IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 005568

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Dominic Joshua Clifford
Date of birth:	17 January 2001
Date of death:	On or before 21 September 2024
Cause of death:	1(a) Plastic bag asphyxia in setting of irrespirable atmosphere induced by nitrogen gas inhalation
Place of death:	Near School Track, Tremont, Victoria

INTRODUCTION

1. On 21 September 2024, Dominic Joshua Clifford was 23 years old when he was found in bushland in circumstances indicating he had taken his own life. At the time, Mr Clifford lived in a Youth Residential Rehabilitation Service in Moorabbin.

2. Mr Clifford was born in England. When he was about one year old, the family moved to Italy. By this stage, Mr Clifford had not yet started speaking and, over the following years, he continued to have issues with talking and certain sounds. He was eventually diagnosed with apraxia.

3. In 2005, Mr Clifford and his family moved to Australia, and he began to receive intensive speech therapy. With this assistance, he began taking albeit with ongoing issues with clarity and fluency. Mr Clifford attended primary school between 2006 and 2013, repeating a year due to learning difficulties and anxiety. He received educational support from a tutor and from his mother for his learning difficulties and from an occupational therapist in relation to fine and gross motor skills.

4. Mr Clifford's father, Stephen Clifford, described his son as a highly sensitive child who was always drawn to people who were experiencing their own struggles. He was also very caring, thoughtful, and a born entertainer.

5. In 2015, the family moved to Cairns but returned to Melbourne in 2016.

6. From late 2016, Mr Clifford parents observed a deterioration in his mental health; he experienced suicidal ideation and began harming himself. He received psychiatric assistance from a psychologist and Monash Health, which included an inpatient admission.

7. In 2018, Mr Clifford moved out of the family home and continued to receive assistance for his mental health from various services and clinicians, however, he did not engage consistently. He attempted suicide on several occasions over the following years. His parents continued to support him steadfastly with Mr Clifford returning to live at the family home intermittently.

8. In May 2024, Mr Clifford attempted to take his own life suing nitrogen gas. Following this attempt, he was admitted to the Alfred Health Inpatient Psychiatric Unit for two weeks and received diagnoses of cannabis use disorder, borderline personality traits, likely autism spectrum disorder, likely attention deficit hyperactivity disorder (**ADHD**), and chronic mood

and anxiety disorder. He reported a positive effect from his medications (fluoxetine and olanzapine) and was discharged to the care of the Maroondah Crisis and Assessment Team (**CATT**).

9. According to Stephen Clifford, his son returned home and was very depressed in mid-2024. He did not socialise or leave the house and was prescribed medication that he said made him feel like a *"Zombie"*. He made plans to take his own life and the family realised he could no longer be left alone.

10. Mr Clifford presented to Alfred Hospital on 26 June 2024 following several days of feeling suicidal and buying a rope. Following discharge, he received follow up in the community from the CATT, the Infant Child and Youth Area Mental Health and Wellbeing Service (**ICYAMHWS**), and the Child and Youth Mental Health Service (**CYMHS**). Mr Clifford engaged well and reported an improvement in his mood and suicidal ideation. In August 2024, aripiprazole was added to his medication regime. This was Mr Clifford's last attendance with CYMHS, and his care was later transferred to a private psychiatrist.

THE CORONIAL INVESTIGATION

11. Mr Clifford'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.

12. 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.

13. 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.

14. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Clifford'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.

15. This finding draws on the totality of the coronial investigation into Mr Clifford's death, 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

Identity of the deceased

16. On 23 September 2024, Dominic Joshua Clifford, born 17 January 2001, was visually identified by his father, Stephen Clifford, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

18. Senior Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 23 September 2024 and provided a written report of his findings dated 23 September 2024.

19. The post-mortem examination was consistent with the reported circumstances.

20. Routine toxicological analysis of post-mortem samples detected diazepam,[2] nordiazepam, oxazepam, and mirtazapine.[3]

21. Dr Lynch provided an opinion that the medical cause of death was *"1(a) Plastic bag asphyxia in setting of irrespirable atmosphere induced by nitrogen gas inhalation"*.

22. I accept Dr Lynch's opinion.

[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.
[2] Diazepam is indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are metabolites. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.
[3] Mirtazapine is indicated for the treatment of depression.

Circumstances in which the death occurred

Weeks leading to Mr Clifford's death

23. At the beginning of September 2024, Mr Clifford moved to Neami Moorabbin Youth Residential Rehabilitation Service. He seemed happy and made an effort to engage with his family who were hopeful this was a turning point in his life.

24. On 9 September 2024, Mr Clifford had his first and only consultation with Dr Anthony Gallagher, consultant child and youth psychiatrist at Ramsay Clinic Albert Road. Stephen Clifford attended part of the consultation with his son.

25. Dr Gallagher stated he received a brief summary of Mr Clifford's history which included diagnoses of schizophrenia, depression, ADHD, and generalised anxiety, multiple hospitalisations to manage both the psychotic symptoms, and suicidal risk. Mr Clifford disclosed that he was frustrated with treatment and the lack of freedom to decide what treatment he wanted.

26. In his statement, Dr Gallagher said – *"Diagnostically, I did make an alteration to the list, in that without dismissing other concomitant diagnoses, suggested to Dominic that I considered that a better option was to amalgamate the depression and the psychosis under the one diagnosis of schizoaffective disorder, based upon the psychotic symptoms he experienced being manifest when he was depressed (this was to begin a process of addressing this in the future)."*

27. Mr Clifford noted aripiprazole was sedating and asked Dr Gallagher for help with this. They agreed to change the aripiprazole/ olanzapine combination to mirtazapine and brexpiprazole, with supplemental oxazepam to address anxiety. Dr Gallagher asked Mr Clifford to contact him immediately if he experienced any negative side effects with the new medication.

28. Dr Gallagher also noted that given Mr Clifford's history of suicide attempts, he thoroughly explored risk with Mr Clifford who assured him that he was not suicidal and had no plans to hurt himself or those around him. He advised Mr Clifford to contact him immediate if there was any change to risk. A further consultation was planned for two weeks.

29. Stephen Clifford stated that the new medication appeared to make his son clear and more motivated.

The day of Mr Clifford's death

30. On 20 September 2024, Mr Clifford spent the day with his mother and attended an exhibition in the city. They had coffee and Mr Clifford bought his mother a broach.

31. In the evening, the family had dinner together and played cards. Mr Clifford had also bought the family dog a gift. He appeared content and happy to be part of the family. When he left, he said goodbye to his family members individually, hugged them, and said he loved them.

32. At about 10.30pm that evening, Mr Clifford left his home and caught a train to Upper Ferntree Gully. From there, he walked to School Track in Tremont wheeling a shopping cart containing a foldable chair, nitrogen gas cylinder, plastic bags, and other items. He had reportedly purchased the gas cylinder in the week preceding his death.

33. Mr Clifford found a place to sit near School Track, set up his chair and smoked a cigarette. He then taped a plastic bag around his head and connected a house from the gas cylinder to the plastic bag. Using this method and at an unknown time Mr Clifford took his own life.

34. At 7.00am on the morning of 21 September 2024, Mr Clifford's family received a pre-scheduled email from Mr Clifford detailing his intention to take his own life. He provided a link to his location, which did not work. Mr Clifford's father reported him missing to Moorabbin Police, who coordinated a police search. Stephen Clifford and his other son, Toby, also searched for Mr Clifford.

35. At approximately 9.00pm, the police airwing located a heat source in bushland near School Track in Tremont. Search and Rescue members then located his body.

36. According to his family, at some point during the COVID-19 pandemic, Mr Clifford found human remains whilst walking bushland in Tremont, which he reported to police, an event which had a profound effect on him.

37. Senior Constable Rebecca Fryters, Coronial Investigator, concluded her investigation by noting that Mr Clifford had extensive mental health issues that went back to his childhood. His family made every effort to get him help and assistance. It was evident that Mr Clifford had carefully planned his death by buying the gas cylinder a week in advance and scheduling the email to his family. He also made sure he was comfortable in his last hours before his death, taking a blanket, headphones, a drink, and cigarettes with him.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Dominic Joshua Clifford, born 17 January 2001;

    (b) the death occurred on or before 21 September 2024 near School Track, Tremont, Victoria;

    (c) the cause of Mr Clifford's death was plastic bag asphyxia in setting of irrespirable atmosphere induced by nitrogen gas inhalation; and

    (d) the death occurred in the circumstances described above.

39. Having considered all of the evidence, including Mr Clifford's mental health history and the lethality of means used, I am satisfied that Mr Clifford intentionally took his own life.

40. Mr Clifford had a long history of mental ill health and previous suicide attempts. On 9 September 2024, he attended his first and only consultation with Dr Anthony Gallagher. At this appointment, there was an agreement to change Mr Clifford's medication to mirtazapine and brexpiprazole, with supplemental oxazepam. Dr Gallagher asked Mr Clifford to contact him immediately if he experienced any negative side effects with the new medication. At this consultation, Mr Clifford assured Dr Gallagher that he was not suicidal and had no plans to suicide. A follow-up consultation was planned for 25 September.

41. In the intervening period, it appeared that Mr Clifford was responding positively to the new medication. There was no report to Dr Gallaher regarding any negative response or increased self-harm risk. There was therefore no event that would have triggered Dr Gallagher's intervention in the intervening period or an earlier follow-up. A two-week follow-up appeared appropriate in the circumstances.

42. The available evidence therefore does not support a finding that there as any want of clinical management or care on the part of Dr Gallagher that caused or contributed to Mr Clifford's death.

43. I convey my sincere condolences to Mr Clifford' family for their loss.

COMMENTS

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

Nitrogen inhalation suicide

44. Mr Clifford died when he intentionally concentrated and inhaled nitrogen gas from a cylinder by feeding the gas through a hose to a plastic bag he had taped around his head. The mechanism of death was asphyxia: when he inhaled the nitrogen in the plastic bag, it displaced oxygen from his lungs.

45. This suicide method is known as inert gas inhalation. An inert gas is one that, in given conditions, does not readily undergo chemical reactions with its environment. Inert gas inhalation suicide is the concentration and inhalation of inert gas with intent to die.

46. The main inert gases inhaled in Victorian suicides are helium, nitrogen, argon, nitrous oxide and hydrocarbons.[4]

47. Nitrogen is mainly sold through specialist gas suppliers. Unlike (say) helium, it does not have any common household uses. Nitrogen has specialist applications in areas such as fire suppression technology, industrial metals manufacturing, diving, incandescent lightbulb manufacture, sample preparation in chemical analysis, and pressurising beer kegs.

48. Nitrogen is not scheduled in the Poisons Standard, and there are no other controls regulating public access to nitrogen gas in Australia.

49. Nitrogen was the second most frequently used gas in Victorian inert gas inhalation suicides between 2000 and 2025, accounting for 91 (24.8 percent) of the 367 deaths. Most deaths occurred after 2013, with a spike in 2014 and then an average of six deaths per year through to 2025 with no discernable trend.

50. Mr Clifford's father, Steve Clifford, established from a bank statement that his son had purchased the nitrogen cylinder at Total Tools in South Melbourne on 16 September 2024, five days before the fatal incident. He stated that he subsequently visited Total Tools to find out how easy it is to purchase nitrogen gas, and:

[4] Other gases have been used in inert gas suicide in Victoria, though rarely. For example, propellant gases in pressurised spray cans (which sometimes include hydrocarbons) have been concentrated and inhaled to achieve fatal asphyxia, as has carbon dioxide bottled for industrial applications.

I asked the lady at the counter, what forms of ID do I need to purchase the gas bottle and she advised me I just need to sign a waiver form. I was shocked it was so easy.

51. Victorian coroners have long been concerned about the ease of public access to gases used in inert gas inhalation suicide (not just nitrogen but also helium, argon and nitrous oxide) and have made multiple recommendations over a time aimed at addressing this issue.

Bottle design

52. One area that coroners have explored in their findings, is whether there might be opportunities to modify the design of gas cylinders, to render them more difficult to use in suicide. This idea was first raised when Victorian coroners were engaging with the Australian Competition and Consumer Commission (**ACCC**) and the Therapeutic Goods Administration (**TGA**) about whether balloon helium could be regulated as an unsafe consumer product given its involvement in a substantial number of suicides.[5]

53. The TGA did not support these efforts, but the ACCC was more positive and indicated, inter alia, that:

> *[…] the ACCC is consulting with the bottled gas industry about possible amendments to the simple valve and nozzle presentation on helium canisters available to the public. The aim is to alter the presentation of the canister to make the gas more difficult to remove from the canister. Changes may include the need to repeatedly depress a part to keep the gas flowing. These changes will mean that someone impaired with alcohol or other drugs e.g. sedatives, will be less able to complete the suicide act and will also stop the flow of gas once the user is unconscious. These changes may also reduce the likelihood of children being able to release helium from the canister, given that these products are in the home*.[6]

54. Coroner Rosemary Carlin (as she then was) noted in a June 2019 finding that the ACCC's work on the design of helium cylinders would be relevant also to other gases, and therefore recommended:

> *That the Australian Competition and Consumer Commission expand the scope of its engagement with Australian gas manufacturers, importers and suppliers, to include*

[5] See *Finding without inquest in death of [name redacted] (unpublished)*, COR 2014 005424, delivered 22 February 2016; *Finding without inquest in death of Lauren Pilkington (published)*, COR 2016 004013, delivered 19 April 2017.
[6] Australian Competition and Consumer Commission, "Application to amend the Poisons Standard: scheduling of helium gas", 3 August 2017, pp.19-20.

> *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*.[7]

55. The ACCC General Manager of the Consumer Product Safety Branch, Neville Matthew, responded to this recommendation and indicated that the ACCC had not yet identified any feasible design modifications for gas cylinders which would reduce people's ability to use them in suicide. He also wrote that efforts would continue:

> *The ACCC intends to conduct further non-public consultation with international regulators and the gas industry to provide the parties with an opportunity to submit new information about the efficacy and viability of the measures suggested in your findings. The ACCC will then assess the further information stakeholders provide before considering whether further action can be taken.*

56. In July 2022, Coroner Simon McGregor followed up with the ACCC on its progress in this respect, recommending that the ACCC continue exploring new gas cylinder design solutions to reduce inert gas suicide, particularly a mechanism that could limit people's ability to produce a steady helium flow to enact suicide plans.[8] Mr Matthew again responded to indicate that this type of mechanism has yet to be developed.

57. In a November 2023 finding into a nitrogen inhalation suicide, Coroner Audrey Jamieson noted that there had been some recent positive developments in preventing helium inhalation suicide, including a new requirement that helium in non-refillable cylinders be diluted with 20% oxygen. Coroner Jamieson commented:

> *It is commendable that these measures have been considered and implemented with regard to helium. However, further focus is required on the use of nitrogen and other inert gases and the ongoing risk they pose to consumers. I am encouraged by the comment of Mr Matthews that the ACCC will continue to "monitor data on the use of helium and substitution to other gases." The Court will also continue to monitor any trends in inert gas inhalation suicides and consider potential prevention opportunities and recommendations*.[9]

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[7] *Finding without inquest in death of Diane Bell (published)*, COR 2017 002906, delivered 13 June 2019, p.10.
[8] *Finding without inquest in death of EBG (published)*, COR 2021 003131, delivered 19 July 2022.
[9] *Finding without inquest in death of [name redacted] (unpublished)*, COR 2021 004452, delivered 23 November 2023, pp.11-12.

Restricting access through regulation

58. The other main intervention that coroners have explored is restricting access to gases through regulation. The rationale for this intervention is that most gases have very specific uses, and the general public do not require access to them, so restricting access to people with a specific need for these gases would help to prevent suicide without causing any great hardship to the general public.

59. At a Commonwealth level, Victorian coroners have engaged with both the ACCC and the TGA about using their regulatory tools to restrict access to gases used in inert gas inhalation suicide. This engagement resulted in the ACCC issuing a new mandatory safety standard for helium sold in non-refillable cylinders but has not led to any new restrictions on access to other gases. In June 2024 correspondence to the Court, the ACCC's Acting General Manager for Risk Management and Policy in the Consumer Product Safety Division, Nick O'Kane, stated that the ACCC:

> *[…] does not propose recommending mandatory standards for argon or nitrogen at this time*.[10]

60. At the state level, Victorian coroners have identified the *Drugs Poisons and Controlled Substances Act 1981* (Vic) as a potential mechanism for regulating access to gases. Under this legislation, the sale of substances that are declared to be deleterious substances can be controlled or restricted. In June 2019, Coroner Carlin made the following recommendation:

> *That the Department of Health and Human Services [**DHHS**] 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*.[11]

61. DHHS Secretary Kym Peake responded in September 2019 to reject this recommendation, stating that:

> *While it is possible to amend the Act, to include helium and other inert gases to enable a retailer to refuse sale, it would be very difficult to establish the substance intended*

[10] The correspondence is quoted in *Finding without inquest in death of JQ (published)*, COR 2022 001320, delivered 28 February 2025, p.13.
[11] *Finding without inquest in death of Diane Bell (published)*, COR 2017 002906, delivered 13 June 2019, p.10.

use was for the purposes of suicide. For the other listed substances, the main indication for inappropriate use is repeated purchases which would not occur for inert gases and it is likely that many retailers would not have the skills to detect the intended use was for suicide.

The department does not capture data on instances where a person has sold or supplied inert gases in Victoria which they knew, or reasonably ought to have known, the end user intended to it for the purposes of suicide. Without such evidence, it is hard to conclude that change to Part IV of the Act would result in a reduction in deaths by suicide.

For these reasons the department believes it is unlikely that amending the Act would have a practical impact on reducing instances where a single premediated purchase of an inert gas is made for the purposes of suicide.

62. In June 2020, Coroner Jamieson revisited this recommendation specifically with respect to argon gas, recommending that the DHHS include argon gas as a deleterious substance.[12] Again, DHHS Secretary Peake rejected the recommendation for the reasons outlined in the above quote.

Monitoring the suicides

63. While Victorian coroners have not to date been successful in convincing either Victorian or Commonwealth authorities to make regulatory changes that would restrict public access to nitrogen gas, or to identify design solutions that may render gas cylinders more difficult to use in inert gas inhalation suicide, these efforts will continue. The Coroners Prevention Unit[13] actively monitors inert gas inhalation suicide on behalf of Victorian coroners and continually look for new interventions that might reduce the toll taken by this suicide method.

[12] *Finding without inquest in death of Gordon Malcolm Wallace (published)*, COR 2018 005646, delivered 15 June 2020.
[13] 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 and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Victorian Suicide Register

64. 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.

65. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from approximately 550 deaths in 2011 to a peak of 795 deaths in 2023 (777 deaths in 2024).[14]

66. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

67. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

[14] Coroners Court Monthly Suicide Data report, September 2025 update. Published 23 October 2025.

DIRECTIONS

68. 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.

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

Stephen and September Clifford, senior next of kin
Dr Anthony Gallagher (care of Avant Law Pty Ltd)
Alfred Health
Australian Health Practitioner Regulation Agency
Jenny Atta PSM, Secretary of the Department of Health
Senior Constable Rebecca Fryters, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 January 2026

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.