IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2906

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**DIANE BELL***
Date of birth:	12 May 1964
Date of death:	Between 19 and 20 June 2017
Cause of death:	1(a) PLASTIC BAG ASPHYXIA AND ASPHYXIA IN THE SETTING OF AN IRRESPIRABLE ENVIRONMENT
Place of death:	Rear carpark of 215 Albion Street, Brunswick, Victoria

* This is an anonymised version of the original signed finding. Names have been replaced with pseudonyms to protect the privacy of the deceased and her family.

HER HONOUR:

Background

1. Diane Bell was born on 12 May 1964. She was 53 years old when she took her own life sometime between 19 and 20 June 2017.

2. Ms Bell lived in Coburg with housemates.

3. In the early 1990s, Ms Bell was deeply affected by the end of a long-term relationship. It appears this relationship breakdown caused her ongoing distress until the time of her death. Ms Bell's mother, Christine Bell, confirmed the relationship had a damaging and lasting effect on her daughter's mental health.

4. After an altercation at the end of the relationship Ms Bell's ex-partner obtained an intervention order against her. According to her mother, Ms Bell breached the order by approaching her ex-partner in the street and yelling at him. She believes it was the intervention order that triggered her daughter's mental health issues.

5. The exact onset of Ms Bell's mental ill health is unclear. Her mother recalls her deteriorating in approximately 2000, at which time she attempted to take her own life via carbon monoxide poisoning on three occasions. However, her psychiatrist, Dr Sreejayan Kongasseri, reported that she had been in contact with mental health services since 1998 with 11 psychiatric inpatient admissions.

6. In approximately 2000, Ms Bell began behaving inappropriately toward certain members of the public. This resulted in numerous personal safety intervention orders against her. At the time of her death, several indefinite intervention orders remained in place. Her mother considered the intervention orders had an *"extremely detrimental effect"* and a *"lasting and damaging effect"* on her daughter's mental health. She believed the intervention orders were inappropriate and excessive.

7. In 2009, Ms Bell was referred to North West Area Mental Health Service (**NWAMHS**) for treatment. She was discharged to the care of her general practitioner in 2014 but was re-referred approximately six months later.

8. From March to April 2015, Ms Bell was treated as an inpatient at Northern Psychiatric Unit (**NPU**). She was thereafter treated via a Community Treatment Order made pursuant to the *Mental Health Act 2014* (Vic).

9. Ms Bell's key clinician at NWAMHS, Aroon Naidoo, confirmed she was diagnosed with delusional disorder and exhibited delusional beliefs of persecution and fixation of perceived corruption of certain persons and organisations. Ms Bell also reported fluctuating suicidal thoughts.

10. At about this time, Ms Bell was referred to a psychologist, Julie Houniet, for counselling. Ms Houniet confirmed that Ms Bell's presenting problems revolved around her fixed belief that a number of prominent people were conspiring against her in a manner that had destroyed her career prospects. She held these beliefs strongly and any attempt to question or analyse them was met with intense rage and threats to walk out of the session. Ms Houniet realised that challenging these beliefs was counter-productive and found the best therapeutic approach was to encourage Ms Bell to develop some positive activities and relationships outside of her entrenched belief system.

11. In August 2016, Ms Bell assaulted a member of parliament. She was subsequently admitted to the NPU. At this time, she was prescribed an antipsychotic medication, with significant initial improvement. Despite the improvement in her psychotic symptoms, her mood and anxiety deteriorated.

12. Ms Houniet nominated the assault as a turning point in Ms Bell's mental health. She noted that prior to the incident, Ms Bell did not display any suicidal ideation or intent. Following the incident, she gained partial insight. She was remorseful that she had resorted to physical assault and felt that this was inexcusable. Her insight, although fluctuating, resulted in two opposite effects. Ms Houniet noted, *"She was horrified by the awareness of the trauma she had afflicted on others and the waste of many years of her own lie. This resulted in the emergence of suicidal ideation"*.

13. Mr Naidoo confirmed that Ms Bell was developing more insight and a recognition that she may need to move on with her life.

14. In September 2016, Ms Bell was arrested in relation to multiple breaches of personal safety intervention orders. She was remanded in custody for nine days before being transferred to the NPU.

15. Between October 2016 and her death, Ms Bell continually voiced suicidal thoughts to family members and members of her treating team.

16. In 2017, Ms Bell attended an art course. Ms Houniet noted that Ms Bell found it enjoyable and was beginning to form friendships with other students.

17. On 8 May 2017, Ms Bell attended a review with her treating team and her sister, Anne. During this session, she reported an increase in suicidal thoughts and her intention to purchase Nembutal. Her treating team believed a further inpatient admission would be too traumatic for her – a decision that her sister supported. In recognition of the increasing risk, the treating team enhanced the level of engagement and changed her medications. Ms Bell was also demonstrating improved engagement with her treating team and continued to engage with her psychologist. Her mother confirmed that inpatient admissions had a negative effect on her daughter.

18. Despite poor insight and judgment, according to Mr Naidoo, Ms Bell indicated a preparedness to work with her treating team so that she could work towards not having to attend the clinic. She was more able to engage in a recovery-focussed approach to her treatment. With support from her sister, she engaged more with her key clinician and treating team.

19. On 2 June 2017, Ms Bell attended a hearing, relating to the intervention orders at the Neighbourhood Justice Court with her sister and mother. Ms Bell told her family that the outcome did not matter as she would not be around much longer and she had already purchased items to carry out the act. Her sister subsequently confiscated a gas bottle from Ms Bell's house.

20. On 13 June 2017, Dr Kongasseri reviewed Ms Bell. At this time, Ms Bell reported disturbed sleep and ongoing suicidal thoughts, which appeared to be less intense than before. Her treating team believed this represented an ongoing chronic risk rather than an acute risk.

21. On this day, Ms Bell also spoke to Ms Houniet to reschedule an appointment she had missed. Ms Houniet noted that Ms Bell sounded buoyant and was clearly still engaged with her daily life, planning to attend her course and her next appointment. She did not have any concerns for Ms Bell at that time.

The coronial investigation

22. Ms Bell'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.

23. 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]

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

25. 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.

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

27. 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.

[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.

28. 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

29. Ms Bell was visually identified by her mother, Christine Bell, on 22 June 2017. Identity was not in issue and required no further investigation.

Medical cause of death

30. On 21 June 2017, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Ms Bell and reviewed a post mortem computed tomography (CT) scan.

31. Toxicological analysis of post mortem specimens taken from Ms Bell identified ethanol,[2] lorazepam,[3] olanzapine,[4] quetiapine,[5] and quinine.[6]

32. After reviewing toxicology results, Dr Francis completed a report, dated 22 June 2017, in which she formulated the cause of death as "*1(a) Plastic bag asphyxia and 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

33. On the evening of 19 June 2017, Ms Bell spoke with her housemate as he was leaving for work. He noted that Ms Bell was getting ready to leave but did not say where she was going. She appeared *"normal"* and he had no concerns for her safety.

34. The next morning, Ms Bell was found by a member of the public unresponsive in the rear of her vehicle in the rear carpark of 215 Albion Street, Brunswick.

35. Emergency services were contacted. Ambulance paramedics subsequently confirmed that Ms Bell was deceased.

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[2] Alcohol.
[3] Lorazepam is a benzodiazepine drug used for the treatment of insomnia and anxiety associated with depressive symptoms.
[4] Olanzapine is used for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.
[5] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.
[6] Quinine is a drug used for the treatment of muscle cramps.

36. Victoria Police members found a handwritten note, with details of Ms Bell's family members, on the front passenger seat of the vehicle. Next to Ms Bell's body in the rear of the vehicle was a BOC branded argon gas cannister which was connected by a small tube to a plastic bag over Ms Bell's head. Also located in the vehicle were two different receipts in Ms Bell's name for the purchase or rental of argon gas cannisters; one from Supagas dated 29 May 2017 and one from BOC, dated 5 June 2017.

37. A further suicide note was found in Ms Bell's bedroom.

Findings

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

(a) the identity of the deceased was Diane Bell, born 12 May 1964;

(b) Ms Bell died between 19 and 20 June 2017 at the rear carpark of 215 Albion Street, Brunswick, Victoria, from plastic bag asphyxia and asphyxia in the setting of an irrespirable environment;

(c) Ms Bell intentionally took her 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. I acknowledge the depth of Christine Bell's disappointment with the legal and public health system. She believes that the indefinite intervention orders were unnecessary, disproportionate and made on trivial grounds and that they had a devastating psychological effect on her daughter. I am not able to comment on whether the intervention orders were appropriate. However, I am satisfied that they had a profound effect on Ms Bell's mental health.

2. I am satisfied Ms Bell received ongoing and appropriate multidisciplinary support from NWAMH and Ms Houniet.

3. I was struck by the ease with which Ms Bell was able to purchase the argon gas which she used to end her life. Further, Ms Bell is the first of six deaths I have investigated in which people ended their life by means of inert gas (four by helium, one by nitrogen and Ms Bell by argon) in the space of one year – 20 June 2017 to 5 June 2018.

4. I commissioned the Coroners Prevention Unit (**CPU**) to investigate whether there were any prevention opportunities arising from the circumstances of Ms Bell's death. The CPU is staffed by specialist researchers and health professionals who assist coroners in their investigations, particularly in the fulfilment of their prevention role.

5. Inhalation of inert gas has been promoted as a peaceful and effective suicide method among right-to-die groups since at least the 1990s.[7] Analysis conducted by the CPU confirmed the existence of a general upward trend in the incidence of inert gas inhalation suicide in Victoria since the year 2000. The incidence of argon gas suicide also appears to be rising, although, it remains a relatively rare suicide method (nine out of a total of 234 inert gas suicides in Victoria between 2000 and 2018). Where able to be identified, the argon source in each of those nine suicides was a gas bottle hired or purchased for welding.

6. Researchers have linked the increasing numbers of inert gas inhalation suicides in Australia and internationally, with the growing availability of material (particularly on the internet) produced by the right-to-death movement.[8] But according to the authors of *The Peaceful Pill Handbook*, another major reason for the growing popularity of inert gas suicide is the increasing convenience of inert gases. In the past they were usually only available in large and heavy and bulky high-pressure cylinders for industrial use, but now they are available as low-pressure disposable cylinders.

7. The CPU searched its database of Victorian Coronial comments and recommendations and could not identify any material that directly addressed argon inhalation suicide. However, there were a series of linked findings commencing in 2016 in which Coroners explored prevention of helium inhalation suicide. I will not recite the various findings here as they are a matter of public record, however they culminated in an application by the Australian

[7] Ogden R and Hassan S, "Suicide by Oxygen Deprivation with Helium: A Preliminary Study of British Columbia Coroner Investigations", *Death Studies*, 35(4), 2001, pp.338-364.

[8] See for example Ogden R and Hassan S, "Suicide by Oxygen Deprivation with Helium: A Preliminary Study of British Columbia Coroner Investigations", *Death Studies*, 35(4), 2001, pp.338-364; Grassberger M and Krauskopf A, "Suicidal asphyxiation with helium: Report of three cases", *Middle European Journal of Medicine*, 119(9-10), p.323; Austin A, Winskog C, van den Heuvel C and Byard R, "Recent trends in suicides utilising helium", Journal of Forensic Sciences, 65(3), 2011, pp.649-651.

Competition and Consumer Commission (**ACCC**) to the Advisory Committee on Chemicals Scheduling (**ACCS**) (a committee within the Therapeutic Goods Administration (**TGA**)) for the introduction of two controls to reduce the risk of helium being used for suicide.

8. On 5 February and 10 April 2018, the ACCS published its interim and final determinations not to accept the application with reasons, however encouraged the ACCC to continue its work with manufacturers to reduce suicide risk by modifying the design of helium cylinders and their valves. In response the ACCC wrote to the State Coroner indicating its intention to write to major retailers of bottled helium gas sold for party supplies to encourage voluntary safety improvements to the valves and nozzles of gas cylinders. The ACCC noted that as most of the bottled helium sold through retail outlets is believed to be imported it considered that approaches to retail suppliers may be more effective.

9. Argon, like helium, is not scheduled in the Poisons Standard and consequently there are no restrictions regarding who can hire or purchase an argon cylinder. A significant difference between argon and helium is that while helium is widely sold for domestic use (particularly in party balloons), this is not the case for argon. The main use of argon is in electric arc welding: it is discharged in a continuous flow around the weld point, to shield the welded metals from other atmospheric gases (particularly nitrogen and oxygen) that might react with and contaminate and weaken them. Reflecting this, argon cylinders are in practice only sold at hardware outlets including specialist welding supply outlets.

10. The restricted scope of argon use and availability should theoretically make it easier to restrict access to it than to helium. However, I recognise that there may be practical difficulties in ensuring that hardware outlets only hire or sell argon cylinders to people who need argon for welding. Apart from listing it in Schedule 7 of the Poisons Standard, so that it cannot be sold or supplied for domestic purposes (an approach unlikely to carry favour with the TGA based on its response to helium), an alternative approach might be to explore regulation through Victorian legislation.

11. 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.[9] 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.

12. Further, whilst I recognise that the legitimate use of argon for welding is quite different to the way in which helium is used, it still may be possible to modify argon cylinder (including valve and nozzle) design to render argon inhalation suicide more difficult.

13. The CPU was not able to identify any obvious opportunities to reduce the incidence of argon inhalation suicide but considered the above warranted exploration. I agree. I recognise that consultation with relevant bodies and organisations will be required to determine whether either intervention is legally and/or technically feasible.

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) might 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 expand the scope of its engagement with Australian gas manufacturers, importers and suppliers, to include not only helium but all common gases used in inert gas inhalation suicide, when considering what design modifications could be made to reduce people's ability to use gas cylinders and associated equipment in suicide.

[9] 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 (i.e. glue sniffing, paint sniffing and similar).

Publication

Given that I have made a recommendation, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*

I convey my sincere condolences to Ms Bell's family.

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

Senior Next of Kins

Melbourne Health (NorthWestern Mental Health)

Office of the Chief Psychiatrist

Senior Constable Natasha Bisogno, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 13 June 2019