IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2770

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**MAGGIE ROSE BANT**
Date of birth:	**18 July 1998**
Date of death:	**On or about 31 May 2019**
Cause of death:	**Plastic Bag Asphyxia with Inhalation of Helium**
Place of death:	**Kings Billabong Lookout, Near 812-782 Cureton Ave, Irymple, Victoria 3498**

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

1. Maggie Rose Bant was 20 years of age at the time of her death. Ms Bant had recently moved out of her ex-boyfriend's family home and resided with her mother Sheleigh Bant in Mildura. Ms Bant had a history of mental ill-health, including suicidality.

2. On 31 May 2019 at approximately 4.00pm, a female (subsequently identified as Ms Bant) was seen by a member of the public in her black Mazda [registration UJY458]. The car was parked at the Kings Billabong Lookout on Cureton Avenue, Nichols Point. The member of the public was concerned for Ms Bant's welfare and contacted emergency services. Victoria Police were requested to attend the area to complete a welfare check.

3. At about 4.15pm, Victoria Police officers attended the Kings Billabong lookout. The police officers observed Ms Bant slumped in the driver's seat against the driver's door with a white plastic bag on her head, tubing connected the plastic bag to the valve of an empty helium gas bottle. The police officers gained access to Ms Bant's vehicle via the passenger side door. They removed the plastic bag; it was evident that Ms Bant was deceased.

4. Ms Bant's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, and was considered unnatural.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Maggie Rose Bant, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Toxicological analysis of post mortem blood detected the presence of sertraline (~ 0.4 g/L)[1] and doxylamine (~0.1 mg/L).[2] Dr Burke

[1] Sertraline is an antidepressant drug for use in cases of major depression.

commented that the post mortem CT scan did not identify any injuries nor natural changes that could have caused or contributed to the death. He reported that the external examination was otherwise unremarkable. The VIFM toxicology laboratory informed me that they are unable to test for the presence of helium. In light of the reported circumstances and in the absence of evidence to the contrary, Dr Burke formulated the medical cause of Maggie Rose Bant's death as plastic bag asphyxia with inhalation of helium.

Police investigation

6. Upon attending the Kings Billabong lookout, Victoria Police officers ("Police") did not find any evidence of third-party involvement in Ms Bant's death. Police did not locate anything which may be termed a "suicide note". Police located a receipt for items that Ms Bant had purchased in Mildura at Big W on 30 May 2019 at 6.40pm. Some of these items were evidently used to construct the apparatus by which she had ingested helium and died:

    a. Helium Tank (13 litres);

    b. Kitchen Tidy Bag (large);

    c. Shower spray;

    d. Rope Cotton (15m), and

    e. Stuk Clear Tape & Dispenser.

7. Leading Senior Constable (LSC) Peter McBain was the nominated Coroner's Investigator.[3] At my direction, LSC Bain investigated the circumstances surrounding Ms Bant's death, including the preparation of the coronial brief. The coronial brief

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[2] Doxylamine is an antihistamine and sleep-inducing agent predominantly used to provide night-time relief from the symptoms of allergies or colds.

[3] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

contained, *inter alia*, statements made by Ms Bant's ex-boyfriend Samual Bane, Mr Bane's mother Vicky Bane and Ms Bant's treating General medical practitioner (GP) of the Ontario Medical Clinic Dr Aseel Marioud.

8. During the investigation, police learned that Ms Bant had a history of mental ill health, including depression, anxiety and self-harm. Between April 2018 and 5 February 2019, Ms Bant consulted Dr Marioud on seven occasions in relation to her mental health. Dr Marioud stated that he had devised a mental health plan which included consultation with a psychologist at Headspace, Steven Carr. Dr Marioud stated that Ms Bant would often fail to attend scheduled monthly appointments but that he did not believe she suffered suicidality:

   Maggie never discussed any thoughts about committing suicide. She seemed fine, she was confident. She appeared fine. She never seemed depressed. Her visits were always brief.[4]

9. For a period of two years prior to their separation, Ms Bant lived with ex-boyfriend, Samual Bane, and his family in Mildura. In the months preceding Ms Bant's death, Mr Bane became concerned that she was distancing herself from her family. Mr Bant's mother Vicky Bane stated that she was concerned that Ms Bant may attempt to end her own life during the day when others were not at home. Mrs Bane stated that Ms Bant would sometimes discuss her mental wellbeing but was taciturn at times. Mrs Bane said that Ms Bant was prescribed medication for her mental ill health but that it was not clear whether she was compliant with her medication regime.[5] Mr Bane and his mother both indicated their belief that Ms Bant attempting to end her own life was a terrible inevitability, due to the severity of her mental ill health.

10. Ultimately, Ms Bant's mental health had deteriorated to the point that her condition was significantly impacting the Bane family. Mr Bant hoped that his ex-girlfriend would

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[4] Coronial Brief, *Statement of Dr Aseel Marioud*, dated 25 October 2019, p 12.

[5] Dr Marioud refers to providing Ms Bant a prescription in his statement, however, he does not provide any specific details. The antidepressant sertraline was identified in toxicological analysis of Ms Bant's post mortem blood.

benefit from living with her own family. Approximately one week prior to her death, Ms Bant and Mr Bane ended their relationship.

Coroners Prevention Unit Investigation[6]

Background

11. On 29 July 2019, Murray Primary Health Network (PHN) Strategic Projects Lead Alistair Bonsey contacted the Coroners Prevention Unit (CPU). Ms Bonsey indicated that between six people in the Mildura local government area (LGA) suicided between May and June 2019. The Murray PHN representative highlighted concerns that the suicides may meet the Centres for Disease Control and Prevention's definition of a suicide cluster; *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

12. The CPU reviewed the contents of the Victorian Suicide Register (VSR) and identified the six suicides of concern. The CPU also identified one death that was initially under investigation by the homicide squad.[7] On 1 July 2019, Victoria Police advised the Court that the death was not deemed to be suspicious by homicide squad and was considered a suicide.

Evidence of statistical clustering

13. To explore this, the CPU extracted information on all suicides which were reported between January 2010 and July 2020, where the location of fatal incident or the location of deceased's usual residence was in Mildura. CPU identified that, between May 2019

[6] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[7] COR 2019 3097.

and June 2019, seven suicides of persons linked to Mildura[8] formed a statistical cluster ("Mildura Suicide Cluster" 2019).

Social Clustering

14. Murray PHN were concerned that some of the deceased persons within the Mildura Suicide Cluster may have known one another ("social clustering"). To investigate probable social clustering among the seven deaths, the CPU reviewed the Coronial Briefs and researched potential, general social connections of the deceased, such as educational intuitions and any utilised health services. The CPU did not identify any evidence that the deceased knew one another. On that basis, the Mildura Suicide Cluster was evident statistically but is not considered a social cluster.

Thematic Clustering

15. Given the strong evidence of statistical clustering, the CPU reviewed the coronial briefs to establish whether there were any commonalities in the stressors the deceased experienced subsequent to death ("thematic clustering"). The following is a short summary of the general themes in each death. Please note that these summaries were curated with the intent of providing an overview of potential thematic connections between the deceased; the summaries were not prepared by staff with clinical mental health training:

    a. Substance misuse was the singular theme common to each death. However, the severity of misuse varied from intermittent to dependency. Other main themes that recurred across multiple deaths were:

    b. In all seven deaths the deceased appeared to suffer from mental ill health, although only four individuals had a clinical mental ill health diagnosis.[9]

[8] The CPU categorised this link by place of death or usual place of residence.

[9] COR 2019 2271, COR 2019 2530, COR 2019 2770, COR 2019 2875.

c. In five deaths,[10] there was evidence of interpersonal abuse, where the deceased was a victim and/or perpetrator. In three of these five deaths,[11] there was evidence of police contact in relation to the abuse.

d. In six deaths,[12] there was evidence of recent or threatened separation from and/or conflict with partner.

e. Two of the deceased were Aboriginal males.[13]

CPU Conclusions & Advice

16. Based on analysis of the available coronial brief material in the seven suicides, the CPU concluded that the identified suicides in Mildura represented a statistical cluster, but not a social cluster. There was evidence of substance use across all deaths, with varying levels of evidence and misuse reported (not all deceased had evident problematic use or dependence). Substance use is reported as a key issue in the Mildura region, though no drug and alcohol rehabilitation facilities exist. Aside from the above, themes were identified across multiple deaths at a time, but not all deaths.

PHN & DHHS Responses to the Mildura Suicide Cluster

Murray Primary Health Network (PHN) response

17. Immediately after Murray PHN identified that suicides in their region had occurred, the suicide postvention response for the region was activated. The elements of the response are described in a detailed submission dated 10 July 2019 from Murray PHN CEO Matt Jones. Additionally, Murray PHN engaged with Orygen and Professor Jo Robinson to review the Northern Mallee Suicide Postvention Protocols, which were found to be aligned with best practice. Some areas where postvention work could be strengthened were identified and this review has informed subsequent work in Mildura. The health

[10] COR 2019 2266, COR 2019 2530, COR 2019 2770, COR 2019 2875, COR 2019 3244.

[11] COR 2019 2266, COR 2019 2530, COR 2019 2875.

[12] COR 2019 2266, COR 201 92271, COR 2019 2530, COR 2019 2770, COR 2019 2875, COR 2019 3244.

[13] COR 2019 2530, COR 2019 2875.

network also conducted a thematic review of the 19 suicides that occurred in Mildura in 2019 to inform ongoing strategic activities for the Mildura Place Based Suicide Prevention Trial and Murray PHN.

18. Murray PHN identified four key issues for consideration by investigating coroners:

    a. Prevalence of substance misuse and addiction in suicide deaths within the LGA – particularly in the context of sustained campaigning by the Northern Mallee Local Drug Action Team (LDAT) for establishment of drug rehabilitation and detoxification facilities in Mildura, as no such services exist in the region.

    b. For one death in the latter half of 2019, gambling addiction was the only known situational stressor.

    c. Intersection of family violence/interaction with police and the justice system and deaths by suicide in the LGA – in early July Sunraysia Community Health Services and Victoria Police have entered into a formal agreement to provide enhanced support services to perpetrators of family violence.

    d. Victoria Police participation in postvention within Mildura LGA has resulted in rapid identification of emerging suicide clusters and elevated understanding by members (self-reported) of suicide risk factors and the benefits of community supports. Adoption of state-wide postvention processes/protocols with high level endorsement and integration between VicPol and local communities could contribute to increased real time monitoring of suicide deaths towards enhanced postvention and prevention.

<u>Department of Health and Human Services (DHHS) response</u>

19. DHHS supported Murray PHN in activating its suicide postvention response for the region once the health network identified the potential cluster. DHHS' response included:

    a. Collaboration with Murray Primary Health Network to engage in the postvention response;

b. Engagement with Professor Jo Robinson, Head of Suicide Prevention at Melbourne University, to support the Mildura suicide postvention group, and

c. Collaboration with Family Safety Victoria.

Potential Expansion of Cluster | Further 14 Suicides

20. Between September 2019 and April 2020, a further fourteen suspected suicides occurred in Mildura. Considered in the context of the historical data, these deaths appear to be an extension of the statistical cluster discussed here. From a preliminary review of the Victoria Police Form 83 text in each death, there are no obvious social nor thematic links between these 14 deaths and the seven deaths reviewed in this memorandum. Coroners investigating the subsequent deaths were provided a copy of the advice in relation to the first seven deaths in case it is of assistance in those investigations.

Access to Helium – Previous Coronial Investigations

21. I have raised my concerns in relation to the relative ease with which someone intending to end the own life may access the asphyxiant gas[14] helium in several previous Findings.

22. On 22 February 2016, I delivered my Finding into the Death of Miki Yamamoto,[15] a young woman who died subsequent to intentionally inhaling helium. I noted that helium gas bottles are often sold off shelves, and photographic identification is not required to purchase them. I also noted that the CPU had identified 81 Victorian deaths, between 2000 and 2014, where helium was used to facilitate the death. The source of the helium could only be positively identified in 32% of the deaths. The most common source that was identified, was helium sold as a party supplement intended for inflating balloons. The frequency of suicides involving helium gas was found to have increased in recent years. I commented that the sale of pure helium gas is largely unregulated.

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[14] When humans breathe in an **asphyxiant gas**, such as pure nitrogen, **helium**, neon, argon, methane, or any other physiologically inert **gas**(es), they exhale carbon dioxide without re-supplying oxygen. Physiologically inert **gases** (those that have no toxic effect, but merely dilute oxygen) are generally free of odor and taste.

[15] COR 2014 5424.

23. By way of letter dated 13 May 2016, the Court received a response to my Findings into Ms Yamamoto's death. General Manager of the Consumer Product Safety Branch at the Australian Competition and Consumer Commission (ACCC) Neville Matthew advised that the ACCC was concerned about the statistics of helium gas misuse and consequent deaths. Mr Matthew added that he had asked his staff to look into the process for making an application for amendment of the Standard for the Uniform Scheduling of Medicines and Poisons (the Poisons Standard), as the most effective restriction of access to potentially harmful drugs and poisons is typically achieved through scheduling. It was also intended that the ACCC would write to national suppliers of helium pa1ty gas to reinforce their understanding of the risks of supplying these substances to potentially vulnerable consumers.

24. On 19 April 2017, I completed my Finding into the death of Lauren Pilkington.[16] Ms Pilkington died after consuming helium in a similar manner to Ms Bant. I had not been appraised of any further developments by the ACCC and remained concerned about the ease of access to helium. In a response to those Findings dated 4 May 2017, the ACCC informed me that the Commission had begun preparing a paper for the Advisory Committee on Chemicals Scheduling (ACCS),[17] to discuss options for controls of the asphyxiant gas helium, including:

    a. changes to public access, through amendments to the Poisons Standard (Schedule for the Uniform Scheduling of Medicines and Poisons);

    b. amending labelling or inclusion of new warnings;

    c. limiting cylinder sizes available to the public;

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[16] COR 2016 4013.

[17] The ACCS is a national committee made up of State & Territory Department of Health representatives and appointed experts in a range of fields including toxicology, OH&S, clinical aspects of human poisoning and industrial/domestic chemicals. The Committee supports and advises the Scheduling delegate, who is the decision maker for the scheduling of poisons in Australia. The ACCS is the committee appropriately placed to amend the controls in place under the Poisons Standard.

d. changes to cylinder/nozzle operation or controls, e.g. a nozzle that needs to be repeatedly depressed and only delivers a small amount of gas each time, and

e. inclusion of a gaseous 'bitterant', e.g. denatonium benzoate, similar to aerosol cans of compressed air used for dusting photographic and electronic equipment.

25. The ACCS meets three times a year; Mr Matthew stated that this matter would be considered at the November 2017 meeting.

26. On 11 August 2017, the ACCC provided a further response to the Court, indicating that it had applied to the Chemicals Scheduling Secretariat for the inclusion of helium in the Poisons Standard. The application sought two additions to the Schedules of the Poisons Standard:

a. Helium supplied to consumers by hire or purchase for domestic/household use (for balloon inflation) is to include an aversive and be included in Schedule 6, and

b. Industrial and commercial supplies of helium without an aversive are to be included in Schedule 7 to prevent their supply to consumers.

27. At the time of the second response, the ACCC was also consulting the industrial gas industry and helium suppliers about potential amendment of the simple valve and nozzle arrangement on helium gas canisters as a secondary mechanism to reduce the ease of use of these products in suicides.

28. On 5 February 2018, an ACCS delegate published an interim decision not to schedule helium on the Poisons Standard.[18] The decision was structured according to relevant considerations pursuant to section 52(E) of the Therapeutic Goods Act (1989):

a. the risks and benefits of the use of a substance:

- *The benefits of helium are that it has many legitimate uses, most of which are non-balloon uses, e.g. industrial, scientific and medical uses.*

[18] Please see: *Scheduling delegates' interim decisions and invitation for further comment: ACCS/ACMS, November 2017*, <https://www.tga.gov.au/book-page/21-helium>.

- *The risks for helium do not exist unless it is deliberately inhaled (resulting in oxygen deprivation, leading to asphyxiation); helium is otherwise safe.*

b. the purposes for which a substance is to be used and the extent of use of a substance:

- *Helium has a small number of therapeutic uses as part of gas mixtures.*
- *Helium has commercial, industrial and medical uses.*
- *A small amount of helium is also used in domestic situations, primarily for balloons and similar items.*

c. the toxicity of a substance:

- *Helium is an inert, non-toxic gas.*
- *Correct and legitimate use of helium does not meet the scheduling criteria (SPF 2015).*

d. the dosage, formulation, labelling, packaging and presentation of a substance:

- *Nil.*

e. the potential for abuse of a substance:

- *Helium may be deliberately misused for the purpose of causing asphyxiation, but use does not result in dependence or addiction.*

f. any other matters that the Secretary considers necessary to protect public health

- *The addition of an aversive may make the gas more dangerous and the evidence that this would lead to aversion is not there.*
- *The ACCC should continue to work with the helium industry to reduce risks such as the proposal to modify valves and nozzles for cylinders that increase the difficulty of completing the suicide act. These changes will also reduce the likelihood of children being able to release helium from a canister.*

29. The ACCCS interim decision included National Coronial Information System (NCIS) data obtained by the ACCC for its application for amendment to the Poisons Standard.

The data identified, *inter alia*, the frequency of use of helium gas for suicide from 1 July 2000 to 31 December 2016:

- *There have been an estimated 400 suicides using helium gas between 2000 and 2016 (an average of about 24 each year). The number of cases gradually increased between 2000 and 2009, but more than doubled in 2009-10, increasing from 23 to 50 cases each year. The higher number of helium asphyxiation suicides per year has been relatively steady since 2010, at about 45 cases per year (figure below).*

- *In over 70 per cent of investigated cases, the source of helium used to commit suicide is unknown. Seventy six per cent of known sources of helium are party goods suppliers (73 cases), followed by 14 per cent from industrial gas suppliers (13 cases). Other minor sources include online, voluntary euthanasia organisations and suppliers of goods for building, lighting, agriculture, diving and pumping.*[19]

30. On 10 April 2018, the ACCS issued a final decision that the Poisons Standard should not be amended to include helium on the basis that helium does not require scheduling. The ACCS noted that helium has many legitimate industrial, scientific and medical uses and the risks for helium do not exist unless it is deliberately inhaled. Submissions made to the ACCS by other stakeholders were primarily opposed to scheduling. Issues raised by these stakeholders included the potential detrimental impact on industry, detrimental effects on the occupational work health and safety of people working with helium and the general public, environmental impact and that helium does not meet the criteria for scheduling. Consequently, Mr Matthews informed the Court that the ACCC believed attempts to include other asphyxiant, inert gases in the Poisons Standard are also likely to be unsuccessful.

[19] Above n 18.

31. On 11 September 2019, Mr Matthews provided a response to coronial Findings[20] completed by my colleague Coroner Simon McGregor and Coroner Rosemary Carlin.[21] Mr Matthews also referred to six other recent coronial findings whereby the deceased died subsequent to inhalation of helium and/or nitrogen.[22]

32. Mr Matthews informed the Court that the ACCC had approached mental health organisations to seek their views on the possible impact of restricting access to use of inert gases as suicide agents. Mr Matthews commented that these agencies did not have experience in relation to restriction of access to suicide agents; their usual approach was in relation to community and personal intervention. He did not otherwise comment on any suggestions made by the mental health organisations.

33. The ACCC also consulted international regulators regarding potential approaches to regulating access to helium gas, including the feasibility of diluting helium gas available for sale and design modifications to gas cylinders. However, the regulators were unable to identify approaches that they consider will be successful in addressing helium inhalation issues. Mr Matthews stated that design modifications to cylinders or control valves to reduce the flow of gas were considered. An obstacle to this approach was that an individual may fill a bag with the gas and inhale its contents separately. Furthermore, gas suppliers raised concerns about the performance characteristics of diluted helium (such as diminished flotation time for balloons), potential flammability issues and the costs to industry of implementing helium dilution at the production stage.

34. Mr Matthews informed the Court that the gas industry has previously taken steps to raise public awareness of the dangers of helium inhalation, albeit in relation to accidental death through misuse. An advertising campaign was commenced by gas suppliers Elgas and BOC in 2014 and gas supplier websites appear to generally provide warnings about the effects of helium inhalation.

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[20] COR 2018 001315; COR 2017 002906; COR 2017 005077.

[21] Her Honour has since been made a Judge of the County Court.

[22] COR 2016 003335; COR 2018 002664; COR 2018 000062; COR 2017 004984; COR 2018 001320; COR 2018 006029.

35. In light of the ACCC's previous discussions with external stakeholders and difficulties encountered by international regulators in identifying viable approaches, Mr Matthews said that the ACCC had reservations about their powers and ability to deliver effective measures which address the multifaceted and complex issues associated with helium and other inert gas inhalation. He informed the Court that the ACCC intends to conduct further, non-public consultation with international regulators and the gas industry to provide the parties with an opportunity to submit new information about the efficacy and viability of the measures aforementioned. Subsequently, the ACCC intends to assess the further information stakeholders provide before considering whether further action can be taken.

COMMENTS

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

1. I endorse and applaud the Murray PHN's recognition of the Mildura Suicide Cluster and reporting the same to the Coroners Court of Victoria. I commend the swift response led by the Murray PHN and support offered to the health network by DHHS. I further commend the inclusion of Victoria Police in the "postvention" response, whereby areas of need may be more efficiently identified.

2. The coronial investigation into the Mildura Suicide Cluster has not identified social connections between the deceased persons. However, the statistical presence of a suicide cluster, as well as subsequent extension of that cluster, indicates that further and ongoing supports are warranted for those experiencing mental ill health in the Mildura LGA. The single, common theme identified across each death investigation is the presence of evident or supposed substance misuse. I note the revision of Mildura Base Public Hospital after twenty years of private management on 15 September 2020. The community and hospital Board have indicated their hope that the transition will help to

'*connect the hospital with local communities, service development and regional health planning*'.[23]

3. I will not make any specific recommendations in this matter in light of the:

   c. Recently increased availability of public health care in the Mildura LGA;

   d. Fact that the Mildura Suicide Cluster was a statistical but not a "social cluster";

   e. Willingness of the Murray PHN and DHHS to determine and implement appropriate responses to the Mildura Suicide Cluster;

   f. Subsequent 14 deaths under coronial investigation, a statistical continuation of the Mildura Suicide Cluster, which may provide insight into issues warranting coronial recommendations, and

   g. Specific facts of this matter: A Coroner investigating another death within the cluster may identify appropriate recommendations to make.

4. I also endorse and applaud the actions taken by the ACCC in their efforts to appropriately and comprehensively address the concerns raised by Victorian Coroners. However, I remain very concerned about the ease of access by the general public to the asphyxiant gas, helium. The most contemporaneous data available[24] suggests that approximately 45 Australians end their life by inhaling helium each year and about 76% of that group will have obtained the helium by retail; the way that Ms Bant accessed the helium with which she ended her life.

5. I note that the ACCC found that their discussions with industry stakeholders predominantly identified obstacles to any potential prevention measures. This is hardly surprising in the context of almost every industry submission objecting to the ACCS amending the poison's standard and where there will be industry-cost imposition with

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[23] Mildura Base Public Hospital, *MBPH Returns to Public Management*, dated 15 September 2020, accessed 30 November 2020 <https://www.mbph.org.au/mildura-base-public-hospital-returns-to-public-management/>.

[24] Identified in the ACCC submissions to the ACCS at paragraph 29.

any changes. I note that the ACCC intends to conduct further consultation with international regulators and industry stakeholders to discuss the efficacy and viability of safety and prevention measures aforementioned. In light of these intentions, I will not make further recommendations and await the outcomes of the further consultation.

6. The coronial brief provides scant information about Ms Bant's medical history in relation to her mental health. There is a sufficient information to identify that Ms Bant suffered suicidality. Despite their close relationship and living situation, Mrs Bane commented that she often felt unsure of Ms Bant's state of mind; she was difficult to draw out on her the subject of her mental health. It appears that Ms Bant was receiving treatment for her presentation as someone experiencing mental ill health but not necessarily suicidality. There is no evidence to indicate that Ms Bant's medical management was insufficient or inappropriate.

7. I extend my sincere condolences to Ms Bant's support system for the loss of their young friend and family member.

FINDINGS

1. I find that Maggie Rose Bant, born 18 July 1998, died on or about 31 May 2019 at Kings Billabong Lookout, near 812-782 Cureton Ave, Irymple, Victoria 3498.

2. I find that Maggie Rose Bant suffered mental ill health prior to her death.

3. I find that Maggie Rose Bant sought treatment from her General Practitioner.

4. I find that Ms Bant did not present as suicidal during consultations with her General Practitioner.

5. I accept and adopt the cause of death formulated by Dr Michael Burke and I find that the cause of Maggie Rose Bant's death was plastic bag asphyxia with inhalation of helium in circumstances where I find she intended to take her own life.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Sheleigh Bant

Geoffrey Bant

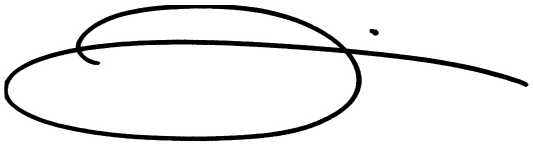
Murray Public Health Network Chief Executive Officer Matt Jones

Department of Health and Human Services Acting Manager Suicide Prevention Fiona Rippin

General Manager of the Consumer Product Safety Branch at the ACCC Neville Matthew

Leading Senior Constable Peter McBain

Signature:



AUDREY JAMIESON

CORONER

Date**: 9 December 2020**