

FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the Coroners Act 2008

Court reference: 2351/09

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname: DICKSON
First name: LINDSAY
Address: 735 Tonimbuk Road, Tonimbuk, Victoria 3815

without holding an inquest:

find that the identity of the deceased was LINDSAY OWEN DICKSON
and death occurred on 8th May, 2009

at Guide Track, Bunyip State Forest, Tynong North, Victoria 3813

from

1a. CARBON MONOXIDE TOXICITY

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr Dickson was aged 55 when he died. He had recently become unemployed. A previous marriage had ended many years ago and Mr Dickson had no children. He lived alone at 735 Tonimbuk Road, Tonimbuk.
2. A police investigation was conducted into the circumstances surrounding the death. It was apparent that on 7 May 2009, Mr Dickson posted a note to Parks Victoria informing them of his plan to suicide and where his vehicle would be found. He then drove his gold Ford Falcon WFY092 into the Bunyip State Forest, parked it on the Guide Track and set about implementing his plan to take his life by motor vehicle exhaust gas poisoning.

3. The next morning a young girl came upon Mr Dickson whilst out walking. Emergency Services were alerted and attended, but it was apparent that Mr Dickson was deceased.

4. Letters he wrote were located in the vehicle and they provided a poignant insight into the reasons for his actions. According to Mr Dickson, he had suffered longstanding unhappiness with "depression and alcohol" taking their toll. It is not apparent from the investigation that Mr Dickson was receiving any professional treatment for his symptoms.

5. The coroner granted an application by the family of Mr Dickson to not direct an autopsy and Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination. In her report she made the following comments:

"The family of Lindsay Owen Dickson have lodged an objection to autopsy under Section 29 of the Coroners Act (Vic) 1985.

Lindsay Dickson was a 55 year old male who according to the circumstances as detailed in the Victoria Police Report of Death Form 83, was seen by a passer by in the Bunyip State Park. The passer by saw plastic hose affixed to exhaust leading into cabin of vehicle the engine running. The police contacted.

The deceased was found slumped over driver's seat. Also in the car was a deceased dog. A suicide note had been sent to Victoria Park Rangers detailing intentions and location of vehicle. A second suicide note to family member was located on the front dashboard. The second note stated that the deceased was an alcoholic and depressed.

Urgent CO levels are measured on blood at 76.85%.

The cause of death in this 55 year old man is carbon monoxide toxicity.

Toxicology is required. Whilst post-mortem toxicological analysis can be undertaken, rational interpretation of the results can be difficult in the absence of a completed post-mortem examination."

6. Unfortunately, I find that Mr Dickson has succumbed to his depression and intentionally taken his life by motor vehicle exhaust poisoning.

COMMENT PURSUANT TO S.67(3) CORONERS ACT 2008

1. The Coroners Prevention Unit (CPU) was requested to provide information on motor vehicle exhaust gas (MVEG) suicides in Victoria. The CPU reported that between 1 January 2000 and 31 December 2009 there were a total of 906 MVEG suicides. The annual number of Victorian MVEG suicides more than halved between 2000 and 2009, mirroring falls that have been observed both interstate and overseas. According to experts in Australia and internationally, the most likely explanation for this decrease is the increasing penetration of catalytic converters (which remove carbon monoxide from exhaust gas) into the car fleet, coupled with stringent carbon monoxide emissions standards. Very low carbon monoxide levels mean that the exhaust is either not fatally toxic, or takes far longer to fatally poison a person, creating opportunities for intervention.

2. The CPU identified a number of previous Victorian coroners' comments addressing MVEG suicide prevention, however pointed out that most of these comments were variations on the following theme:

"It is noted that there has been a recent Monash University Accident Research Centre report by Routley, Short and Ozanne-Smith (June 2004) entitled "Motor Vehicle Exhaust Gassing Suicides in Australia: An Update" which details the ongoing extent of the problem for the community. In relation to countermeasures, the report makes a number of recommendations which are worthy of consideration by the appropriate authorities, manufacturers and suppliers of motor vehicles. A copy of the report can be obtained from Virginia Routley, Monash University Accident Research Centre. Previously a copy of the report has been forwarded to relevant authorities by the State Coroner's Office."

3. In the 2004 report referenced in the above quote, Routley et al offered seven suggestions for how to approach MVEG suicides and associated opportunities for prevention. Four of the suggestions concerned the need for further research and improved data on MVEG suicides. The other three suggestions addressed preventative countermeasures. In summary, they were:

- (a) That all vehicles manufactured prior to 1997 be retrofitted with specially designed attachments that hinder attempts to connect hoses. Proposed features of such an attachments include a grill to cover the end of the pipe, and an extra-wide pipe mouth.
- (b) That exhaust pipes on new vehicles be designed to hinder attempts to connect hoses.
- (c) That new vehicles be fitted with sensors to detect the level of carbon monoxide and carbon dioxide in the cabin. If the level is potentially harmful (as occurs during an MVEG suicide attempt), the sensor switches off the engine and rolls down the windows.

4. In the six years since Routley et al's paper was published, there do not appear to have been any major developments in Australia with respect to pursuing any of these three countermeasures.

5. In 2007, Virginia Routley published an paper on MVEG suicides titled, "Motor Vehicle Exhaust Gas Suicide: Review of Countermeasures", Crisis, vol 28 (supplement 1), 2007, pp.28-35, in which she provided an update on the evidence supporting the countermeasures and reviewed the recent literature on MVEG suicide.

6. Consideration should be given to undertaking further research to reduce the number of similar preventable deaths from carbon monoxide toxicity due to the inhalation of motor vehicle exhaust gas. Although the significant decrease in Victorian MVEG suicides over the past decade is encouraging, further opportunities for intervention could productively be explored. Two such areas are:

- (a) Why MVEG suicide victims are dying in cars that comply with current stringent emissions standards. Are they still dying from carbon monoxide poisoning? Or asphyxia as a result of elevated carbon dioxide levels and diminished oxygen supply in the vehicle cabin? Or, as has also been suggested by some researchers, are they dying from methemoglobinemia? The cause of death will in large part shape the search for further interventions.

- (b) Is the decrease in Victorian MVEG suicides a result of less people attempting MVEG suicide because they know catalytic converters will inhibit their attempts? Or it is a result of more attempts that do not culminate in death because the reduced levels of carbon monoxide mean that victims are found before they die?

Signature:



HEATHER SPOONER
Coroner



3rd February 2011