IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4013

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of LAUREN PILKINGTON

without holding an inquest:
find that the identity of the deceased was LAUREN PILKINGTON
born 23 September 1995
and the death occurred on 23 or 24 August 2016
at apartment 301, 6 High Street, North Melbourne Victoria 3051
from:

1 (a) ASPHYXIA SECONDARY TO INHALATION OF HELIUM

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

1. Lauren Pilkington was 20 years of age at the time of her death. She was originally from South Africa and moved to Western Australia with her family in 2001.

2. Ms Pilkington was completing postgraduate studies at the Murdoch Children's Research Institute through the University of Melbourne, and lived alone in North Melbourne. She had a history of anxiety and had previously attempted to take her own life. Ms Pilkington was recently suffering from depression. Shortly prior to her death, Ms Pilkington was a voluntary inpatient at the Delmont Private Hospital.

3. On Wednesday 24 August 2016, Ms Pilkington's friend Sophie Prober made a number of attempts to contact her between 12.30pm and 3.00pm, with no reply. The previous evening, Ms Prober had spoken with Ms Pilkington by telephone, and she had mentioned that her anxiety was building again. Ms Prober contacted one of Ms Pilkington's classmates, who advised that she had not been in class that day. Ms Pilkington's mother Sonja Pilkington also tried to call her at 1.19pm and again at 4.16pm and 5.47pm, but she did not answer.

4. Mrs Pilkington also used an 'app' to locate her daughter's telephone; it indicated the phone was inside her apartment. Mrs Pilkington contacted Ms Prober, who was at this time en route to Ms Pilkington's apartment with a friend. They arrived at Ms Pilkington's apartment and knocked on her door, but there was no answer. At approximately 7.00pm, Ms Prober contacted emergency services.

5. At 7.50pm police attended the premises, along with Metropolitan Fire Brigade (MFB) members. Lauren's father Michael Pilkington arranged for a locksmith to attend, and police gained access to the apartment at approximately 9.00pm. Ms Pilkington was located lying on the floor near her bed. A plastic bag was over her head, and a tube ran from the plastic bag to a small canister of helium. Ms Pilkington was wearing earphones, connected to an electronic device. Ambulance Victoria paramedics arrived shortly afterwards and attempted resuscitation, before declaring that Ms Pilkington was deceased.

INVESTIGATIONS

Forensic Pathology investigation

6. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Ms Pilkington, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of Ms Pilkington's post mortem blood detected diazepam and its metabolite nordiazepam,[1] and fluoxetine.[2] Dr Burke ascribed the cause of Ms Pilkington's death to asphyxia secondary to inhalation of helium.

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[1] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

[2] Fluoxetine is a substitute propylamine indicated for the treatment of major depressive disorders and obsessive compulsive disorders.

Police investigation

7. Upon attending the North Melbourne apartment after Ms Pilkington's death, Victoria Police did not identify any signs of third party involvement. Two 'suicide notes' were located on Ms Pilkington's bed, along with other letters. Multiple packets of medication were found around the apartment.

8. Senior Constable Kula Mayne, the nominated coroner's investigator,[3] conducted an investigation of the circumstances surrounding Ms Pilkington's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms Pilkington's mother Sonja Pilkington, friend Sophie Prober, Psychiatrist at Delmont Private Hospital Dr Steven Jones and General Practitioner Dr Lynette Hatherley.

9. Sonja Pilkington reported that her daughter excelled academically at St. Stephen's School in Perth and had lots of friends in her age group. When Ms Pilkington was in year 11, one of her classmates took his own life. Mrs Pilkington reported that shortly after this event, her daughter also made a suicide attempt. A number of other students at the school had also attempted to take their own lives, and Mrs Pilkington stated that the central issue was cyberbullying. During Ms Pilkington's final year of high school, she was in regular contact with two friends who lived in Sydney. Mrs Pilkington stated that her daughter tried to support both of her friends, both of whom were suffering from depression. However, one of the friends took her own life, while the other made a number of attempts.

10. After graduating from high school, Ms Pilkington completed an undergraduate degree at the University of Western Australia, where she met her friend Sophie Prober. Mrs Pilkington reported that her daughter subsequently chose to complete a project at the Murdoch Children's Research Institute (MCRI), focusing on anxiety and depression, as part of a master's degree in biomedical science at the University of Melbourne. On 4 January 2016, Ms Pilkington left for Melbourne. Ms Prober also left for Melbourne at this time and the friends stayed in very regular contact.

11. Mrs Pilkington reported that after her daughter moved to Melbourne her anxiety worsened. She added that Ms Pilkington felt unworthy and undeserving of being at MCRI. Ms Prober also

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[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 takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

reported that Ms Pilkington's anxiety became more severe with the stress of moving. She noted that Ms Pilkington's project involved gathering data from patients, a number of whom took their own lives during this period. Ms Prober stated that Ms Pilkington received support from both her supervisor and academic institution. In around March or April 2016, Ms Pilkington acknowledged to Ms Prober that she was suffering from depression.

12. Ms Pilkington visited General Practitioner Dr Lynette Hatherley on 5 July 2016. Dr Hatherley reported that she presented with depression and anxiety, but denied suicidal ideation. Ms Pilkington requested a referral to an inpatient anxiety and depression program. Ms Pilkington was subsequently voluntarily admitted to the Delmont Private Hospital on 12 July 2016. Psychiatrist Dr Steven Jones reported that on admission, the impression was that Ms Pilkington was experiencing a major depressive episode and generalised anxiety disorder. These problems occurred in the context of stressors including self-imposed pressure to do well academically and social isolation. At admission, Ms Pilkington denied any suicidal thoughts or plans.

13. Ms Pilkington was prescribed the antidepressant fluoxetine; and additionally given limited amounts of diazepam for anxiety symptoms. Ms Pilkington's difficulty with sleep initiation was treated with the sedative, zopiclone. She was also prescribed pregabalin to assist with sleep and reduce anxiety. Dr Jones noted that Ms Pilkington had not previously been treated with medication for psychiatric reasons. He saw Ms Pilkington three times per week during her admission. At an appointment on 26 July 2016, she did indicate some suicidal ideation, but had no plan or intent to take her own life. While admitted, Ms Pilkington completed a Safety Plan, which included warning signs of deterioration, coping strategies, support people and crisis phone numbers.

14. At their last appointment on 7 August 2016, Dr Jones noted that Ms Pilkington appeared anxious and continued to experience passive suicidal thoughts at times. However, she expressed she felt a subjective improvement in her mood. Ms Pilkington advised Dr Jones that she would independently arrange to see a psychologist through MCRI, and was still considering whether to undertake the Delmont Day Program – an outpatient psychological therapy group aimed at supporting patients after discharge. Dr Jones said that Ms Pilkington was discharged with only a limited quantity of sedative-type medications diazepam and zopiclone, to reduce the risk of misuse or overdose. Dr Jones stated that he did not feel Ms Pilkington was a high risk to herself on discharge, and noted that while there had been passive suicidal ideation, there had never been any active suicidal plans or intent.

15. Upon her discharge from hospital on 8 August 2016, Ms Pilkington decided not to attend the Delmont Day Program – due to distance and transport issues. Dr Jones stated that Ms Pilkington had agreed to attend an appointment with him three weeks post discharge. On 9 August 2016, she spoke to administrative staff at Delmont Private Hospital, and booked an appointment for 20 September 2016. Dr Jones noted that there were earlier appointments available if she had wished to take them.

16. Following discharge, Ms Pilkington lived with Ms Prober until 16 August 2016. Ms Prober reported that she had frequent panic attacks during this period, and did not sleep much. Ms Pilkington referenced suicidal ideation, but was opposed to Ms Prober's suggestion that she return to hospital.

17. Ms Pilkington returned to her apartment in North Melbourne and she spoke with Ms Prober by telephone during the evening on Friday 19 August 2016. Ms Prober stated that she later learned Ms Pilkington had planned to overdose on this day, using zopiclone tablets, but had not followed through after their phone conversation. During their talk, Ms Pilkington referred to 'suicide notes'. However, Ms Prober stated that when they spoke the next day, she did not remember talking about them. Ms Pilkington advised Ms Prober that she had broken up with her boyfriend. Ms Prober stated that she had been dating her boyfriend for several years but he was still in Perth.

18. Mrs Pilkington noted that her daughter's supervisor was really understanding, and helped her apply for special consideration. However, she noted that Ms Pilkington was required to do an intensive five full days of lectures at the MCRI upon her return to university.

19. On Sunday 21 August 2016, Ms Pilkington advised her mother that she had been asked to pick up some helium and balloons for some PhD students who were finishing up that Thursday. Mrs Pilkington reported that her daughter sounded happy on the phone.

20. Mrs Pilkington spoke to her daughter by telephone at 8.17pm on Tuesday 23 August 2016. Ms Pilkington described feeling tired; she had emailed her mother that morning and said her anxiety was '23 out of 10'. She had an assignment due the next day, which she had not yet begun. Mrs Pilkington stated that her daughter was not anxious about the assignment; she did not seem to care, which was unusual.

21. During the evening of 23 August 2016, Ms Prober spoke with Ms Pilkington for a few hours. Ms Pilkington wanted to talk about general things. Ms Prober recalled that towards the end of their conversation, Ms Pilkington took two diazepam tablets because she was feeling anxious.

Ms Pilkington reportedly told Ms Prober her suicidal ideation had worsened, but she had no intent. In addition, Ms Pilkington relayed that she could feel an anxiety attack building, but felt she would be better after it had passed. Ms Prober also noted that Ms Pilkington had no motivation regarding her assignment due the next day, and said this was very out of character. Ms Prober stated that Ms Pilkington had become adept at faking that she was okay.

22. Following her daughter's death, Mrs Pilkington found a receipt for two gas masks and plastic tubing in a box in the apartment. The receipt was dated 22 August 2016.

COMMENTS

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

1. The investigation into Ms Pilkington's death has not identified the source of the helium that was located in her apartment. This was also the case following my investigation into the death of Olga Jucan,[4] which was finalised in an unpublished Finding dated 28 November 2016. In response to this Finding, the Court received acknowledgement from the Therapeutic Goods Administration (TGA) on 22 December 2016, which noted that the report was entered into the Australian Adverse Drug Reaction Scheme (ADRS) database. The correspondence also noted that the TGA undertakes regular analysis of the ADRS to identify new and emergency safety issues that may be related to medicines in use in Australia.
2. In the Finding into the Death of Miki Yamamoto without Inquest,[5] delivered on 22 February 2016, 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 Coroners Prevention Unit[6] 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 presently, the sale of pure helium gas is largely unregulated.
3. By way of letter dated 13 May 2016, the Court received a response from Neville Matthew, General Manager of the Consumer Product Safety Branch at the Australian Competition and

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[4] COR 2015 5316.

[5] COR 2014 5424.

[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 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.

Consumer Commission (ACCC). Mr 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 party gas to reinforce their understanding of the risks of supplying these substances to potentially vulnerable consumers. I have not been appraised of any further developments in this regard. I remain concerned about the ease of access to helium.

FINDINGS

The investigation has identified that Ms Pilkington had a history of suffering from anxiety, which worsened after her relocation to Melbourne in early 2016. I note that Ms Pilkington appears to have had strong support from her family and Ms Prober, and that upon discharge from the Delmont Private Hospital she was not believed to be at high risk to herself. However, I also note that Ms Pilkington was experiencing the social stressors of self-imposed pressure to perform academically, and living alone in a new city.

On the evidence available to me, I find that Ms Pilkington's increasingly severe anxiety, and a recent diagnosis of depression, were the main contributing factors which caused her to adopt the course of action she ultimately chose.

I accept and adopt the medical cause of death as identified by Dr Michael Burke, and find that Lauren Pilkington intentionally took her own life by means of asphyxia secondary to inhalation of helium.

RECOMMENDATIONS

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

1. In light of recurrent deaths involving helium gas, and with the aim of preventing like deaths, **I recommend that** the Australian Competition and Consumer Commission consider working to restrict the ease of access to helium gas, by members of the Australian public.

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

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

Mr Mike and Mrs Sonja Pilkington
Dr Steven Jones
Neville Matthew, General Manager, Consumer Product Safety Branch, Australian Competition and Consumer Commission
Therapeutic Goods Administration
Senior Constable Kula Mayne

Signature:

AUDREY JAMIESON
CORONER
Date: 19 April 2017