IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003131

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	EBG[1]
Date of birth:	1975
Date of death:	16 June 2021
Cause of death:	1(a) Combined effects of helium toxicity and plastic bag asphyxia
Place of death:	Brunswick East, Victoria, 3057
Key words:	Helium, helium toxicity, plastic bag asphyxia, suicide

[1] This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with psuedonyms of randomly generated three letter sequences to protect their identity and to redact identifying information.

INTRODUCTION

1. On 16 June 2021, EBG was 46 years old when he was located deceased in circumstances suggestive of suicide at his home address in Brunswick East. At the time of his death, EBG had been staying with his partner in Greensborough.

2. In November 2020, EBG attempted to take his own life in the context of significant family stressors. He spent three weeks at The Melbourne Clinic after which he attended an appointment with his general practitioner, Dr Ee Leong, in January 2021 who noted that he was in a supportive relationship and appeared to be help-seeking.[2]

3. Dr Leong further noted that EBG displayed some residual suicidality but denied active planning. EBG attended a follow up appointment with Dr Leong and completed a mental health care plan. Dr Leong also referred EBG to a local psychologist, prescribed antidepressants, and booked a follow up appointment however EBG failed to attend.[3]

4. EBG worked at Bostik however, at the start of 2021, he left his position and began searching for alternative employment. During this time, EBG placed his residence on Airbnb and began staying with his partner. EBG's partner stated that she encouraged EBG to speak to a psychologist about his mental state however he assured her that he was fine.[4]

5. In February 2021, following an argument, EBG sent his partner a photo of a helium gas canister that he had obtained from a party shop and told her that 'it didn't work'. When she attended EBG's residence in the morning, EBG admitted that he had been suicidal the night before but refused to seek help. EBG's partner stated that EBG appeared to revert to his normal self however he continued to refuse to speak to anyone about his mental state.[5]

6. At the end of March 2021, EBG's access to his son was restricted pending mediation proceedings with his ex-wife to organise custody arrangements. On 13 June 2021, EBG asked his partner to lend him money. She later found out that EBG had become bankrupt.[6]

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[2] Coronial brief, statement of Dr Ee Leong dated 18 October 2021, pages 17-18.
[3] Coronial brief, statement of Dr Ee Leong dated 18 October 2021, pages 17-18.
[4] Coronial brief, statement of HNU dated 14 September 2021, pages 21-23.
[5] Coronial brief, statement of HNU dated 14 September 2021, pages 23-24.
[6] Coronial brief, statement of HNU dated 14 September 2021, pages 24-25.

THE CORONIAL INVESTIGATION

7. EBG'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.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of EBG's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of EBG including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[7]

12. In considering the issues associated with this finding, I have been mindful of EBG's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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[7] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On 15 June 2021, EBG told his partner that he needed to go home to clean the house for the next Airbnb guest. He later sent her a text suggesting that she have her children over for a family dinner and that he would stay an extra night at his residence which was unusual for him. The couple continued to message each other that night until 12.00am when EBG sent his partner a message telling her that he loved her.[8]

14. On 16 June 2021 at 3.15pm, after being unable to contact him throughout the day, EBG's partner attended his residence but realised that EBG had taken her key off her keychain. She continued to knock on his door without success.

15. At around 4.00pm, EBG's partner contacted Victoria Police who attended EBG's residence and forced entry. The police members located EBG inside; he was deceased, after having apparently asphyxiated himself. Several suicide notes were found at the scene.[9]

16. Ambulance Victoria paramedics attended the scene and verified that EBG was deceased at 7.07pm.[10]

Identity of the deceased

17. On 21 June 2021, EBG, born in 1975, was visually identified by his partner.

18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 17 June 2021 and provided a written report of his findings dated 22 June 2021, which was co-signed by Dr Melanie Archer, a Forensic Pathologist at VIFM.

20. The post-mortem examination revealed findings consistent with the history given.

21. The post-mortem computed tomography scan showed incidental findings of liver steatosis.

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[8] Coronial brief, statement of HNU dated 14 September 2021, page 25.
[9] Coronial brief, statement of Constable James Greuter dated 7 January 2022, page 46.
[10] Ambulance Victoria Verification of Death form dated 16 June 2021.

22. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a level equivalent to a Blood Alcohol Content of 0.06 per cent.

23. Dr De Boer noted that helium is an inert gas and does not accumulate in the blood. It therefore cannot be identified in post-mortem toxicology analysis.

24. Dr De Boer provided an opinion that the medical cause of death was from the 1 (a) combined effects of helium toxicity and plastic bag asphyxia.

25. I accept Dr De Boer's opinion.

FINDINGS AND CONCLUSION

26. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was EBG, born in 1975;

    b) the death occurred on 16 June 2021 in Brunswick East, Victoria, 3057, from *combined effects of helium toxicity and plastic bag asphyxia*; and

    c) the death occurred in the circumstances described above.

27. Having considered all of the circumstances, I am satisfied that EBG intentionally took his own life as evidenced by the presence of the suicide notes and lethality of means chosen.

28. Whilst I am unable to identify the exact trigger for his decision to do so, I note his previous suicide attempts as well as his refusal to seek psychological support, his ongoing issues with his ex-wife regarding custody arrangements, and his recent declaration of bankruptcy.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

29. The prevalence of helium-assisted suicides continues to be a worrying trend. I note that from 2010 to 2021, there were 112 instances of individuals using helium to take their own lives, with the source of the helium often being identified as a retail outlet or from a specialist party shop. In cases where the source of the helium could not be identified, the description of the helium bottle or cannister was consistent with a balloon kit or party hire source.

30. *In the matter of the death of Miki Yamamoto*[11] Coroner Audrey Jamieson highlighted the risk of the unregulated sale of helium to vulnerable persons in the Victorian community and commented that pure helium in party-related products could be regarded as an 'unsafe product'. In response, the Australian Competition and Consumer Commission (**ACCC**) made an application to the Advisory Committee on Chemicals Scheduling (**ACCS**) for the inclusion of helium in the Standard for the Uniform Scheduling of Medicines and Poisons (**Poisons Standard**), however this was rejected on 10 April 2018. From a policy perspective, the principal reason for the rejection was because the ACCS consider physical asphyxiants like helium as non-toxic, and thus not suitable for inclusion in the Poisons Standard.

31. Other recommendations made by this court aimed at decreasing the number of instances of helium-assisted suicide include the dilution of helium with other gases, including oxygen or nitrogen, to reduce or delay the lethality of balloon gas inhalation.[12] I note the response from the ACCC received on 9 June 2021 in which they acknowledged industry concerns regarding the performance and flammability characteristics of using diluted helium.

32. These concerns were addressed through a commissioned study by the Australian National University (**ANU**) which found that a mixture of 79 per cent helium and 21 per cent oxygen did not significantly diminish the performance of balloons, and that there were no risks associated with an increased risk of flammability or explosive potential. Whilst it still may be possible for individuals to obtain helium gas directly from suppliers, given the prevalence of retail-sourced cylinders involved in the suicides of individuals, such measures to dilute balloon gas cylinders would undoubtably have a positive effect.

33. A further possible strategy recommended by this court included modifications made to helium (and other inert gas) cylinders in order to increase the difficulty by which an individual could produce a steady helium flow needed for suicide by inhalation. The ACCC responded by stating that, due to the low cost of helium balloon kits, it considered such an approach from both an engineering and cost perspective to unlikely be feasible or practical at the time of writing, however the ACCC noted that it was undertaking an analysis of the helium gas industry and exploring alternative options to reduce helium balloon gas related suicides.

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[11] COR 2014 5424.

[12] COR 2017 5077.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

i. That the ACCC make 20 per cent oxygen dilution of helium in balloon kits mandatory, as well as the possibility of the addition of an aversive agent similar to aerosol cans of compressed air used for dusting electronic equipment;

ii. That the ACCC and the gas industry reconsider the feasibility of introducing mandatory modifications to helium cylinders in order to limit the ability of individuals to produce a steady flow to enact suicide plans;

iii. That the ACCC continue to work with industry and commercial operators to inform any potential regulatory or other interventions that they may consider in the future to reduce the risk of inert gas inhalation involving balloon helium; and

iv. That Consumer Affairs Victoria consider what regulatory approaches to reducing the accessibility of helium as a means of suicide might be feasible in the regulatory environment of the State of Victoria, including requiring helium to be mixed with other gases for sale as balloon gas as well as approaches already considered by the ACCC at the Commonwealth level.

I convey my sincere condolences to EBG's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

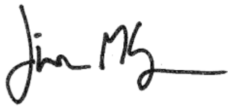
HNU, Senior Next of Kin

David Joyner, Consumer Affairs Victoria

Scott Gregson, Australian Competition and Consumer Commission

Senior Constable Stephanie Taylor, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 18 July 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.