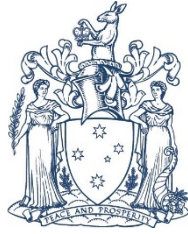

IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	COR 2020 004224

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Joshua Michael Perkins
Date of birth:	30 April 1993
Date of death:	4 August 2020
Cause of death:	1(a) Asphyxia 1(b) Plastic bag asphyxia with inhalation of argon gas
Place of death:	1 / 15 Pryor Street, Mount Pleasant, Victoria, 3350

INTRODUCTION

1. On 4 August 2020, Joshua Michael Perkins was 27 years old when he was found deceased in his bedroom by his friend and housemate Luke Murtagh. The two lived in Mount Pleasant.

THE CORONIAL INVESTIGATION

2. Joshua's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the A**ct). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Joshua's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as the forensic pathologist and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Joshua'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]

[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.

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

Circumstances in which the death occurred

7. Born and raised in the Albury Wodonga area, Joshua was the second child of Mark and Amanda Perkins. He had two siblings: an older sister Katie and a younger brother David.

8. Joshua was an intelligent and inquisitive child who established many strong friendships. He became more introverted as a teenager, but was capable student, particularly in English, and surprised himself with higher final school grades than anticipated. He subsequently left home to study Arts at the University of Melbourne in 2012. Whilst he appeared interested in his courses, particularly philosophy, Joshua deferred his studies at the end of the year and moved to Wagga Wagga with friends to commence a course in medical radiology, telling his parents he hadn't made friends in Melbourne.

9. In January 2014, following a friend's mental health crisis, Joshua shared with his mother that he had been *"pretty depressed for a long time now too."* When his mother confirmed she had thought this to be the case he wrote an expansive email in which he described having felt depressed since about year 11 in high school.[2] He said he could not pinpoint a single reason, but rather attributed his feelings to a pessimistic and cynical worldview consequent to betrayals and described himself in a *"perpetual existential crisis"*.[3] Joshua's parents offered him support and encouraged him to get help for his mental health, but he was very reluctant to do so.[4]

10. That year, Joshua returned to living with his family in Wodonga and did some part time work with his father, but appeared unmotivated and unsure about what he wanted to do. He finally saw a doctor later that year for physical health and sleep issues, but his parents remained concerned about his mental health. In late 2015, Joshua told his parents that he viewed his *"melancholic disposition"* as part of his being, rather than mental illness, and he continued to refuse to seek any treatment. He returned to living and working in Melbourne in 2016.[5]

11. In 2018, Joshua moved to Ballarat and started working in a friend's virtual reality store. He also obtained work writing English language media for a Chinese company. Whilst in China seeking work, he met Meiling and they commenced a romantic relationship. They stayed in

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[2] Statement of Mark Perkins dated 16 February 2021.
[3] Emails between Joshua Perkins and family, attached to the statement of Mark Perkins dated 16 February 2021.
[4] Statement of Mark Perkins dated 16 February 2021.
[5] Statement of Mark Perkins dated 16 February 2021.

touch online and travelled to spend time together. In early 2019, Joshua was furloughed from his writing job and struggled to find further freelance work.[6]

12. In early 2020, Meiling travelled to Australia and spent time with Joshua and his family, who were pleased to see he appeared happy.[7]

13. In late March 2020, Meiling returned to China amidst growing concerns about travel in the emerging pandemic. The uncertainty of when they would be able to see each other again was challenging.[8]

14. In July 2020, Joshua sent his father a text message in which he said he had had *"a really fucking rough couple of months emotionally"* and apologised for not having been supportive during the recent passing of his paternal grandfather, and his grandmother's health issues. He noted the recent suicide of a favourite online personality and the discussions it was generating in his community. As always, his father offered love and reassurance.[9]

15. Later that month, Joshua outlined travel plans to his parents, so that he and Meiling could be together, hopeful that travel conditions would change.[10]

16. At about 6.30pm on 1 August 2020, Joshua and his friend and housemate, Luke, went out to buy dinner. Once back home, they returned to their respective bedrooms. Luke last heard from Joshua at 1.30am early the next morning (Sunday 2 August 2020) via a link shared through the application 'Telegram'. Luke could later tell that Josh was last active on Telegram at about 3am that morning.[11]

17. At about 4.00pm on 3 August 2020, Luke knocked on Joshua's bedroom door. A mutual friend had told him Meiling was concerned because she hadn't heard from him. There was no response to the knocking.[12]

18. The following day, Luke knocked on Joshua's door several times, having heard no movement. There was still no response. At about 7pm, Luke knocked again, stating he was going to enter.

[6] Statement of Mark Perkins dated 16 February 2021.
[7] Statement of Mark Perkins dated 16 February 2021.
[8] Statement of Mark Perkins dated 16 February 2021.
[9] Messages between Joshua Perkins and family, attached to the statement of Mark Perkins dated 16 February 2021
[10] Statement of Mark Perkins dated 16 February 2021.
[11] Statement of Luke Murtagh dated 4 August 2020.
[12] Statement of Luke Murtagh dated 4 August 2020.

On opening the door, he saw Joshua with a plastic bag over his head. He closed the door and contacted a friend to help him request emergency services.[13]

19. Victoria Police officers attended soon after. Joshua was seated at the desk in his bedroom with a gas canister connected to the plastic bag over his head. Paramedics attended and expressed the view that Joshua likely had been deceased for at least 24 hours.[14]

20. Next to Joshua, police located a handwritten note in which he expressed struggles in his life and alluded to having taken his own life.

21. The note spoke at length about an event in 2011, and Joshua's rumination on that event. He said he had been raped at party after he hadpassed out. The note indicated he believed many of his friends, and his brother knew about this event, though his brother was in fact unaware of any accusation of this sort.[15] In light of this information, the note was provided to the Wodonga Sexual Offences and Child Investigations Team, who conducted an investigation. The investigation identified that a video had been taken of in 2011 of Joshua unconscious, whilst sex acts were simulated on him whilst he and the others in the video were fully clothed.[16]

Identity of the deceased

22. On 4 August 2020, Joshua Michael Perkins, born 30 April 1993, was visually identified by his friend Luke Murtagh.

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

Medical cause of death

24. Senior pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 6 August 2020 and provided a written report of his findings dated 7 August 2020.

25. Toxicological analysis of post-mortem samples identified the presence of alcohol (at a concentration of 0.05 mg/100 mL) and argon, but no other commons drugs or poisons.

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[13] Statement of Luke Murtagh dated 4 August 2020.
[14] Statement of Senior Constable Ashley Sheriff dated 18 January 2021.
[15] Statement of Mark Perkins dated 16 February 2021.
[16] Statement of Senior Constable Ashley Sheriff dated 18 January 2021.

26. Dr Burke opined that a reasonable medical cause of death was:

    1(a) Asphyxia;

    1(b) Plastic bag asphyxia with inhalation of argon gas.

27. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Joshua Michael Perkins, born 30 April 1993;

    (b) the death occurred on 4 August 2020 at 1 / 15 Pryor Street, Mount Pleasant, from asphyxia due to plastic bag asphyxia with inhalation of argon gas; and

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

29. Having considered all of the circumstances, I am satisfied that Joshua intentionally took his own life. The information obtained for this investigation did not identify any acute event that precipitated Joshua's decision to end his life. Nor did it identify any history of suicidal actions or thoughts. However, he had what he recognised and described as a "melancholic" or "pessimistic" disposition. And, despite sometimes admitting to suffering with his mental health, he was reluctant to seek mental health treatment.

30. Whilst this investigation cannot conclude with any certainty whether Joshua was victim of sexual assault beyond the video produced at the party, it is evident that his subjective belief that he had been raped by people he knew, and had not been assisted by his friends or family, felt like a betrayal to him and caused him anguish.

COMMENTS

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

31. This investigation has not identified when or how Joshua obtained the argon gas used to end his life. However, as access to these gases remain largely unregulated, understanding exactly when or where he obtained it can offer only minor insight in terms of future prevention opportunities.

32. Suicides involving asphyxia with a plastic bag and inhalation of inert gases, such as argon gas, have been subject to previous coronial investigation, comment, and recommendation.[17] Other inert gases used in Australian suicides include helium, nitrogen and hydrocarbons.

33. The inhalation of inert gases has been promoted as a peaceful and effective suicide method by 'right-to-death' advocates and groups for decades. As noted in my previous finding,[18] with this information readily available, it does not seem feasible to prevent people from learning how to end their life from inert gas inhalation. Consequently, prevention efforts by coroners have focussed on limiting availability of inert gases (primarily helium, and with subsequent investigations, argon gas), following the proposition that regulating access to a means of suicide reduces associated suicides.

34. The ongoing tension for regulators is that whilst the inhalation of these gases is a known suicide agent, they have a range of legitimate uses and are only lethal when inhaled in large quantities (usually deliberately). As such, a balance must be struck so that the gases can be obtained and used for their intended purposes, while avoiding making access to the means to suicide. Recommendations have considered limiting access to inert gases at the point of sale, and modifications to the concentration, packaging, or dispensing method to limit its effectiveness as a suicide method.

35. I will not rehash the details of each of the preceding coronial investigations that considered how the number suicides associated with inert gas inhalation might be reduced, other than to say that I concur with the comments concerning argon gas made by Coroner Audrey Jamieson in her findings delivered on 15 June 2020.[19] Concluding that investigation, Coroner Jamieson recommended:

> *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.*

36. The Department of Health and Human Services (DHHS) provided a response confirming the suggested amendment had been considered, but not implemented. The rationale was multifaceted, and explained as follows:

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[17] See COR 2016 004013, COR 2017 002906, COR 2017 005077, COR 2018 001315, COR 2018 005646
[18] COR 2017 005077 Finding into the death of Mr L.
[19] COR 2018 005646 Finding into the death of Gordon Malcolm Wallace.

"The deleterious substances provisions in Part IV of the Drugs, Poisons and Controlled Substances Act 1981 (the Act) are intended to discourage supply of substances which can cause harm with inappropriate use. Supply of a deleterious substance is prohibited under Section 58 of the Act if a person knows or reasonably ought to have known that the person intends to use the substance by drinking, inhaling or otherwise introducing it into their body. For a retailer the main indicator of inappropriate use in relation to the substances which fall within the definition of deleterious substances in section 57 of the Act is the repeated purchase of these substances. The purchase of argon gas with the intent for use as a means of suicide only requires a single transaction. The department believes that placing an expectation on retailers to have a role in assessing whether a single purchase is intended for legitimate use is not feasible in these circumstances. While the department acknowledges that evidence supports that restricting access to a means of suicide assists in suicide prevention, using the provisions of the Act to achieve this outcome in relation to argon gas would be difficult to enforce and hence ineffective.

Furthermore, an amendment to the Act would require consultation and supporting communications to relevant retailers around legal requirements of sale. This would raise public awareness of argon gas misuse and may have the unintended effect of increasing the attractiveness of inert gases as a means of suicide. As a result, there may be an increase in the use of inert gases for suicide rather than less."

37. Given the relative recency of this recommendation and the substance of the response. I do not propose to make further recommendation on this issue. However, I note my ongoing concern that access to argon gas remains unrestricted in this way.

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.

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

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

Mark and Mandy Perkins, Senior Next of Kin

Department of Health

Senior Constable Ashley Sheriff, Coroner's Investigator

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 18 March 2022

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.