

4. The Prevalence of Aboriginal Suicide—Definitional Problems

Statistical data on suicide as they are compiled today deserve little if any credence; it has been repeatedly pointed out by scientific students of the problem that suicide cannot be subject to statistical evaluation, since all too many suicides are not reported as such. Those who kill themselves through automobile accidents are almost never recorded as suicides; those who sustain serious injuries during an attempt to commit suicide and die weeks or even months later of these injuries or of intercurrent infections are never registered as suicides; a great many genuine suicides are concealed by families; and suicidal attempts, no matter how serious, never find their way into the tables of vital statistics ... one is justified, therefore, in discarding them as nearly useless in a scientific evaluation of the problem.

—Gregory Zilboorg¹

1. Aborigines in vital statistics

Until the mid-1960s, most Aboriginal affairs administrations and other service agencies kept separate statistics on Aborigines because they were a separate legal class of persons in most states and the Northern Territory. They were, in effect, minors, subject to special statutes which prescribed their separate, segregated and incarcerated lives in reserves, missions and settlements. Every aspect of life was separate, and inferior—housing, wages, employment, training, health services, voting rights, social service benefits, and status in the courts. Section 128 of the Australian constitution had precluded the counting of ‘full-blood’ Aborigines in the national census. Thus, no vital statistics were available, apart from those kept ‘unofficially’ by special Aboriginal affairs administrations, health and police services.

The 1967 referendum removed the census preclusion, and Aborigines became, in theory, part of the national count after 1971. Because the initial framing of the ‘indigenous’ question was awkward, it is fair to say that the 1991 census was the first one to approximate the realities of Aboriginal and Islander demography. However, the disparities between the 1991 and 1996 figures are so great that the former must be disregarded as inaccurate. Between the 1960s and the mid 1970s, most states took refuge in the contention that keeping separate statistics was a form of *apartheid* and therefore unconscionable. Aboriginal vital statistics became part of the mainstream. In the name of assimilation or equality, or both, a range of serious problems was lost in mainstream figures. Aboriginal affairs administration operated in a statistical vacuum. Administrations sought parliamentary budgets for unspecified numbers of people in diverse programs. Problems could not, therefore, be adequately addressed because they could not be quantified or even accurately estimated.

The Australian Bureau of Statistics (ABS) has published material showing the

changes in population between 1991 and 1996. The greatest increase was that of Aboriginal and Islander populations. The NSW Aboriginal population ‘increased’ from 70,019 in census 1991 to 101,485 actually counted in census 1996. There is much evidence, however, to suggest considerable under-enumeration, on both occasions, of people of ‘indigenous origin’. Many minority groups under-enumerate. (For example, demographers believe the under-enumeration of Jews to be as high as 25 per cent. Historic reasons explain why they do not wish to be part of any national ‘list’.) It is probable that the growth in Aboriginal numbers between 1991 and 1996 was due to a greater willingness in 1996 to self-identify rather than to reproductive growth and/or a diminution in mortality. To this the ABS adds ‘the higher fertility of Indigenous women’ and the fact that ‘many children of Indigenous origin have one rather than two parents of Indigenous origin’.²

There are many examples of under-enumeration in this study. Kempsey town and surrounds records a 1996 census figure of 2,273 Aborigines, yet every agency there asserts an ‘area of Kempsey’ population of 5,000; there is no reason to doubt the higher figure. The region known as Eurobodalla—which includes Batemans Bay, Mogo, Moruya, Wallaga Lake, Narooma, Bodalla, and surrounds—lists 1,134 Aborigines. Police and Aboriginal organisation sources say the truer figure is at least 3,300. For Orange and Bathurst, the claim is between two and three times the census figures. It is also improbable that Narooma has only 79 Aborigines. On the other hand, in the small town of Dungog, the census shows 393 persons of ‘indigenous origin’, yet the police sergeant and local publicans claim, at most, two or three. We are convinced of the accuracy of their local knowledge. Cobar is listed as having 372 Aborigines, but the local Aboriginal Land Council considers half that number more realistic. On the basis of our ‘coverage’ of just over a third of the State’s Aboriginal population, it is likely that a more accurate total is 130,000, perhaps even 150,000 people.

In sum, Aboriginal demography remains a confused and confusing area and attempts to define rates of various phenomena—from causes of death to the prevalence of delinquency or renal disease, let alone suicide—must remain speculations, even high order speculations. There are no hard ‘data’.

The ABS has published *Causes of Death—Australia* for the year 1997.³ The following appears in a very short, but important, paragraph headed ‘Indigenous Deaths’:

This publication includes Indigenous deaths data for South Australia, Western Australia and the Northern Territory. ... It is *estimated* that more than 90% of Indigenous deaths in these States and Territories are identified. While other States have provision for the identification of Indigenous deaths on their death registration forms, deaths for these States *are considered to be under identified*.⁴ [my italics]

It concerns me to read what purports to be a better than 90 per cent accuracy in recording ‘Indigenous’ death in the three states mentioned. The first problem, discussed more fully below, lies in how to determine death by suicide and its recording by coroners.

The second is in establishing the Aboriginality of the deceased. In 1997, in South Australia, there were 6 Aboriginal suicides officially recorded as such; in Western Australia, 9; and in the Northern Territory, 11. In New South Wales for that year, there were, at the very least, 28 Aboriginal suicides in the 55 locations we examined *in situ* and in the State Coroner's Office in Glebe. I believe that the figure was higher, but Aboriginality, as will be explained, is difficult to determine.

In sum, either New South Wales is grossly aberrant or the figures for the other three jurisdictions are under-reported. The more likely possibility is that in none of the jurisdictions is there any mechanism, such as a set of protocols, for the proper identification of Aboriginal deceased. This leads to one major conclusion from this study: that Aboriginal suicide is under-reported and therefore under-recorded, and is perhaps three or four times higher—especially for young males—than stated in official documents and research papers.

2. The Aboriginal population in this study

The ABS has published a document on population based on the 'indigenous geography' maps developed from the 1996 census.⁵ The ABS gives populations based on actual counts on census night as well as estimates of population, that is, it attempts to add in people who belong in an area but who were absent from that area on census night. The sample in this study is 59 communities: the Aboriginal population in each of the areas covered by this study, based on the ABS document, is given below. The figures for the ACT (Canberra, Wreck Bay and Jervis Bay) are listed separately. The full list of sites visited is in Appendix I.

**Table I : ABORIGINAL [CENSUS COUNTED] POPULATIONS
OF SITES/COMMUNITIES VISITED**

(a) New South Wales

Armidale	1026	
Batemans Bay/Bingi Point	324	
Bathurst	828	
Bathurst surrounds	662	(excluding jail population)
Bega surrounds	207	
Bega	148	
Boggabilla	276	
Bomaderry & North Nowra	492	
Bourke	868	
Brewarrina	607	
Broken Hill	772	
Casino	631	
Cobar	372	
Coffs Harbour/Corindi Beach	712	
Coffs Harbour surrounds	345	

Condobolin	524	
Coonabarabran	492	
Cowra	477	
Dareton/Wentworth	422	
Dubbo	2714	
Dungog	393	
Eden/Two-fold Farm	162	
Eurobodalla:		
(excl. Narooma, Wallaga Lake)	650	
+ Forbes	+ 417	
Forster	399	
Grafton surrounds	564	
Grafton	646	(excluding 82 in jail)
Gunnedah	700	
Inverell	413	
Kempsey/Greenhills, surrounds	2273	
La Perouse (Botany)	488	
Lake Cargelligo & surrounds	309	
Lismore surrounds	675	
Lismore	1081	
Lithgow	402	
Menindee	138	
Moree	1822	
Murrin Bridge	199	
Nambucca/Macksville/Bowraville	650	
Narooma	79	
Narrabri & surrounds	549	
+ Newcastle	+ 1880	
Nowra	885	
Orange	1040	
Parkes	478	
Port Macquarie	517	
Purfleet	206	
Queanbeyan	704	
Tamworth	1626	
Taree	667	
Tingha	166	
Toomelah	222	
Tweed Heads	1064	
+ Walgett	+ 832	
Wallaga Lake	81	
Wee Waa	254	
Wellington surrounds	269	
Wellington	743	
Wilcannia	406	
+ Wollongong	+ 2138	
Woodenbong/Urbenville	403	
Total:	40,487	

Total NSW estimated resident Aboriginal population 1996: 106,294
Counted population in the study as a percentage of
the total estimated population:
38 per cent

(+ Not visited but suicides in each of these towns are included in the study)

(b) Australian Capital Territory

Canberra and district	2899
Jervis Bay/Wreck Bay	178

Total ACT Aboriginal population 1996: 3,077

Total New South Wales + ACT estimated resident populations:
106,294 + 3,153 = 109,447

Counted population in the study as a percentage of
the two total estimated populations: 43,566 in a total of 109,447 = 39.8 per cent.

3. Establishing Aboriginality in suicide records

Neither police reporting of non-natural causes of death, nor the coronial determination of the causes of such death, indicate the deceased's Aboriginality. Until early 1999, the police protocol form, known as 'P79A—Report of Death to Coroner', did not make provision for Aboriginal or Islander identity. It sought only citizenship—as in 'Australian' or 'foreigner'. The new form, not yet widely in use, includes the words: 'Deceased a native of Torres Strait Islander/Aborigine'. (Victoria's equivalent Form 83 does not provide for Aboriginal identification, although identification does appear every time a prisoner is placed in custody. The ACT police form does not stipulate Aboriginal identification.)

A typical 79A form, completed by the investigating or reporting police officer, describes the deceased, his or her personal details, the manner of finding the body, the apparent circumstances of the death, and any interviews concerning anyone who might have been last to see the person alive, and when. Rarely does a reporting officer specify Aboriginality. In some instances, where cause of death is uncertain, or where suicide seems the likely cause, a coroner's file will include witness or relatives depositions taken by police. These can be voluminous. Where the 79A does not mention Aboriginality, which is most usual, where there are no witness statements, and where no inquest is required by the coroner, *there is no way of knowing if the deceased was an Aborigine.*

The Registrar of Births, Deaths and Marriages has a compulsory form known as 'PR13 Registering a Death in New South Wales'. The cover sheet states: 'Ensure that the question about Aboriginal and Torres Strait Islander origin in part A is accurate in all cases.' The Part A questionnaire asks whether the deceased was of either group, or of 'mixed origin'. However, the PR13 requires the funeral director to answer whether there was a medical certificate or Cause of Death issued, or whether there was a

Coroner's order with or *without* cause of death. Unless the coroner issues an order *stating suicide as the cause of death*, we cannot rely on a PR13 as the basis for documenting Aboriginal suicide. The 'PR11 Order of Disposal of Body' form has no Aboriginal question. Put another way, unless someone in a statistics bureau compares a 79A form and its attachments with a PR13 form registering the death, we can never know who was an Aboriginal suicide. The one form almost never mentions Aboriginality; the other, which is required to, does not *require* the manner and cause of death to be specified.

Inquests are rare, and coroners usually dispense with them. Occasionally, the parents of a deceased will ask for, or demand, an inquest if they believe there was foul play in custody. Such inquests are intense and serious matters, especially since the Royal Commission. Inquests are not a ready avenue of identity. Where a coroner does send a body for autopsy, the forensic pathologist fills in a variety of protocol forms, including one with headings such as external and internal examinations, toxicology and alcohol readings. In no more than 15 to 20 per cent of cases will the pathologist describe the deceased, for example, as 'an undernourished young Aboriginal male', or 'female of Aboriginal appearance' or 'obese Caucasian male'. Even such bare descriptions are not a reliable index, based as they are on the criterion of skin-visibility, or that which 'appears in the eyes of the beholder'. There is no requirement for origin or identity. Nor is there any attempt in New South Wales to establish 'psychiatric' or 'mental' profiles of the deceased. If we are serious about establishing causes of suicide and strategies for intervention, there is a strong case for 'psychiatric autopsy', including both personal and social profiles of the deceased. Michael Dudley *et al* have reported on non-rural youth suicide in New South Wales.⁶ They used coroners' records but constructed a 'best guess' psychiatric diagnosis, using demographic data; potential risk factors, including psychiatric symptomatology, past attempts, substance abuse, chronic illness or handicap, criminality, and exposure to suicide; circumstances surrounding the deaths, including precipitants, involvement of alcohol and other drugs, notes left, geographic location and method of death. I could suggest several other topics for such autopsy. The National Health and Medical Research Council has asked for tenders from people who are willing to construct models for 'psychiatric autopsy'.

[I am drawn to the approach used in the United States. In Texas, for example, the *Code of Criminal Procedure*, at chapter 49, allows for the medical examiner (coroner) to 'request the aid of a forensic anthropologist in the examination of a body'. Such a person must be professionally trained and an accredited forensic science specialist. The job is to help determine physical characteristics and also 'the cause, manner, and time of death'. These anthropologists are usually brought in from universities, as consultants. The social and physical aspects of an autopsy are as important, if not more so, than the 'psychiatric'.]

The Office of the NSW Coroner, located in Glebe, has a copy of every local coroner's findings. The short reports are in Glebe, while the fuller versions remain in each coronial jurisdiction. Since very little can be gleaned from central records, the search for Aboriginality has to be conducted by field visits to each location. Even then,

Aboriginality must be checked with the local Aboriginal community.

Two examples of definitional problems occurred in this study. The first was in a north coast town where the coroner had two official suicides. We were given the name of a third suicide by the Aboriginal Legal Service (ALS), a name known to the coroner but one with no apparent Aboriginal connections. ALS checking found that he was Aboriginal, and a known client of the legal service. The second, in 1997, when a man hanged himself in the cells in Tamworth. One Aboriginal informant, a clinical psychologist, knew him well: she claimed he was not Aboriginal but had 'lived' Aboriginal and had associated only with Aborigines. Another informant employs the deceased's mother whom she insists is Aboriginal. While in the cells, the deceased said he was Aboriginal.

In sum, how does one recognise a suicide as Aboriginal? The *partial* answer lies in consulting a long-serving local coroner, or a long-serving police officer who knows the local townspeople and who recollects, from local intelligence and local networks, that the deceased was Aboriginal. The smaller the town, the more likely it will be that the deceased is recalled. Although each coroner maintains a hand-written index of suicides by name and by year, nowhere did we find an index which lists Aboriginality alongside the name.

We deduced many instances of Aboriginal suicide by reading the witness depositions. The family name of the deceased and of their relatives was often well-known. The names of the places of interview, the domicile area of the witness, the clues given by a witness, such as references to 'the mission', and often, the use of what is clearly 'Aboriginal English' added to a portrait of the deceased. In most cases, certainly for the 55 places visited in this study, Aboriginal suicides were traced and documented for us by relatives, then double-checked with the local coroner's files.

Interviews with relatives and family, interviews with coroners and police officers, checking the local coroner's files, and double-checking in the Glebe records office is an excruciatingly tedious and wasteful way of establishing the picture and prevalence of Aboriginal suicide. Unlike the Hunter-Reser study of North Queensland, there were no discrete communities, like Yarrabah, Mornington Island and Palm Island, which keep their own records of such events.

There are similar problems in New Zealand. All informants expressed the view that there is under-reporting of Maori suicide, and that even where there is a record of attempted and actual suicide, 'classification' of the person is (too often) dubious. Tension arises, for example, where a research project examines suicidal deaths within a particular geographic area but where the young Maori has taken his life outside of that area. There are two domains of belonging: a Western, geographic boundary for research purposes, and a strong Maori sense that the youth belonged to their *iwi*, and will be buried in their *marae*. Coroners and police have sometimes overlooked the Maoriness of those suicides who take their lives distant from family and who are blonde, blue-eyed and 'non-Maori-looking'.

4. What is suicide?

There is a strongly adhered to convention rather than a law which regulates coronial dealing with suicide. Keith Waller's *Coronial Law and Practice in New South Wales* states 'suicide is not to be presumed. It must be affirmatively proved to justify the finding.' The custom derives from the British precedent, made plain in 1912 and reinforced in 1975 in *R v HM Coroner for City of London*.⁷ The Chief Justice held that a coronial presumption of suicide, however strongly suggested, by a man who had climbed over 'effective rails' on the roof garden of his apartment building and fallen, was invalid:

If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict.

There is a phenomenon I describe as 'kind hearts and coroners'. It has several ingredients, not all of which, of course, are shared by all coroners in all times and places. In general, the factors underlying coronial bias are:

- the concealment of suicide for humane reasons;
- avoiding the stigma which families see as inherent in 'a suicide';
- avoidance mechanisms through kinder labelling as 'accidental death', 'death by misadventure', 'cause unknown', 'open finding';
- Catholic or other religious adherence which generates a reluctance to make a finding of suicide, especially if the victim is a fellow co-religionist;
- perceived difficulties, real or imagined, about legal, inheritance or insurance consequences.

A considerable number of people in New South Wales die from overdoses of drugs and prescription pharmaceuticals. In virtually every case, the coronial finding is *not* suicide. Coroners often simply don't know. In the absence of trained 'profilers', the more uncertain suicides—the single-vehicle road accident and the overdose cases—will remain uncertain. However, some people die because they do not care whether they live or not.

The Australian Institute for Suicide Research and Prevention has suggested a three-option model: those cases which are *beyond reasonable doubt* (BRD, greater than 90 per cent certainty), those which are *probable* (PROB, 50 to 90 per cent certainty) and those which are *possible* (POSS, 20 to 25 per cent certainty). I suggest that coroners should be explicitly allowed what are sometimes called 'error bars', 'margins of error' or 'tolerance levels'. In this way, we may well arrive at a better picture of the suicide phenomenon in our society.

Most coroners' courts are in buildings either close to, adjacent to, or even under the same roof as, the local police station. There is a strong sense of social mix, of tea and lunch breaks, of *camaraderie* between police and court officers. There is no inference of collusion but a circumstance which can lead to a well-intended 'corruption of truth' to spare individuals in small towns from any avoidable ignominy, stigma or shame. The Australian systems, at least in Victoria and New South Wales, do not require the coroners or coroner-clerks to bring in verdicts of suicide, or to use the word.

All but two coroners interviewed admitted to a predilection for avoiding a suicide finding if possible. Thus, all single-vehicle car smashes, some occurring on good roads, in good weather, with no alcohol or drug impairment, and no skid or braking marks, are listed as accidental death. Some prefer the term 'misadventure'. Several such cases include reports of the deceased clutching rosary beads. (A preliminary Victorian study of fatal single-vehicle crashes in 1995–96 suggests that in 'less than 5 per cent [of 127 crashes] was there any positive evidence of suicide (note, deceased had told friends')⁸. Even if only up to 5 per cent of such deaths were suicide, given the relatively small raw number of suicides, the rates of suicide would be considerably altered.) Most insist on the Waller dictum, the legalistic approach, which they define in this way: in the absence of a note and an overwhelming presentation of suicide, suicide will not be the verdict. Some have gone to greater extremes in the matter of what constitutes evidence. One example: Coroner XY, at town U, wrote in 1998: 'Z died as a result of Alcohol and Amitriptyline intoxication, however, I am not satisfied on the evidence that the deceased intended to take her own life.' Yet a Senior Constable had signed the P79A, which included this extract: 'It would appear the deceased [wife of a policeman] had become depressed over an incident on Friday night and during this Saturday night has (sic) drunk two bourbon and taken a quantity of tablets with the intent to take her life. A torn up note was located in the rubbish bin which indicates this intention.'

Following the ACTs recent appointment of a senior magistrate as chief coroner, there may well be greater uniformity of suicide verdicts, probably of a more legalistic nature. Until now, the system has meant that five or six stipendiary magistrates have given divergent coronial opinions concerning suicide.

None of the above implies, for one moment, that coroners lack integrity or are anything but dedicated. What is suggested is that suicide reporting and recording is deficient, often with good intention. Bias, which should have no place in such matters, is also inevitable, considering the State's system and geography. Two coroners in my research sites have lost sons to suicide. Several have stated that, even though their Catholicism has lapsed, they still regard suicide as sinful. Our observations, from a reading of all the files in all the locations listed in the Appendix, is that the raw figures for youth suicide in this State are *at least* two to three times greater than those officially listed.

It may well be that the actual numbers and the establishment of higher rates is really of little consequence, because what we need to recognise is that suicide by the young, both Aboriginal and non-Aboriginal, is rampant and needs serious attention.

Professor Peter Herdson—Director of ACT Pathology—gave me the results of a ten-year retrospective study of suicide in the ACT by his colleague, Dr Sene Colomboge. Of 2,600 autopsies, only 335 (12.8 per cent) were established as suicide. Only one was Aboriginal, a male, aged 19, recently found in a toilet block with a ligature round his neck. The authorities believe it was suicide; the parents claim it was murder and the matter has been sent to the ombudsman.

Of interest is that there were 99 carbon monoxide deaths, 88 by hanging, 50 by gun, 47 by prescription drug overdose, 15 by jumping, 7 by stabbing, 5 by drowning, 8 by chemical ingestion, 8 by fire or electrocution and 2 by plastic bag. Predisposing factors were: marital/domestic disputes—18 per cent of cases; psychiatric illness—28 per cent; unemployment—17 per cent; financial difficulties—9 per cent; facing trials—3 per cent; physical illness—7 per cent; drug addiction—4 per cent; alcoholism—3 per cent; loss of a loved one—1 per cent and perhaps 1 per cent in custody. I mention this study for two reasons. First, it may well serve as a portrait of non-Aboriginal suicide. Second, it suggests that autopsy, including ‘predisposing autopsy’, is more likely to reveal suicide than inquest. Professor Herdson contends that New Zealand has the best medical statistics in the Western world. However, their system is based on possibly one autopsy in every 20 coronial-necessary deaths: he wonders about the nature of the remaining 19.

There is much less of the imponderable in Dallas, for example. The Chief Medical Examiner has a staff of 10, including himself: between them they do some 4,000 autopsies annually. Importantly, *75 per cent of non-natural deaths go to autopsy*. The only omissions, are, for example, where a severely injured car crash patient lingers and eventually succumbs to injuries.

The British-derived model of not presuming suicide should be reconsidered. United States coroners may so presume. The injunction not to presume is a legacy from the earlier centuries of both stigma and criminality attending the act of self-destruction. Is there any ‘positive’ way of defining or declaring suicide? Wekstein describes suicide as ‘the human act of self-inflicted, self-intentioned cessation’. There is room for a model which is not predicated on the avoidance of presumption or of circumstantial evidence, but one which:

- excludes the presence or participation of second parties;
- excludes, by autopsy, possible or probable homicide;
- examines the deceased by physical autopsy for cause of death;
- excludes ‘almost certain’ accident;
- investigates, through trained assessors or forensic anthropologists, the personal, social and, where relevant, the community profile of the deceased;
- gives a weighting to the manner of death as a factor in the final assessment;
- renders a conclusion framed as being ‘suicide beyond reasonable doubt’, ‘probable suicide’ or ‘possible suicide’.

Using this model, and provided we are willing, as a society, to ‘stretch’ suicidal behaviour beyond that which is manifestly suicide, as determined by our present forensic or coronial evidence culture, the assessors could achieve most of what coronial enquiries are intended to achieve. A ‘full-scale’ inquest can always be invoked as the final arbiter. In this way, we should be able to do better than we are doing. We should be able to diagnose or confirm suicide in many of the categories discussed in the following chapter. Some instances—the suicides by omission—simply cannot be substantiated: those, for example, who ‘fail’ to take their medications or their insulin injections, or whose indulgence in high-risk activities, such as running red traffic lights, might be hard to differentiate from anti-social behaviour.

Attempted suicide, or parasuicide (I use both terms), has to be viewed in conjunction with suicide. Stengel defines it as ‘the non-fatal act of self-injury undertaken with conscious self-destructive intent, however vague and ambiguous’. Attempted suicide has only recently received attention: ‘It used to be treated as merely bungled suicide, undeserving of special interest except as a symptom of mental disorder, but in fact requires special study because it presents many important problems of its own which do not arise from suicide.’⁹

In the mid-1990s, there was a move to have a uniform coronial system in Australia. For reasons unknown to me, it was taken off the agenda. Given the problems experienced in this study, in Hunter and Reser’s work, and in suicide research in Victoria and elsewhere, I suggest that the uniformity issue be reconsidered.

5. Who is a coroner?

In Victoria, all magistrates are qualified as coroners but not all of them do coronial work. They usually undergo a two-week coronial training course. Perhaps ten per cent of their workloads involve coronial matters. Some 90 per cent of these cases do not go to inquest, and in non-inquest matters in the non-metropolitan regions, clerks of petty sessions write up the findings. As in New South Wales, there is a full-time State Coroner and two (rather than three) full-time senior coroners.

In the United Kingdom, some jurisdictions require the coroner to be medically or legally qualified, or to have both qualifications. In some United States jurisdictions, the office of coroner is considered a prize, earned through a hard-fought electoral contest. Few untrained people occupy these positions. For the larger cities, coroners are appointed as medical examiners, that is, they are salaried, qualified and accredited forensic pathologists. In smaller towns, justices of the peace act as coroners and inevitably refer ‘uncertain’ deceased cases to a forensic pathologist, either locally or in the nearest larger city. New Zealand appoints coroners from among the ranks of practising solicitors or barristers, professional people who remain distant and aloof from police procedures. All but three of New Zealand’s coroners are legally qualified. Each coroner has at least one full-time inquests officer, a policeman, whose loyalties—at least as judged by interviews with them—reside with the coroners, not with the

police. In cities like Dallas, the medical examiner has several ‘death investigators’, men and women with university degrees as well as on-the-job training. They work to, and for, the medical examiner and have co-equal access to death and crime scenes with police. In New Zealand, there appears to be no local clerk-coroner system, as in New South Wales. Nonetheless, almost all of our informants confirmed under-reporting of suicide.

In New South Wales, most small town and rural coroners have a mixed set of duties: they act as clerks of petty sessions courts, chamber magistrates, court registrars, licensing officers and coroners. Very few (of those encountered in this study) have tertiary education. Only one, to my knowledge, has a university degree. Some attended a short training course in Sydney (two days to a week long) in coronial practice; others have not had even that small benefit. Several refer cases to the State Coroner in Glebe, which is staffed by professionals, when they feel a case is too difficult and beyond their ken.¹⁰ All report immediate and positive response from head office. However, self-confidence and self-sufficiency operates in most cases.

Catholic countries tend to show lower rates of suicide than Protestant societies. David Lester—among many other scholars—reports on the perennial problem of the reliability of suicide figures, but suggests that, in the United States, there has been some consistency in reporting, even over a period of a century. My report is not an investigation of coronial practice, but I do suggest that a study be undertaken of several aspects of this State’s coronial system. Several matters, pertinent to reporting, consistency and reliability in suicide matters, warrant attention and amelioration.

6. Who is a youth?

The convention in suicidology, that youth lies between the ages of 15 and 24, has its origins in a consensus World Health Organisation model which was adopted for statistical convenience. I can find no valid social or sociological reason for the confinement of ‘youth’ within these margins. Moreover, to confine Aboriginal youth suicide to the same 15 to 24 cohort as would apply to non-Aborigines is to equate quite different life-spans. An Aboriginal man’s life has neither the structure nor the seasons of a white American or a white Australian male’s life. Non-Aboriginal life expectation at birth is now close to 80; the Aboriginal figure, as I have mentioned, is lower, averaging 15 to 20 years less than the non-Aboriginal. In general, Aboriginal life is at least two, even three, decades shorter. There is, undoubtedly, an accelerated ageing in Aboriginal men, with lifestyle diseases occurring much earlier in life. In many respects, Aboriginal youth becomes older sooner than non-Aboriginal youth: there is earlier sexual development and experience, earlier exposure to danger, disease, and death. Their age of innocence ends much earlier.

Since—rather than if—most Aboriginal males are dead by 50, or even by 40, there is an insurmountable problem in adhering to the WHO definition by classifying Aboriginal youth as 15 to 24. There may be value in devising a new framework for

Aboriginal youth, one which attempts to establish a template incorporating both biological age and something akin to ‘social maturity’. The ‘youth’ cohort may more appropriately be considered as 12 to 18. The objective must be better definition and the alleviation of Aboriginal-specific suicide problems, rather than the publication of neat tables of cohorts for statistical comparison with societies which are inherently different and, therefore, not comparable, as elaborated in this and the next chapter.

A growing proportion of Aboriginal suicides, especially in Queensland, are younger than 15. This study includes a 12-year-old and a 14-year-old, neither of whom should be omitted. Strict adherence to the WHO model would preclude them. There is, indeed, a strong case for establishing a new category of ‘child suicide’. This study includes an 8-year-old parasuicide, another 8-year-old old possible suicide, and evidence of many self-harm cases among those under 15.

Endnotes 4. The Prevalence of Aboriginal Suicide—Definitional Problems

1. Durkheim, 18. Zilboorg’s quotation is from his ‘Suicide Among Civilized and Primitive Races’, *American Journal of Psychiatry*, 92, 1935–36.
2. ABS, *Population Distribution*, 9.
3. Australian Bureau of Statistics, Catalogue No 3303.0, 1999.
4. *Ibid.*, 74.
5. ABS Catalogue 4705.0.
6. Dudley *et al.*
7. *All England Law Reports* [1975] 3 All ER, 538–40.
8. Personal communication from Annette Graham, research officer, State Coroner’s Office, Victoria. The study referred to is ‘Characteristics of Fatal Single Vehicle Crashes’, Narelle Haworth *et al*, Monash University Accident Research Centre, September 1997, Report No 120. Ms Haworth is the author who is quoted as talking with Ms Graham.
9. Stengel, 11–13.
10. The Coroner’s Support Unit has an Inspector, a sergeant and a senior constable in Glebe, a sergeant and senior constable in Westmead, five case officers and four investigators at Glebe, two prosecutors and two investigators at Westmead. The Office contends that it is understaffed.