REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:
1. The Right Honourable Theresa May, MP
CORONER
I am Zafar Siddique, Area Coroner for the coroner area of Birmingham and Solihull.
CORONER'S LEGAL POWERS
I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
INVESTIGATION and INQUEST
On 10 th April 2014, I opened an Inquest touching the death of David Reginald Giles, aged 64 years old. The investigation concluded at the end of the inquest on 4 July 2014. The conclusion of the inquest was that the cause of David's death was due to 1(a) Asphyxia due to helium inhalation and 2) Hyperglycaemia, Morbid obesity.
CIRCUMSTANCES OF THE DEATH
 On the 31st March 2014 David Reginald Giles was discovered in his lounge at his home address with a plastic bag over his head connected by tubing to a helium gas canister. He had no relevant history of suffering from depression. In evidence at the inquest hearing his wife, confirmed that she had recently announced that she would be divorcing him and her solicitor had sent him a letter confirming this. She was aware he had received this letter previously (approximate date received 6 March 2014). Mr Giles had written letters and sent an e-mail to his friends and colleagues confirming his intention to take his own life the day before being discovered. When Mr Giles was discovered by his wife, she alerted neighbours who called the ambulance and paramedics attended and confirmed his death at 0834 hours on the 31 March 2014.
7. There was no evidence to suggest that any other person was involved in his death.
CORONER'S CONCERNS
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.
The MATTERS OF CONCERN are as follows. –
(1) The sale of Helium gas canisters is readily available to members of the general

	[SIGNED BY CORONER]
9	9 th July 2014
	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
0	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-
8	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 September 2014. I, the coroner, may extend the period.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you [and/or your organisation] have the power to take such action.
	 public with no apparent restrictions or conditions on sale or place. (2) Helium gas canisters appear to be sold in a standard size which contains a sizable volume of Helium. (3) Helium canisters are not fitted with any modified control valve which if in place could restrict the volume of gas being released and are generally sold in standard sizes. (4) The type of immediate and easily accessible information through internet search engines which provides clear and detailed guidance on how to commit suicide by inhalation of helium gas. (7) The latest statistical update on Suicide report issued in January 2014 by the Department for Health suggests that there were 51 deaths mentioning helium in 2012 in England, almost five times higher than the 11 deaths recorded in 2008. Although the number of deaths involving these substances is still relatively small, the large increases are of particular interest as almost all of these deaths were suicides.