IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 5646

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**GORDON MALCOLM WALLACE**
Date of birth:	**20 April 1947**
Date of death:	**8 November 2018**
Cause of death:	**Plastic bag asphyxia and argon gas inhalation**
Place of death:	**53 Lorimer Drive, Eastwood Victoria 3875**

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

1. Gordon Malcolm Wallace was a 71-year-old man who lived with his wife, Dawn Wallace at 53 Lorimer Drive, Eastwood Victoria 3875.

2. On 8 November 2018, Mrs Wallace returned from a walk to find her husband deceased in the garage with a clear plastic bag over his head. The bag had two tubes running into it. These tubes were connected to three gas bottles.

3. Mr Wallace'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

4. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mr Wallace, reviewed a post mortem computed tomography (CT) scan, information in the VIFM contact log and referred to the Victoria Police Report of Death, Form 83.

5. Dr Lynch commented that the results of the external examination showed findings consistent with the history. The post mortem CT scan revealed left hydronephrosis and hydroureter and nil else of note.

6. Mr Wallace had a medical history that included chronic renal failure secondary to metastatic bladder cancer. In 2012, he had his bladder removed and a stoma and bag put in place.

7. Dr Lynch noted that Mrs Wallace was interested in determining the cause for the bleeding from the stoma and for his vomiting. Dr Lynch detailed that the bleeding is likely related to superficial inflammation around the stoma site and the vomiting may well be related to his ongoing problems with renal failure.

8. Dr Lynch ascribed the cause of death to plastic bag asphyxia and argon gas inhalation.

Police investigation

9. Upon attending the Eastwood premises after Mr Wallace's death, Victoria Police officers observed Mr Wallace lying on the floor of the garage with a clear plastic bag over his head. The bag had two tubes running into it. These tubes were connected to three gas bottles.

10. Senior Constable (SC) Arlene Burnett was the nominated Coroner's Investigator.[1] At my direction, SC Burnett investigated the circumstances surrounding Mr Wallace's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, friends, treating clinicians and investigating officers.

11. During the investigation, police learned that Mr Wallace had a primary medical diagnosis of chronic renal failure secondary to metastatic bladder cancer. He was under the specialist care of nephrologists, Professor Jeremy Grummet and Doctor David Hooke.

12. Mr Wallace was a previous member of Victoria Police. He left the workforce around late 1979 to assume the primary carer role of their newborn son, Daniel. Mr Wallace stayed at home for approximately three years. Despite working on the family home during this period, Mr Wallace is said to have started experiencing feelings that he was not providing for his family.

13. In 1983, Mr Wallace started working for the "Roads Authority" as a licence tester in Morwell. The family moved to Sale, Victoria but would travel back to their previous location of Paynesville on weekends because Mr Wallace was an avid fisherman and enjoyed going offshore in his boat.

14. In 1984, Mr Wallace re-joined Victoria Police as a reservist. He commenced work in Sale and not long after, transferred back to Bairnsdale. Mr Wallace was happy to be back in Victoria Police. He felt appreciated by colleagues and built many positive relationships.

[1] 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.

15. Mr Wallace went on to become an analyst and is said to have created the Data Intelligence Unit (DIU) in Bairnsdale. Mr Wallace loved his job and took great pride in his work. He received five commendations for his achievement while working in the DIU.

16. In 2000, the Mr Wallace and his wife built a home in Lakes Entrance. The house overlooked the ocean and Mr Wallace is said to have enjoyed living there. He engaged in fishing, walking, playing table tennis and reading.

17. In 2007, Mr Wallace had a tumour removed from his bladder. The tumour was alleged to have been the size of an orange and had gone undiagnosed for a period of four years. This marked the beginning of Mr Wallace's 12 year "cancer journey".

18. From the time he was diagnosed, Mr Wallace was convinced that his cancer would always come back. He is said to have been pessimistic and not hopeful for his final outcome. Mr Wallace attended many medical appointments and underwent many medical procedures during this period and is said to have become dejected and miserable, especially over the colder months.

19. Mr Wallace remained working at Victoria Police until his retirement in 2010.

20. In March of 2011, Mr Wallace was diagnosed with multiple cancers in the bladder. He underwent treatment that caused significant side effects that Mr Wallace described as "six weeks of hell". He continued with this treatment for 12 months before having his bladder removed in 2012. Mr Wallace had a stoma and bag to replace his bladder. He coped adequately with the changes but did not want to leave the house.

21. Mrs Wallace encouraged her husband to resume his old lifestyle and eventually, he joined a table tennis club and started gardening and fishing again.

22. In 2013, Mr Wallace had a cancerous kidney removed. Consequently, he decided to sell the family home in Lakes Entrance and buy a lower-maintenance property back in Bairnsdale.

23. Over the next two to three years, Mr Wallace continued to undergo regular testing, scans and medical procedures. In early 2017, Mr Wallace started seeing a kidney specialist due

to the decline in his renal function. Over the next twelve months, Mr Wallace was said to have become miserable, sick and very weak.

24. In 2018, Mr Wallace was told that he had reduced renal function that required dialysis. He subsequently underwent a procedure to make a fistula in his arm for the dialysis. Mr Wallace grew ill four weeks later and was taken to the Bairnsdale Regional Health Service, Emergency Room. He was transferred to Monash Medical Centre, where he stayed for ten days on dialysis. Mr Wallace was then transferred back to Bairnsdale Regional Health, where he continued his dialysis treatment.

25. In late June of 2018, Mr Wallace started to experience heart issues and felt that the dialysis was restricting his life. Around this time, he had a discussion with his specialist about his "end of life" wishes. Mr Wallace signed a "not for resuscitation" document.

26. In September of 2018, Mr Wallace was seen by a urological surgeon in relation to continuing infections. The surgeon advised that Mr Wallace's non-functioning kidney was the source of the infections and recommended the kidney be removed.

27. During this time, Mr Wallace discussed and signed "Advanced Care Directives" with his treating clinicians. He also advised his treating clinicians that he had his "end of life plan" organised. Mr Wallace did not go into details about what his "end of life plan" involved. Mrs Wallace stated that her husband was "[…] a very proud dignified man, and I knew that at some time, when all the medical intervention got too much, he would take matters into his own hands.".

28. Mr Wallace's health continued to deteriorate. He was not leaving the house and was said to have barely been eating or drinking. Mr Wallace "made it clear that he did not want to go but was finding it hard to stay". Mrs Wallace stated that she knew what her husband meant by this and "knew he would do things his way in the end". Mr Wallace had told Mrs Wallace not to call an ambulance if he got "that" sick, "he just wanted to go his own way".

> Gordon's wish was to put his plan into effect and not involve me in any way. He was always in control of his own life, and wanted to be in control of his own destiny,

29. On 24 October 2018, Mr Wallace spent the day with his long-time friend, Sharon Blegg. Mr Wallace confided in Ms Blegg about how he was feeling. Namely, that he felt as

though he had no quality of life. Mr Wallace mentioned an "exit strategy" to Ms Blegg and told her that he had researched on the internet and found that gas was the "fastest, less impacting and easy to obtain" method. "He said it just pretty much knocks you out and then the body just shuts down".

30. Ms Blegg told Mr Wallace that it would not be fair if Mrs Wallace "just found you unexpectedly". Mr Wallace reassured Ms Blegg that he had told his wife about his "exit plan" but had not given her details. He further stated that he would let his wife know when the time was right but would not otherwise get her involved. "He said that he didn't know when, but it would be when there was no hope, and when he just couldn't take the dialysis and medical intervention anymore."

31. In the early evening of 8 October 2018, Mr Wallace told his wife to go for a walk and not to come back for an hour. Mrs Wallace left the house and did not ask any questions. She stated that she knew in her "heart that this was his way of saying goodbye".

32. An hour later, Mrs Wallace returned and found her husband deceased in the garage. Mrs Wallace called emergency services at approximately 7.50pm and waited for them to arrive.

33. Ambulance Victoria declared Mr Wallace deceased a short time later.

COMMENTS

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

34. Subsequent investigations revealed that the gas Mr Wallace used to take his own life was argon gas, which he purchased online. Argon gas is an inert gas. An inert gas is a gas that, in given conditions, does not readily undergo chemical reactions within its environment. The main inert gases inhaled in Victorian suicides are helium, nitrogen, argon and hydrocarbons.

35. Argon gas is not scheduled in the Poisons Standard and consequently, there are no restrictions regarding who can hire or purchase an argon cylinder. The gas has no common domestic applications. Its main use is in electric arc welding whereby, it is discharged in a continuous flow around the weld point to shield the welded metals from

other atmospheric gases. Reflecting this, argon cylinders are widely sold at hardware stores and industrial gas supply businesses, including specialist welding and industrial gas outlets.

36. The mechanism of death with inert gas inhalation suicide, as was the case with Mr Wallace, is asphyxia. Inhaling the gas (almost always with the aid of a plastic bag secured over the head or a mask or similar to ensure sufficient concentration of the gas is inhaled) displaces oxygen from the lungs, in turn preventing blood from being oxygenated (hypoxia) and leading to unconsciousness and death. The use of inert gas has been promoted as a peaceful and effective suicide method among "right-to-die" groups since at least the 1990s.

37. Argon gas was used in nine Victorian inert gas inhalation suicides between 2000 and 2018 (3.8%). The circumstances of these deaths were reviewed by the Coroner's Prevention Unit (CPU)[2]. The CPU found that where able to be ascertained, the gas was obtained as a gas bottle either hired or purchased for welding.

38. I note my previous recommendation into the helium gas inhalation suicide death of Lauren Pilkington[3]. Namely, that my recommendation was founded in an evidence-based prevention proposition: that regulating access to a means of suicide reduces associated suicides. This proposition applies not only to helium but other inert gases, including argon gas.

39. Exploration into the regulation of inert gasses through Victorian legislation has been at the forefront of recent prevention discussions. Specifically, the *Drugs Poisons and Controlled Substances Act 1981 (Vic)* (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[4].

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[2] The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the autopsy report and any particular concerns which have been raised.

[3] Coroners Court of Victoria, court reference: COR 2016 4013.

[4] 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" and similar).

40. Section 58 of the DPCS Act details,

> **Sale of deleterious substances**
>
> (1) Except as otherwise expressly provided in this Act or the regulations, a person shall not sell a deleterious substance to another person if the first-mentioned person knows or reasonably ought to have known or has reasonable cause to believe that the other person intends-
>
> (a) to use the substance by drinking, inhaling, administering or otherwise introducing it into his body; or
>
> (b) to sell or supply the substance to a third person for use by that third person in a manner mentioned in paragraph (a).

41. If the DPCS Act was amended so that deleterious substances defined in section 57 include helium, nitrogen and argon gas, 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 Department of Health and Human Services (DHHS) to educate retailers about the risks of misusing these gases and how to refuse sale.

42. As already mentioned, outside of heavy industry the only licit use of argon gas appears to be in welding. If there was a requirement that hardware stores only hire or sell argon cylinders to people who need argon for welding, this would present a hurdle for those who seek to acquire argon for suicide.

43. The 2018 Finding into the death of Jae William James Manning[5] culminated in the following recommendation:

> 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.

44. By way of reply, DHHS advised that the intent of Part IV of the DPCS Act is to deter supply of substances, such as aerosols, petrol and methylate spirits etc. which have a harmful effect following recurrent use. They noted that while it is possible to amend the

[5] Coroners Court of Victoria, case reference COR 2018 1315.

DPCS Act to include inert gases to enable a retailer to refuse sale, it would be difficult to establish intended misuse, namely for the purpose of suicide.

45. The DHHS detailed that for the other listed substances, the main indication for inappropriate use is repeated purchases. This indication would not be applicable to the purchase of inert gas for the purpose of suicide.

46. The DHHS further noted that they do "not capture data on instances where a person has sold or supplied inert gases in Victoria which they knew, or reasonably out to have known, the end user intended to it for the purposes of suicide." They noted that without such evidence, it is hard to conclude that changes to Part IV of the DPCS Act would result in a reduction in deaths by suicide.

47. For those reasons, the DHHS detailed that it was their view that it would be unlikely that changes to the DPCS Act would have a practical impact on reducing instances where a single premeditated purchase of an inert gas is made for the purposes of suicide.

48. I note that the ongoing investigations into inert gas cylinder design changes and oxygen dilution of helium balloon cylinders is still underway. Namely, whether such means would inhibit successful suicide.

49. The dilution with oxygen is only an option where it will not compromise the uses of the gas. With argon gas, dilution is not possible because the central purpose of argon in welding is to create a gas barrier preventing atmospheric gases including oxygen from reacting with and weakening the weld point.

50. I note the difficulty that would be posed with solidifying an appropriate means for establishing that a person was acquiring argon gas for legitimate welding needs. However, I am nonetheless of the view that the benefits of restricting access specifically to argon gas outweigh the impost on redefining the grounds for distribution.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend the Department of Health and Human Services consider amending the deleterious substances provisions of the *Drugs Poisons and Controlled Substances Act 1981 (Vic)* to specifically include argon gas.

FINDINGS

1. I find that Gordon Malcolm Wallace, born 20 April 1947, died on 8 November 2018 at 53 Lorimer Drive, Eastwood Victoria 3875.

2. There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken his or her life can have long lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence. In this case, there is sufficient evidence to support a finding that Gordon Malcolm Wallace intended to take his own life.

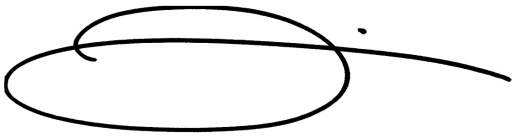
3. I accept and adopt the cause of death ascribed by Dr Matthew Lynch and I find that the cause of Gordon Malcolm Wallace's death was plastic bag asphyxia and argon gas inhalation in circumstances where I find that he intended to end his own life.

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:

Dawn Lynette Wallace
Juliette Wenn, Bairnsdale Regional Health Service
Danielle Wooltorton, Department of Health and Human Services
Ken Teoh, Therapeutic Goods Administration
Neville Matthew, Australian Competition & Consumer Commission
Senior Constable Arlene Burnett

Signature:



AUDREY JAMIESON
CORONER
Date**: 15 June 2020**