminal or civil liability* to a determination of the cause of and circumstances connected with a death.**

Facilitating investigations of medical-related deaths

- **Promoting effective investigations of medical-related deaths.**
- **Appropriate safeguards to maintain a balance between collation of documentary, testimonial and expert evidence and the protection of witness from liability in giving candid evidence. Doctors can be expected to be more *candid* about what *actually happened* to their patient if they are assured that there will be no certified transcript coming from the coroner's court, hence they *are not damning themselves* by giving evidence at the CI.**
- **Essential as medical procedures available in Singapore become more complex and sophisticated.**

Prime directive of Coroner's Act

- Fault-finding to Fact-finding
- In tandem with the modern coronial legislation in Australia, New Zealand, the United Kingdom, and Hong Kong.

- Segregating the fact-finding process from criminal/civil/ disciplinary proceedings.

- A Coroners Inquiry now focuses on identifying the deceased and ascertaining how, when and where he had died, rather than attributing or apportioning blame. Proceedings and evidence at inquiry must be directed to ascertaining the above matters.

Reportable Deaths – Second Schedule

An imposed obligation to report a death in Singapore…

1 **of a person whose *identity* is not known.**

2. **that was *unnatural or violent*.**

3. **that resulted or is suspected to have resulted, directly or indirectly, from an *accident*.**

4. **that occurred, directly or indirectly, as a result of any *medical treatment* or care.**

5. **while the person was *in official custody*, except death as a result of capital punishment.**

6. **where the person was, *before* his death, in official custody and where the death was related, or suspected to be related to that custody.**

7. **occurring apparently or possibly as a consequence of l*aw enforcement operations*.**

Reportable Deaths – Second Schedule

8. Any death occurring at any workplace, or as a result of any accident or dangerous occurrence at a workplace, as defined in the Workplace Safety and Health Act (Cap. 354A).

9. Any death in Singapore involving a public vehicle or commercial transport vehicle.

10. Any death on board a Singapore-registered vessel, or aircraft while in flight.

Death in Singapore

11 that was caused or suspected to have been caused by an unlawful act or omission.

12. the manner or cause of which is unknown.

13. that occurred under suspicious circumstances.

Coroner's jurisdiction

A Coroners Inquiry is *mandatory* when where:

- **(a) person dies in *official custody*;**
- **(b) death was the result of *lawful execution* of death sentence;**
- **(c) Public Prosecutor so requires; or**
- **(d) death occurred in circumstances set out in Third Schedule, unless death was due to *natural causes*.**

A Coroners Inquiry is discretionary where:

A inquiry is not required if Coroner is satisfied that:

- (a) death was due to natural causes and it is unnecessary to do so; or
- (b) in the circumstances, it is *not necessary* in the public interest to do so.
- In deciding whether to hold an inquiry, Coroner may have regard to

(a) whether death appears connected to *action or inaction* of another person;

(b) drawing attention may reduce occurrence of other deaths in similar circumstances;

(c) Wishes of immediate family;

(d) whether death caused by matters arising *outside* Singapore;

(e) whether an inquiry or investigation will be conducted by a coroner or *corresponding authority* of foreign country; and

(f) any other matter the Coroner thinks fit (catch all).

Dispensation of Inquiry

- **In lieu of a CI, a dispensation is done (a short write-up usually from 300-400 words). Cf formal inquiry findings that will run from 1500 to 8000 words. Specimen below of a case of suicide**

- **Ms XX** Lim, a female Chinese, aged 37, was pronounced dead on 14 May 2016 at 6.55 pm. after she was found hanged in her residence at Blk xxxx,, Singapore. Ms Lim was a civil servant at xxx. On 14 May 2016 at 6.55 p.m., police were informed of her discovery. Her husband had upon reaching their residence at 6.50 pm found Ms Lim, clad in a light colored singlet with black shorts, hanged from a power cord tied around her neck and a ventilation hole of the store room. After he cut the power cord and brought Ms Lim down, he noted that Ms Lim had become stiff and cold. She was pronounced dead on 14 May 2016 at 7.04 pm. *The Forensic Pathologist has stated her death to be from Hanging.* A toxicological analysis found only Fluvoxamine, which played no part in her demise. Ms Lim had a medical history of Thyrotoxicosis. She was also seem at Alexandra Hospital in November 2014, for anxiety episodes that she was being followed by unfamiliar strangers in red shirts, and that her phone messages were being monitored for unknown reasons. *Ms Lim was diagnosed with delusional disorder, persecutory type, a psychiatric disorder characterized by preoccupation with fixed false beliefs.* She was last seen on 12 May 2016, when she revealed that her husband had recently asked for a separation, and seemed to be in a low mood. Ms Lim's Apple MacBook, a stack of insurance documents, a piece of paper with passwords, a framed photo and a plush toy were found neatly arranged on a coffee table, beside the sofa, in the living room. Police also found a suicide note urging her parents not to blame her husband and that matters in the past few years which caused her to become depressive. Her husband had in early 2016, expressed his intent to separate with Ms Lim. He noted her being affected, and that she seemed to hope for a reconciliation. Ms Lim had on 13 May 2016 at 7.16 am, created a note in her mobile phone, addressed to her husband, on her preferred funeral arrangements. On 13 May 2016 at 10.06 pm, Ms Lim sent a WhatsApp message, enquiring whether he would be coming home on that night. Her husband had responded on 14 May 2016 at 6.08 pm, that he would be back by 7.00 pm on that day. Her browser history showed that Ms Lim had been visiting websites on different methods of suicide since 18 April 2016. There is no basis to suspect foul play. Hs Lim's hanging *is a deliberate act of suicide*.

Dispensation specimen (misadventure) No CI, but still sufficiently informative for record and research

- Mr Xu XX, a Male Chinese, People's Republic of China national, Age 73, was pronounced dead on 2 January, 2016 at 5.27p.m, in Tan Tock Seng Hospital, following a his near drowning in a pool at his son's residence at xxx, The W, Singapore. Mr Xu had came to Singapore with his wife on a social visit pass on 26 December 2015 to visit their son. On the 2 January 2016 at 5.45p.m, police were informed of his demise. Earlier, 4.25p.m, police were notified of his discovery in the pool. On the 2 January 2016 at about 4.25p.m, he had been discovered by resident Mr Y, who sought help from security guards of The W condominium, informing that Mr Xu appeared to have drowned at the swimming pool. He was taken out of the swimming pool, and another resident commenced chest compressions of Mr Xu while waiting for the arrival of the paramedics. His initial cardiac rhythm when attended to by paramedics was ventricular fibrillation and was shocked once. On arrival at the Emergency Department, TTSH, cardiopulmonary resuscitation was continued, and adrenaline given. An examination showed no pulse and no breathing. Pupils were fixed and dilated. Resuscitation effort was stopped in view of prolonged down time at 5:27 pm, when he was pronounced dead. Mr Xu was found with dried blood on his nostrils. There was no wound or injuries on his person. ***The Forensic Pathologist has certified his cause of death to be from Drowning.*** No drugs or other substances have been implicated in his demise. The Closed Circuit Television (CCTV) facing the swimming pool showed Mr Xu and his wife had initially gone to use the facilities at the swimming pool. Between 4:10 pm to 4:15pm, Mr Xu was seen swimming alone. At the time of 4:16:10 pm Mr Xu was seen standing inside the swimming pool and splashing with both hands, ***and struggling in pool,*** before disappearing behind a wall with planted vegetation. At 16:16:45, Mr Xu reappeared in frame and seemed motionless and floating inside the swimming pool faced downwards. The depth of the swimming pool at the point where Mr Xu was discovered was 1.2meters. No residents of The Waterina condominium had witnessed Mr Xu drowning or struggling in the swimming pool. There is no basis to suspect foul play. Xu was swimming alone at the swimming pool prior to him drowning. There were no suspicious injuries on Mr Xu which could suggest foul play. His drowning is an unfortunate misadventure.

Common Verdicts / Shorthand verdicts (to accompany narrative verdict)

- **Suicide** - *where deceased intended to, and did do an act to end his/her own life*
- *'a deliberate act of suicide'*
- *Common : Fall from height, drownings, hanging*
- *Unusual: Oleander poisoning*

- **Misadventure** - *where death resulted from events beyond human control/'Acts of God'; unintended act/accident; deceased's own fault or conduct; deliberate but lawful act which unexpectedly takes a turn that led to death*
- *'A or an sad/tragic/unfortunate misadventure'*
- *Common: Falls, choking, overdose*
- *Unusual: insect anaphylaxis, impalement by stingray barb*

Verdicts; Then and Now

- **Negligent Act of a Potential Defendant** - *death due to a criminally negligent act of the PD*
- *'A or an sad/tragic/unfortunate (traffic/industrial/medical) misadventure'*

- **Murder by Person/Persons Unknown** - *death by foul play but police exhausted leads to establish identity and/or whereabouts of suspect*
- *'Unlawful killing'*

- **Open Verdict** - *where cause of death is unascertained; manner and circumstances of death not disclosed; identity of deceased not established or where evidence unable to establish a categorical verdict*
- *'Constrained to give an open verdict'*

Engaging the press in prevention efforts. Stories covered:

CI	NAME OF DECEASED	CASE NUMBER	Media and Date	Awareness raised on these areas/ issues
1	K S	CI-901168-2015	The Straits Times, New Paper: 12 November 2015	Korean hostess's misadventure death from acute alcohol intoxication: Dangers of binge drinking, indiscriminate consumption while playing drinking games
2.	M S D S,	CI 901558-2015	The Straits Times: 12 December 2015	Drowning of a 7 year old Malay Singaporean child at Hard Rock Hotel RWS; Drowning prevention, vigilance for parents and lifeguards, avoiding blind spots
3.	L B C	CI 900096-2015	The Straits Times: 25 December 2015	Drowning of a 5 year old from China Drowning prevention, tourists' lack of familiarity with pools.
4	F O Z W	CI-901951-2015	The New Paper 15 January 2016	Motor vehicle misadventure; hazards of drink-driving, and failing to use designated-driver/valet service when severely intoxicated
5	I J and A T P C	CI-901504-2015 & 901505-2015	Straits Times, New Paper: 13 February 2016	Inhalational death from fire which broke out when UAV drone batteries were charged: Risk of fire from charging high lithium if charging site is unattended
6	M M	CI 902638-2015	Straits Times 11 March 2016	Industrial accident while cutting a tree at Eu Yan Sang headquarters: Care to avoid risk of tree collapse if trunk has been hollowed out by termite activity
7	T B G	CI 903141-2015	Straits Times, New Paper: 29 April 2016	Australian Jockey's misadventure fall death; Dangers of attempted re-entry into locked flat by climbing balcony, especially while intoxicated

Engaging the press (continued)

8	Taufik Zahar	CI 901381-2015	Straits Times, New Paper, Today; 25 April 2015	Lawful killing of drug intoxicated driver who ran a barricade: Driving while under influence of methamphetamines, failing to heed warnings in protected zone
9	M M T	CI-903282-2015	Straits Times; 5 May 2016	Misadventure death of French E-stake board rider: Care in handing E-stake boards, use of headgear
10	H G	CI-901719-2015	Straits Times, New Paper; 31 May 2016	Hazards of purchasing of weight-loss drugs over the Internet
11	A T B	CI-903739-2015	Straits Time ;3 June 2016	Care in handling motorised bicycles
12	P Y J	CI-903689-2015	Straits Times 7 June 2016	Heatstroke death of a China worker from Hebei : Acclimitisation, avoiding and mitigating heat stroke and other heat injuries, expediting diagnosis and treatment of heat stroke and heat injuries.
13	C K S	CI 000092-2016	Straits Times 23 June 2016	Industrial death, driver pinned on wall because of brake failure; importance of maintenance of industrial equipment
14	A H B M B	CI-000105-2016	Straits Times; The New Paper 30 June 2016	Drowning prevention, use of AEDs for young children.
15	Y L C And P H Y K	CI-000292-2016 & CI-000292-2016	Straits Time; The New Paper 12 July 2012	Drowning deaths of mother and daughter after their vehicle drove into a canal: Driving with care over car park ramps, and when transitioning to main road, handling sudden vehicle submersion
16	S L X H	CI-000532-2016	Straits Times; New Paper 29 July 2016	Death after tuina massage: Hazards of being in an immune-compromised state from eating disorder (anorexia nervosa)

Engaging the press – continued

17.	N S B S	CI-000511-2016	Straits Times; New Paper 3 August 2016	Misadventure Fall from height of a 3 year old child left alone at home: leaving child alone with ungrilled windows
18.	Benjamin Lim Hui Jun	CI-317-2016	Straits Times, New Paper, Today; 19 & 20 August 2016	Suicidal Fall from height of a 14 year old student: Suicide prevention, proposed expanded role of counsellor, importance of understanding psyche of young persons especially propensity for 'catastrophic thinking' in case of adverse event, formation of multi-agency group to study youth suicides
19.	S B G	CI-000797-2016-	Straits Times 30 August 2016	Exertional Heat stoke death of New Zealand banker in 10.5k green corridor run: Importance of acclimazation, and proper hydration, All ambulances should have AEDs and GPS tracking
20.	L N A	CI-000933-2016	Straits Times; New Paper; 7 Sep 2016	Choking death from consumption of ondeh-ondeh in a Home by a 73 year old resident; Hazards from elderly glutinous, lump shaped food items, and practical precautions.
21.	K G C S	CI-000963-2016	Straits Times; New Paper; 7 Sep 2016	Misadventure death of E-scooter rider: Care in handing E-stake boards, use of headgear
22.	N S K	CI-001139-2016	Straits Times; New Paper; 16 Sep 2016	Pool death of a Indonesian child in a hotel pool: Precautions to take. Proximity and attentiveness of care-giver, flotation devices, clear demarcation of child and adult levels.

23	Master H (name redacted)	CI 1624 – 2016-	The Straits Times, The New Paper 22 October 2016	Suicide fall from height of an 11 year old who was due to receive his exam results . Importance of parents paying attention to psychological and emotional health of child facing school pressures.
24	M A B Z	is CI-1714-2016	The Straits Times, : 25 October 2016	Accidental fall from height of a 113 year old boy when intoxicated from abuse of butane gas from lighter refill canisters. Dangers from self harm of solvent abuse.
25	T W T	CI 001779-2016	The New Paper 28 October 2016	Immolation death of a 70-year-old male who had found in to have deliberately set himself on fire, Prompt treatment for persons mental health especially if they are facing a crisis
26	C J	CI-001584-2016	The Straits Times: 29 October 2016	Death of a 44 year old worker from anaphylaxis from a bee sting venomg. Awareness of unique vulnerability ti fatal allergic Discretion is the best policy when encountering stinging insects
27	L P H	CI-903389-2015	The Straits Times 5 November 2016	Drowning of a 25 year old man at Pungol Water park. Self harm while swimming in natural bodies of water with unseen obstacles and indeterminate depth and water currents

Telling 'teachable lesson' stories; the *Cordyceps* case

Teachable lessons in *Chew Kim Kee* (CI901461-2015), reported in the Straits Times on 27 May 2016:

30. Assoc Prof Yeo found it most likely that *Cordyceps consumption pre-operation, was the factor contributing to the unusual post-operative bleeding*. He deemed no other causes of bleeding to be plausible. He makes this apt observation in the final paragraph of his report:

> I hope that this patient will not have died in vain and that the association between *Cordyceps* ingestion and intra-operative bleeding will be disseminated widely to the Singapore population as many of the Chinese population here are taking *Cordyceps* regularly for its purported healthy effects.

31. Assoc Prof Yeo has been pro-active in informing his neurosurgery division at the National University Hospital, and doctors at Khoo Teck Puat Hospital and Ng Teng Fong General Hospital, of this link between *Cordyceps* consumption and intra-operative bleeding.

32.Given the prevalent use of *Cordyceps* as a restorative supplement by patients, who are often proffered *Cordyceps* by their well-meaning family members, I join Assoc Prof Yeo to take **the vie**w that steps should be taken to increase awareness among the medical profession, as well as the general public, of this significant risk, and *to prevent any future incidence of uncontrolled surgical bleeding from inadvertent Cordyceps consumption. To be safe, patients undergoing surgery should be mindful of the recommendation in medical literature for Cordyceps ingestion to cease two weeks before elective surgery*

The Benjamin Lim Case

The Benjamin Lim case: A timeline of what happened

1 of 2 Benjamin Lim's bedroom in his family's Yishun HDB flat on the 14th floor. PHOTO: THE NEW PAPER FILE

PUBLISHED MAR 1, 2016, 4:53 PM SGT | UPDATED MAR 3, 2016, 7:29 AM

Seow Bei Yi

SINGAPORE - On Jan 26, a 14-year-old Secondary 3 schoolboy was found dead at the foot of a block of flats in Yishun. He had lived on the 14th floor with his family.

The boy, Benjamin Lim, had earlier been questioned by the police in connection with an allegation involving outrage of modesty.

In Parliament on Tuesday (March 1), Home Affairs Minister K. Shanmugam laid out the facts of the case. Here is a summary:

- Suicide Fall from height of a 14 year old student *post*
- Police interview for a lift molestation charge, also excluded from school camp.
- No harsh police interview techniques uncovered, but would have been ideal to explain implications and context of police interview to youthful suspect.
- Poor communication between school counsellor may have played a major role.
- Case underscores importance of understanding psyche of young persons especially propensity for 'catastrophic thinking' in case of an adverse event.

Suicide prevention

- Following *Benjamin Lim*, and the revelation of the rise in incidence of youth suicides
- Combined effort by stakeholders from MOH, IMH, HSA and SOS to develop a more *integrated* approach to death investigations in youth suicides.
- Goal is to developing a better understanding of *why these cases occur, and developing future interventions* to preventing youth suicides in Singapore.

MORE TEEN SUICIDES, PARENTS MUST MANAGE EXPECTATIONS

SAMARITANS OF SINGAPORE REPORTED RECENTLY THAT 27 TEENS COMMITTED SUICIDE LAST YEAR - A 15-YEAR HIGH. WHAT DRIVES TEENS OVER THE EDGE?

1587

Aug 8, 2016 6:00am

BY ARYA SHREE THAMPURAN, KINTAN ANDANARI

Only 12, but he wanted to kill himself.

Tim (not his real name) had failed to enter his desired stream in his primary school.

The disappointment sent him into a downward spiral and his confused parents took him to see a counsellor, thinking he was simply being naughty and rebellious.

They did not know he wanted to end his life.

Fortunately, they got help in time and the counsellor was able to help Tim give up on suicide and to take another shot at life.

Tim had been achieving examination results in the 70 to 80s range, but this fell short of his parents' expectations.

Youth Suicide Questionnaire

For police investigation officers to complete in their interviews with NOK and witnesses following a youth suicide.

The questionnaire will prompt officers to look into salient factors in each case including the presence of conditions such as *depression, schizophrenia; autism, ADHD, impulse control* **and** *rage* **issues.**

Officers will also inquire into the presence of *bullying, stalking, sexual harassment***, as well as difficulty in coping with studies, parental and peer relations, and the presence of** *prior suicide ideation* **or** *attempts***.**

To be applied retroactively to the unclosed cases of youth suicides that have occurred in 2016.

A version, adapted for adult suicides, is being developed.

A copy can be provided to you.

Drowning prevention

- 9 drowning cases in 30 month period (Jan 2014 to June 2016) of children aged 12 and below
- Near drownings according to a major children's hospital saw 105 cases of children ages 1-15 years between 2011-2015
- 7 of 9 cases involved children age 6 and below.
- Three were tourists, another three were residents who visited unfamiliar public/resort pools.
- Supervision issues played a major role. In two cases parents were engrossed over handphones. In 5 cases, there was no designated caregiver. In one case both parents assumed the other was looking after the child.

Drowning prevention

- Absence of overt signs of drowning

Effective measures

- Touch supervision (ie being in pool and close enough to touch) is the gold standard
- Conspicuous depth markets to address child's propensity to wander
- Pool design to avoid blind spots, better lighting, and avoiding hidden obstacles in landscaping
- Educating in use of AED, in one case lifeguard appeared ignorant that AED could be used for a five year old
- CCTV to aid in prevention, and be an incontrovertible record

Certification by National Association of Medical Examiners

- 'The FMD (Forensic Medicine Division of the Health Sciences Authority), operating under the auspices of the State Coroner, *is a stellar example of a modern and professional medico-legal death investigation system that epitomises the paradigm of the multidisciplinary investigation*, and provides outstanding service to the residents of Singapore. Coroner Marvin Bay has an impressive level of knowledge in the area of knowledge of forensic medicine and death investigation, and is an outstanding ambassador…'.
- Dr Barbara Wolf, Chairperson of the Inspection and Accreditation Committee of the National Association of Medical Examiners (NAME).

Singapore is the first country, outside North America, to have received this certification

STATE COURTS
SINGAPORE

Thank You

Any questions?