IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1315

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**JAE WILLIAM JAMES MANNING**
Date of birth:	13 February 1992
Date of death:	On or about 20 March 2018
Cause of death:	1(a) ASPHYXIA IN THE SETTING OF AN IRRESPIRABLE ENVIRONMENT
Place of death:	Quest Apartments, 43 Lonsdale Street, Melbourne, Victoria

HER HONOUR:

Background

1. Jae William James Manning was born on 13 February 1992. He was 26 years old when he took his own life on or about 20 March 2018.

2. Mr Manning was raised in Queensland. His childhood was affected by the separation of his parents and the death of his sister. His mother, Linda Exley, described her son as a very affectionate person who was outgoing and social.

3. In recent years Mr Manning moved to Sydney and became somewhat estranged from his family. Ms Exley explained that her son kept some parts of his life distinctly separate. For example, she had never met her son's partner during their two-year relationship. Similarly, she was unsure about his employment.

4. In 2017, Mr Manning moved to Port Melbourne with his partner, Jacob Squire.

5. In the days before his death, Mr Manning's relationship with Mr Squire ended. Mr Manning subsequently moved out of their townhouse and into a hotel. He later sent a text message to a friend that he had made some changes to his will.

6. At the time of his death, Mr Manning was charged with a number of fraud-related offences and was due to appear in a New South Wales court on 26 March 2018, and at the Melbourne Magistrates' Court on 7 June 2018. It appears that his family and friends were unaware of the extent or detail of these legal issues.

7. His medical and mental health history is unknown as he did not attend any medical practitioners in Victoria.

The coronial investigation

8. Mr Manning's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

9. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding

circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

10. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

11. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

12. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Manning's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

13. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

14. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

15. Mr Manning was identified via circumstantial evidence and fingerprint identification on 22 March 2018. Identity was not in issue and required no further investigation.

Medical cause of death

16. On 21 March 2018, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Manning and reviewed a post mortem computed tomography (CT) scan.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

17. Toxicological analysis of post mortem specimens taken from Mr Manning was negative for common drugs and poisons.

18. After reviewing toxicology results, Dr Francis completed a report, dated 23 March 2018, in which she formulated the cause of death as "*1(a) Asphyxia in the setting of an irrespirable environment*". I accept Dr Francis's opinion as to the medical cause of death.

Circumstances in which the death occurred

19. At approximately 12.30pm on 20 March 2018, Mr Manning was found lying on the floor of a Quest serviced apartment in Melbourne. He had a plastic bag tied around his head, which was connected to a small gas cylinder via a tube. The cylinder contained helium.

20. Ambulance paramedics were called but they could not revive him.

21. Victoria Police attended the scene and found a number of letters addressed to Mr Manning's family and friends. A receipt for two helium tanks was also found in the apartment.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Jae William James Manning, born 13 February 1992;

(b) Mr Manning died on or about 30 March 2018 at Quest Apartments, 43 Lonsdale Street, Melbourne, Victoria, from asphyxia in the setting of an irrespirable environment;

(c) he intentionally took his own life; and

(d) the death occurred in the circumstances described above.

Comments

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. Mr Manning is the second of six deaths I have investigated in which people ended their life by means of inert gas (four by helium, one by nitrogen and one by argon) in the space of one year - 20 June 2017 to 5 June 2018. The first such death was by argon and my finding with comments and recommendations will be published on the website: reference **COR 2017 2906**. In that finding I discussed the prevalence of inert gas inhalation suicide, previous coronial comments and recommendations in relation to helium gas, the response of the Australian Competition and Consumer Commission (**ACCC**) and the decision of the Advisory Committee on Chemicals Scheduling (**ACCS**) (a committee within the Therapeutic Goods Administration (**TGA**)). I will not repeat that discussion here.

2. Helium is widely used in Victoria for blowing up balloons and can be purchased for this purpose at many outlets from general retailers through to specialist industrial gas suppliers. Helium also has medical uses in procedures such as lung inflation during surgery and supportive treating for respiratory obstruction; and has a large range of industrial applications for example in materials manufacture, lasers, commercial deepsea diving (as part of special breathing mixtures), cooling nuclear reactors, and as a carrier gas for chromatography. Helium is not scheduled in the Standard for the Uniform Scheduling of Medicines and Poisons (**Poisons Standard**). This means that access to helium is not regulated or restricted in Australia.

3. Analysis by the Coroners Prevention Unit (**CPU**) reveals that between 2000 and 2018, 118 people died via helium gas inhalation in Victoria. It is by far the most common of the inert gases

4. used in suicide. There were two main ways helium was accessed:

   (a) purchasing a helium balloon kit that included a helium cylinder sold at common retailers; and

   (b) hiring or purchasing a helium cylinder (not as part of a balloon kit) from a gas supplier. Gas suppliers range from party supply stores to industrial-focused outlets.

5. The Court's previous findings and recommendations in relation to helium advanced the proposition that regulating access to a means of suicide reduces associated suicides. I continue to support action being taken to reduce the public's access to pure helium.

However, given the recency of the ACCS decision, it appears that a recommendation to the TGA would be fruitless at this time.

Regulating access to helium in Victoria

6. In my finding COR 2017 2906 I suggested an alternative means of regulating access to inert gases, namely through Victorian legislation. I said:

> *The Drugs Poisons and Controlled Substances Act 1981 (Vic)* ***(the DPCS Act)*** *prohibits the sale of deleterious substances to people who may be seeking to misuse them. Section 57 of the DPCS Act defines a deleterious substance as being methylated spirits or volatile substances.*[2] *If the DPCS Act was amended so that deleterious substances defined in Section 57 were to include helium, nitrogen and argon, this would create a legal requirement for retailers of these gases to refuse sale if they believe the gas will be misused. It would also create an imperative for the DHHS to educate retailers about the risks of misusing these gases and how to refuse sales.*

Dilution of helium with oxygen

7. Dilution of inert gases with oxygen would undoubtedly reduce inert gas inhalation suicide, because it renders ineffective the mechanism of death (replacing oxygen with inert gas in the lungs).

8. However, noting the ACCS decision, dilution with oxygen is only an option where it will not compromise the uses of the gas. Regulation of balloon kits appears to be the most appropriate vehicle for diluted helium given it is one of the main ways people access helium for the purposes of suicide and dilution does not affect its purpose.

9. The ACCC referred to the possibility of diluting domestic-use helium with oxygen in their 3 August 2017 submission to the ACCS, although they did not advocate for this in the submission itself:

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2 Volatile substances in the context of the DPCS Act include solvents, paint thinners, aerosol propellants and other aromatic hydrocarbons that are concentrated and inhaled for recreational purposes (ie 'glue sniffing', 'paint sniffing' and similar).

ANZIGA [Australia New Zealand Industrial Gas Association] members have provided informal advice that approaches considered in New Zealand and the UK have included the use of 'Heliox' (79% helium plus 21% oxygen) as an inflation gas for balloons and the inclusion of aversives. The New Zealand Ministry of Business, Innovation and Employment consulted their local gas industry about the 'Heliox' approach in March-April 2016.

Advice from ANZIGA is that in New Zealand there was concern about flammability issues with balloons inflated with 'Heliox', especially as helium is likely to leach from a balloon faster than oxygen, leaving the highly flammable oxygen in the balloon.

10. Despite these concerns, I note that the website for helium balloon kit manufacturer Balloon Time includes the following in their product description, which suggests oxygen dilution is being used in practice:

> *Due to global helium supply issues, some of our products contain a mixture of helium and air with not less than 80 percent helium and float standard latex balloons for 5-7 hours.*[3]

11. Balloon Time is a major international manufacturer of helium balloon kits (including kits sold in Australia). Given they are already producing oxygen-diluted helium for balloon inflation in some markets, it appears that concerns about helium leaching and possible explosive oxygen-filled balloons are not a significant concern in practice.

12. Therefore, dilution with oxygen continues to be an option for balloon helium cylinders.

Purpose of my recommendations

13. Inert gas inhalation suicide has been championed by organisations and individuals concerned to provide peaceful (non-traumatic) end of life choices for the terminally ill. However, the CPU's review of such suicides indicates the majority of the deceased were not terminally ill, but had serious mental illnesses. Preventing suicide in this cohort is a public health imperative and preventing access to means is an effective way of preventing suicide, particularly when the action is impulsive or in response to acute stressors. Mr

[3] Balloon Time, "Products", 2019, https://www.balloontime.com/products/products-list/ accessed 15 April 2019.

Manning was only 26 and his suicide appears to have been in response to a relationship breakdown and other acute stressors in his life.

Recommendations

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

1. That the Department of Health and Human Services explore whether the deleterious substances provisions of the *Drugs Poisons and Controlled Substances Act 1981* (Vic) should be amended to include the major gases used in inert gas inhalation suicide in Victoria; and whether such an amendment would have any practical impact on Victorians' ability to access these gases for purposes of suicide.

2. That the Australian Competition and Consumer Commission declare undiluted helium in balloon kits to be an unsafe product, and make 20% oxygen dilution of helium in balloon kits compulsory.

3. I commend and encourage the Australian Competition and Consumer Commission to continue its work with helium manufacturers and suppliers.

I convey my sincere condolences to Mr Manning's family.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Linda Exley, Senior Next of Kin
Darren Manning, Senior Next of Kin
Australian Competition and Consumer Commission
Advisory Committee on Chemicals Scheduling, Therapeutic Goods Administration
Victorian Department of Health and Human Services
Detective Senior Constable Nicole Walker, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 13 June 2019