IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003929

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	TMP
Date of birth:	[redacted]
Date of death:	[redacted]
Cause of death:	1(a) Argon gas and plastic bag asphyxia
Place of death:	An address known to the Court
Key Words:	Argon gas; inert gas inhalation; asphyxia

INTRODUCTION

1. On [redacted] TMP was 33 years old when he was found deceased in his home. At the time of death, TMP lived at address known to the Court.

2. TMP had a difficult childhood and experienced mental ill health from a young age. He was diagnosed with anxiety and depression and attended two different high schools, as well as an alternative living arrangement due to his complex needs.

3. At the age of 17, TMP met his then partner, and they started a relationship in 2008. They were married in 2011 and had two daughters together. In 2016, TMP and his then partner separated and later divorced in 2018.

4. After the separation, TMP lived with his mother who supported him and his daughters. On one occasion, TMP threatened his mother with a kettle of boiling water which resulted in an intervention order ('**IVO**') against him.

5. TMP started working with his psychologist in mid-2018 and sought counselling for depression, anxiety and suicidal ideation. According to his psychologist, he described this in the context of a traumatic childhood involving a fractured relationship with his mother, an absent father, navigating the foster system and a complex relationship with his foster mother and her ensuing death.

6. TMP also sought counselling for his relationship breakdown with his ex-wife, which was reported to be controlling and abusive. The abuse extended beyond the breakdown of their marriage to include disputes over custody arrangements for their two daughters, whom he had not had in-person contact since October 2023.

7. According to TMP's current partner, TMP tried to arrange mediation several times, however his ex-wife 'always backed out' leaving their issues unresolved. Conversely, his ex-wife noted that they had attempted mediation through many services over the years however TMP refused to attend court to obtain parenting orders.

8. In March 2024, TMP's mental health significantly deteriorated, and he took about three weeks off work. During this time, he expressed to his General Practitioner ('**GP**') that he was suicidal and had a plan. A referral letter was sent to his psychiatrist, and TMP had an appointment booked with his psychologist in two days, with further GP follow up in one week.

9. In June 2024, TMP attended his ex-wife's home with a letter for his daughter on her birthday. His daughter tore the letter up and sent him a text message telling him he could not 'come in and out of her life'. At the end of 2023, TMP also attended his daughter's graduation however neither of his daughters spoke with him.

10. In the weeks prior to TMP's death, he shared he was feeling better and looking forward to the future. He had plans to move to Ballarat with his partner and return to university.

11. However, in the week prior to his death, he contacted his partner one evening and asked her to come over, saying he was 'out of sorts' and did not want to be alone. She went over to his house and stayed the night.

THE CORONIAL INVESTIGATION

12. TMP'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.

13. 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.

14. 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.

15. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of TMP's death. The Coronial 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.

16. This finding draws on the totality of the coronial investigation into the death of TMP 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.[1]

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

Circumstances in which the death occurred

17. On the evening of [redacted] his partner called TMP on FaceTime and noticed he was more down than usual. She thought it might have been because he had not taken his medication, however he told TMP that he had just been to the chemist to collect his medication and that he had purchased oat milk for the weekend.

18. On [redacted] his partner did not hear from TMP. She attempted to call him on FaceTime after work, but he did not pick up. She assumed he was still working and fell asleep on the couch.

19. When she woke up, she realised TMP had still not replied. She tried to call him again with no answer. She attended his address however TMP did not answer the door. She returned home thinking she was being paranoid, however an hour later she returned to the address and contacted the police non-emergency number. She was put through to Triple Zero and advised police would attend.

20. While waiting for the police to attend, she contacted a locksmith to access TMP's house. Once access was gained, she asked the next-door neighbour to enter the apartment and check on TMP. Upon entry, the neighbour located TMP on the bed with a plastic bag over his head.

21. The neighbour contacted Triple Zero and Ambulance Victoria arrived shortly after. The plastic bag was lifted from TMP's face, and he was declared deceased by attending paramedics.

Processing of scene

22. Victoria Police attended the scene and observed a plastic bag on TMP's head, with two hoses extending from beneath the plastic bag and connected to two argon gas cylinders. Tape had been used to prevent the gas from escaping the plastic bag, and a cord secured tubing close

[1] 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.

to his mouth. Both argon gas cylinders were noted to be empty.

23. Next to the argon gas cylinders was a Bunnings Warehouse receipt dated 3 March 2024 which listed the purchase of two argon gas cylinders, two gas regulators, tape and tubing.

24. Police observed the apartment to be clean and tidy and no 'note' was located. Medication prescribed to TMP was located on the kitchen servery and included apo-esomeprazole, trimethoprim, and agomelatine.

Identity of the deceased

25. On 10 December 2024, TMP born [redacted], was visually identified by his partner, who completed a Statement of Identification.

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

Medical cause of death

27. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of TMP on 15 July 2024. Dr Fronczek reviewed the post mortem computed tomography ('**CT**') scan, the Victoria Police Report of Death (Form 83), the VIFM contact log and scene photographs and provided a written report of her findings dated 16 July 2024.

28. The findings at external examination were consistent with the reported circumstances and the CT scan showed no significant findings.

29. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

30. Dr Fronczek provided an opinion that the medical cause of death was 1(a) ARGON GAS AND PLASTIC BAG ASPHYXIA.

COMMENTS

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

<u>Suicides by inert gas inhalation</u>

1. Victorian Suicide Register[2] data shows that there were 342 inert gas inhalation suicides for the period of 2000 to 2024. An inert gas is a gas that, in given conditions, does not readily undergo chemical reactions with its environment. The main inert gases used in suicides in Victoria are helium, nitrogen, argon and hydrocarbons.

2. The mechanism of death with inert gas inhalation suicide is asphyxia. When the gas is inhaled (usually with the aid of a plastic bag or similar to ensure sufficient concentration of the gas is inhaled), it displaces oxygen from the lungs and prevents blood from being oxygenated, which in turn leads to unconsciousness and death.

3. Inert gas has been promoted by 'right to die' groups such as Exit International as a peaceful and effective suicide method since at least the 1990s. Researchers have linked the spread of inert gas inhalation suicide in Australia and internationally with the dissemination of material, particularly on the internet, produced by the 'right to death' movement.[3] Exit International have also suggested that another reason for the method rising in popularity may be due to the increasing availability and convenience of access to inert gases, which were previously for predominantly industrial use.[4]

4. Victorian Coroners have engaged at length with Commonwealth and state government entities regarding measures to reduce inert gas inhalation suicide, with mixed degrees of success. The most success has been in curbing the ease of access to helium, which is the most frequently used gas in inert gas inhalation suicides in Victoria. Between 2000 and 2024, 45.9% of inert gas inhalation suicides involved the use of helium.

5. On 16 April 2023, following several coronial investigations culminating in findings referencing the ease of access to helium and including relevant recommendations to stymie its use in suicide, Consumer Goods (Non-refillable Helium Cylinders) Safety Standard 2022 came into effect. The Australian Competition and Consumer Commission ('**ACCC**') advised the Court of the following with regard to the standard:

[2] The Victorian Suicide Register (VSR) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

[3] 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), 2007, 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.

[4] Nitschke P and Stewart F, *The Peaceful Pill Handbook*, revised edition, Bellingham: Exit International US, October 2009, p.67.

On 16 April 2023 the mandatory safety standard (Consumer Goods (Non-refillable Helium Cylinders) Safety Standard 2022) for all non-refillable helium cylinders supplied in Australia came into effect. This means that from 16 April 2023, suppliers must (by law) comply with the requirements of the mandatory safety standard. Significant penalties apply to those suppliers who do not. The mandatory safety standard applies to the sale of non-refillable helium cylinders to intermediaries and consumers.

The mandatory safety standard makes it much more difficult to misuse non-refillable helium cylinders for suicide by requiring a mixture of 21% +/- 1.0% oxygen and 79% helium. This means that attempted use will result in unpleasant side effects associated with cumulative levels of carbon dioxide and delayed loss of consciousness, providing opportunities for reconsideration by the user and intervention by others, compared to a 100% helium mixture.

The mandatory safety standard also includes a requirement to add labelling to the cylinder and/or secondary packaging to advise that the cylinder contains an oxygen and helium blend. It also requires warnings about inhalation of the gas such as 'do not inhale' and 'may cause suffocation'.

The mandatory safety standard does not apply to refillable helium cylinders. The ACCC's research indicates that the purchasing or renting of these products generally requires the customer to either establish an account with the supplier and/or provide identification. They are generally supplied to commercial operators and smaller businesses. It would appear that the heightened barriers to access these cylinders provides a deterrent at this time. However, following the introduction of the mandatory safety standard the ACCC will monitor the market to assess whether regulatory intervention results in any behavioural change.

<u>The availability of argon gas</u>

6. Of the 342 inert gas inhalation suicides between 2000 and 2024, 21 (6.1%) of these deaths, including TMP's, involved argon gas. Unfortunately, and perhaps as its use in suicide is less common, the Court's efforts to restrict the availability of argon gas have not been successful.

7. Argon gas is primarily used in electric arc welding and accordingly, the evidence in most cases is that the deceased obtained welding argon from a specialist industrial supplier. However, there were four recent deaths, including TMP's, where the deceased used disposable bottles of argon gas from Bunnings Warehouse.

8. On 13 June 2019, Coroner Rosemary Carlin (as she then was) delivered her finding in the death of Diane Bell[5], who took her own life by argon gas inhalation. Coroner Carlin explored the possibility of regulating argon (and other inert gas) sales through Victorian legislation.

9. The *Drug, Poisons and Controlled Substances Act 1981* (Vic) (‘**DPCSA**’) prohibits the sale of deleterious substances[6] to those seeking to misuse them, for example by ingestion or inhalation. Coroner Carlin considered that an amendment to the DPCSA to include inert gases in the definition of “deleterious substances” *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 (Department of Health and Human Services) to educate retailers about the risks of misusing these gases and how to refuse sales.*

10. Coroner Carlin made the following recommendations:

    a. *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 the purposes of suicide.*[7]

    b. *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.*

11. The Department of Health and Human Service (‘**DHHS’**) rejected the recommendation. Secretary Kym Peake noted that while the suggested amendment to the DPSCA was possible, *it would be very difficult to establish the substance intended use was for the purpose of suicide … it is likely that many retailers would not have the skills to detect the intended use was for suicide.* By contrast, the main indication for inappropriate use of the listed “deleterious

[5] Coroner Rosemary Carlin, COR 2017 002906, *Form 38 Finding into Death without Inquest of Diane Bell (a pseudonym),* delivered 13 June 2019.

[6] “Deleterious substances” is defined by section 57 of the DPCSA and means methylated spirits and volatile substances, the latter including plastic solvent, cleaning agent, glue, gasoline etc.

[7] Coroner Carlin repeated this recommendation in the matter of Jae Manning, who died by helium inhalation suicide. COR 2018 001315 refers.

substances" is repeated purchases, which would not be the case where inert gas was purchased for the purpose of suicide.[8]

12. The ACCC advised that in consultation with international regulators, they had not identified any feasible design modifications for gas cylinders that would reduce the ability to use them in suicide.

13. On 15 June 2020, I delivered my finding in the death of Malcolm Wallace, who died by plastic bag asphyxia and argon gas inhalation. In my finding I acknowledged the responses to Coroner Carlin's recommendations, in particular the difficulty in establishing that someone was purchasing argon gas for legitimate welding needs, but I maintained then, and still do, that *the benefits of restricting access specifically to argon gas outweigh the impost on redefining the grounds for distribution.*[9] Accordingly, I made the following recommendation:

    a. *With the aim of promoting public health and safety and preventing like deaths, I recommend that 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.*

14. DHHS again rejected the recommendation providing the same reasons as in the case of Diane Bell, though expanded on these by noting that placing an expectation on retailers to assess whether a single purchase of an inert gas is for legitimate purposes would not be feasible, and that amending the DPCSA would require consultation and communication which in turn would raise public awareness of argon gas misuse, which may *have the unintended effect of increasing the attractiveness of inert gases as a means of suicide.*

Recent developments

15. On 28 May 2024, Dr Jeremy Dwyer of the Coroners Prevention Unit wrote to the ACCC on my behalf, enquiring as to whether the ACCC had identified any new countermeasures to reduce the risk of inert gas inhalation suicide in Victoria or Australia and specifically, had

[8] Letter from Department of Health and Human Services to Coroners Court of Victoria, dated 20 September 2019. https://www.coronerscourt.vic.gov.au/sites/default/files/2019-11/2018%201315%20and%202017%202906%20Response%20to%20recommendations%20from%20DHHS_MANNING%20and%20BELL_Redacted_0.pdf

[9] Coroner Audrey Jamieson, COR 2018 005646, *Form 38 Finding into Death without Inquest of Malcolm Wallace,* delivered 15 June 2020.

they explored any new interventions that might reduce the public's access to argon and nitrogen. Dr Dwyer also enclosed updated Victorian coronial data.

16. Nick O'Kane, Acting General Manager, Risk Management and Policy, Consumer Product Safety Division provided a response on 19 June 2024. Mr O'Kane's response spoke to the changes that have been made regarding helium gas. He noted that *the ACCC directs its resources to matters that provide the greatest overall benefit to the Australian community and is unable to pursue all product safety matters that come to its attention.* Further, while the ACCC is aware that gases such as argon (and nitrogen) can be used in suicides, it *does not propose recommending mandatory standards for argon or nitrogen at this time.* He advised that *the ACCC will continue to work closely with other government departments and agencies that have roles in suicide prevention, identification of unsafe consumer goods and administration of schemes regulating goods that present safety risks to Australian consumers.*

17. I see no merit in making a recommendation in this matter given the Department of Health has twice declined to amend the deleterious substances provisions of the *DPCSA* following coronial recommendations, and the ACCC's advice that they have been unable to identify any feasible design modifications for gas cylinders which would reduce the ability to use them in inert gas inhalation suicide, and do not propose recommending mandatory standards for argon.

18. It is certainly frustrating and disappointing to be in a position where making a recommendation would be fruitless, particularly as the data held by the Court indicates that these suicides will continue. However, I and my colleagues at the Court will continue to monitor these deaths and conduct comprehensive investigations with the view to identifying and making appropriate recommendations as soon as they may arise.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was TMP, born [redacted]

   b) the death occurred on [redacted] at an address known to the Court;

   c) I accept and adopt the medical cause of death ascribed by Dr Judith Fronczek and I find that TMP died from argon gas and plastic bag asphyxia.

2. AND I further find that the evidence indicates a background of long-term mental ill health and complex personal relationship issues likely contributed to TMP's declining mental health and precipitated his decision to purchase argon gas to intentionally end his own life.

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

Pursuant to section 73(1B) 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:

Mother of TMP, Senior Next of Kin

Australian Competition and Consumer Commission

Leading Senior Constable Shane Ruwhiu, Coronial Investigator

Signature:

AUDREY JAMIESON

CORONER

Date: 20 June 2025

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.