The Right Honourable Theresa May, MP.,
House of Commons,
2 Marsham Street,
LONDON.
SW1A 0AA

Our ref: MTB/AP/B169H-13

20 November 2013

Dear Mrs. May,

Re: Luke Jacob Goodwin, deceased
Report to Prevent Further Deaths
Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and
Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

1. CORONER

I am Mary Teresa Burke, Assistant Coroner, for the Coroner area of West Yorkshire (Western).

2. 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.

3. INVESTIGATION and INQUEST

On 18th September 2013 I commenced an investigation into the death of LUKE JACOB GOODWIN, aged 21 years old, a university student at Huddersfield University and whose family lived in Birkenhead. The investigation concluded at the end of the inquest on 18th September 2013. The conclusion of the inquest was that the cause of Luke's death was due to 1(a) Hypoxia as a result of 1(b) Helium Inhalation.

4. CIRCUMSTANCES OF THE DEATH

1. Luke Goodwin shared a house with fellow students.
2. Luke had no history of suffering from depression or any significant illness or condition.
3. On the evening of the 17th January 2013 he was seen by one of his housemates, who confirmed there was nothing untoward in how Luke presented.
4. On the following morning, 18th January 2013, his housemate got up and found a handwritten note attached to Luke's bedroom door indicating that Emergency Services should be summoned as he had taken his own life.
5. Luke Goodwin was found laid on his bed with a plastic bag secured around his head, plastic tubing was leading from the bag, which in turn was attached to a helium canister.

Continued/…….

6. Paramedics attended and confirmed Luke Goodwin's death at 8.14 hours on the 18th January 2013.
7. A further detailed note, confirmed to be in Luke Goodwin's handwriting, was found in his bedroom.
8. There was no evidence to suggest that any other person was involved in his death.
9. There was evidence that Luke had undertaken research on the internet, including access to [redacted]" handbook published by [redacted] of [redacted], which is also available via Amazon and Kindle.
10. At the inquest Luke's parents made representations and provided details of the proliferation and ease of gaining clear and explicit information on how to commit suicide on the internet. Two specific websites, [redacted] and [redacted] were specifically referred to. In addition I was advised that [redacted] provides an opportunity to order a suicide kit by mail order. His parents expressed concern that such information was so easily available to individuals who may be low in mood and contemplating ending their own life.

5. 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 canisters is readily available to members of the general public. There appears to be no restrictions or conditions on sale or place.
(2) Helium 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.
(4) The type of information which is readily available on the internet. Such information provides clear and detailed guidance on how to commit suicide. Internet sites also provide advertisements and links to enable the viewer to order and purchase appropriate products to commit suicide. Two sites in particular, [redacted] and [redacted] appear to provide clear and comprehensive details.

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.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th February 2014. I, the coroner, may extend the period.

Continued/……..

20th November 2013

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.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted], who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response. 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.

Yours sincerely,

M. T. Burke
Assistant Coroner

cc. [redacted]
The Chief Coroner
[redacted] Coroner's Officer