IN THE CORONERS COURT
OF VICTORIA
AT WANGARATTA

Court Reference: 4056 / 2010

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, SUSAN JANE ARMOUR, Coroner having investigated the death of XY

without holding an inquest:
find that the identity of the deceased was XY
aged 54
and the death occurred on or about 21 October 2010
near Upper King River Road, Lake William Hovell, Cheshunt South, Victoria, 3678
from:

1 (a) CARBON MONOXIDE TOXICITY

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**[1]:

1. XY was a 54-year-old unemployed man who resided alone near Shepparton in Victoria at the time of his death. He had separated from his wife, the mother of his two sons, in 2001 and although they subsequently divorced, they had remained good friends.

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[1] The circumstances of XY's death were the subject of an investigation by Detective Leading Senior Constable Jason Bray (29378) of Victoria Police who prepared an Inquest Brief for the Coroner. I have drawn from this investigation in making my factual findings. I was also provided with a copy of the Victoria Police Ethical Standards Oversight Report dated 25 May 2011.

2. Mr XY originally sought help for depression in 1992. Family members reported that he attempted suicide by carbon monoxide poisoning in 1998 but did not seek any treatment at that time. On 7 May 2000, he sought assistance from Goulburn Valley Mental Health at which time he advised of a second recent suicide attempt by carbon monoxide poisoning. Mr XY was subsequently referred to his GP and although he routinely saw one over the following years, there was only one other occasion when he sought assistance for depression.

2. On 18 October 2010 Mr XY was arrested and interviewed by Victoria Police in relation to allegations of historical child sexual assaults. Mr XY was spoken to by a Sergeant before being released from custody at about 11.03am that same day and Victoria Police reported that during police contact, Mr XY did not complain or raise any concerns about his welfare and no concerns were held or identified by police at that time.

3. On 18 October 2010, following his release from custody, Mr XY withdrew the bulk of the funds from his bank account. On the morning of 19 October 2010, Mr XY sent a text message to his son asking that he look after his dog and his son assumed his father was going away fishing for a few days. That afternoon Mr XY withdrew a further $40.00, leaving a balance of $1.14 in his account. On arriving at his father's home around 6.30pm that evening, his son found a note from Mr XY, together with a Superannuation Statement, which he read as meaning his father intended to kill himself. These concerns were reported to the Shepparton Police that evening and Mr XY was listed as a Missing Person on the Victoria Police LEAP databases. Police Communications also requested patrolling police in the Shepparton region keep a lookout for Mr XY and his vehicle.

4. At approximately 10.30am on Thursday, 21 October 2010 Mr Leigh Maples, an employee of the Department of Sustainability and Environment, was investigating a report of a suspicious vehicle. He found Mr XY deceased in his vehicle that was parked on a bush track situated at the rear of car parking facilities off the Upper King River Road at Lake William Hovell, Cheshunt South in Victoria. The keys were in the ignition and the car engine was still running. On finding the vehicle unlocked, Mr Maple turned the engine off but otherwise left the vehicle

undisturbed. Police attended and observed a garden hose, inserted under the surrounds of the front passenger window, that was connected to the car's exhaust pipe and secured with tape. A loaded double barrel sawn-off shotgun was located on the front passenger seat.

5. Victoria Police did not identify any suspicious circumstances during their investigation and formed the view that Mr XY had taken his own life. The firearm was unregistered and very old and had belonged to Mr XY's father. The cuts on the firearm appeared fresh and the reduction in the length suggested that Mr XY may have considered taking his life using that means.

6. Family members indicated that, prior to his death, Mr XY was showing signs of stress and depression as a result of financial difficulties and poor employment prospects but had been too proud to seek help. They were not aware of his interview with Victoria Police on 18 October 2010.

7. No autopsy was performed as the Coroner determined, after advice from the medical investigator, Dr Sarah Parsons, Forensic Pathologist with the Victorian Institute of Forensic Medicine, that a reasonable medical cause of death could be established on the existing information. Dr Parsons performed an external examination of Mr XY at the mortuary, reviewed the circumstances of his death, the CO (carboxyhaemoglobin) levels and the post mortem CT scan and provided a written report of her findings. Dr Parsons considered that a reasonable cause of death in all of the circumstances was carbon monoxide toxicity.

8. The toxicologist, Ms Melynda Hargreaves reported the level of carboxyhaemoglobin at approximately 74% saturation and noted that levels of carboxyhaemoglobin that exceed 50% saturation are considered life threatening. She further noted "analysis of a series of fatalities due to accidental or intentional inhalation of automobile exhaust gases has revealed carboxyhaemoglobin concentrations ranging from 48 to 93% with an average of 72% (Baselt, 2004)." Mr XY's blood alcohol concentration was 0.02 g/100ml but no other common drugs or poisons were detected.

9. Given all of the circumstances, I find that Mr XY intentionally took his own life on or about 21 October 2010 and that the cause of his death was carbon monoxide toxicity.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2*008 I make the following comments connected with the death:

1. In light of the circumstances of Mr XY's death I asked the Coroners Prevention Unit (CPU)[2] to report on the frequency of suicide deaths among Victoria males involved in the justice system in relation to alleged sexual offences against children. I also requested they undertake research into whether other police forces have in place any procedures to manage suicide risk when a suspect is questioned regarding sexual offences involving children and then released, and whether they provide any information to those suspects regarding support and counselling services.

2. The CPU performed a preliminary keyword-based search of coronial data bases and identified 36 deaths[3] reported to the Coroner between 1 July 2000 and 30 June 2011 which were the result of self-harm and the deceased person had been involved with the justice system in relation to sexual offences involving children. In 17 of the 36 deaths identified by the CPU, the deceased had a date of legal significance within 24 hours of their death. The CPU research is still at an early stage, and whilst the proximity between justice system contact and suicide does not necessarily translate into a causal relationship between the two, there is anecdotal evidence to suggest that the risk of self-harm may be higher for those individuals being investigated for sexual offences, including sexual offences involving children, than for other types of offences.

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[2] The Coroners Prevention Unit ("CPU") was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner in formulating prevention recommendations and comments, and monitors and evaluates their effectiveness once published.

[3] I am advised by the CPU that 36 deaths identified in the keyword search may be a significant under-estimation for the period. The CPU, in a separate pilot examination of Victorian suicides in the first four months of 2009, identified a further six deaths that were not identified using the keyword search.

3. The CPU could not identify any police force that has specific formal policies or procedures in place for dealing with suspects in child sexual offences although the Western Australia Police are currently working on a policy for their Child Abuse Squad regarding perpetrator support.

4. Victoria Police advised that their members are required to undertake a number of welfare/risk assessment type checks when interviewing offenders generally but there are no specific policies and procedures in place for managing self-harm or suicide risk among individuals questioned in connection with child sexual offences. Within Victoria Police, however, it is recognised that the psychological and social implications of being interviewed or charged with sexual offences is significant, especially when the offending is against children or involves child pornography. Victoria Police advised the CPU that the Internet Child Exploitation Team (ICET), which is part of the Victoria Police Sexual Crimes Squad, has developed an internal policy on suspect welfare management which emphasises the need to ensure an offender's wellbeing is maintained and identifies suitable questions and suggested welfare strategies to be considered at the conclusion of an interview with a suspect.

5. Whilst I acknowledge the legitimate concerns - both in Victoria and interstate – that it is not reasonable to expect police officers to undertake clinical suicide risk management as part of their duties, the process adopted by ICET is in the nature of a welfare exercise. I commend ICET for this initiative and believe it might be productive to extend it to other areas of Victoria Police that are dealing with sexual offences.

RECOMMENDATION

Pursuant to section 72(2) of the *Coroners Act* 2008 I make the following recommendation connected with the death:

1. That Victoria Police consider the development of guidelines for the welfare management of suspects charged or interviewed in relation to child sexual offences with a view to minimizing the risk of self-harm. Such guidelines might include information about appropriate support and crisis assistance services available to suspects in their locality.

PUBLICATION OF FINDINGS AND REPORT

Pursuant to Rule 64(3) of the *Coroners Court Rules* 2009, I order that my finding, comments and recommendation be published on the internet. Publication of my finding, comments and recommendations is subject to my further order pursuant to Rule 62A of the *Coroners Court Rules* 2009 to suppress details that identify, or may tend to identify the deceased or his family.

DISTRIBUTION OF FINDING

Apart from the family and the investigator, I direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to –

Chief Commissioner Ken Lay, Chief Commissioner, Victoria Police

Secretary – Department of Justice

Signature:

SUSAN JANE ARMOUR
Coroner

Date**: 13 September 2012**