



Department  
of Health

*From Rt Hon Norman Lamb MP  
Minister of State for Care and Support*

Department of Health  
Richmond House  
79 Whitehall  
London SW1A 2NS

Mr Z Siddique  
Area Coroner  
Coroner's Court  
50 Newton Street  
Birmingham  
B4 6NE

*Dear Mr Siddique,*

Thank you for your letter following the inquest into the death of David Giles. In your report you state that the cause of death was asphyxia due to helium inhalation, hyperglycaemia and morbid obesity.

Mr Giles was found at his home address on 31 March 2014 with a plastic bag over his head connected to a helium gas canister. He had no history of depression but had received a letter earlier in the month from his wife's solicitor announcing her intention to divorce him. On the day before he was discovered he had written an email and letters to friends and colleagues confirming his intention to take his own life. When his wife discovered him on 31 March 2014, she alerted neighbours who called the ambulance services. Paramedics attended and confirmed his death.

I was sorry to read of Mr Giles's death and wish to extend my sincere sympathies to his family.

**You raise the following matters of concern:**

- The sale of helium gas canisters is readily available to the public with no restrictions or conditions on sale or place.
- Helium gas canisters are sold in a standard size which contains a sizable volume of helium.
- Helium canisters are not fitted with any modified control valve which could restrict the volume of gas being released.
- Clear and detailed guidance on how to commit suicide by helium inhalation is easily accessible through the Internet.
- The latest statistical update on Suicide by DH, January 2014, shows a large increase in the number of deaths involving helium – from eleven such deaths in 2008 to fifty one deaths in 2012.



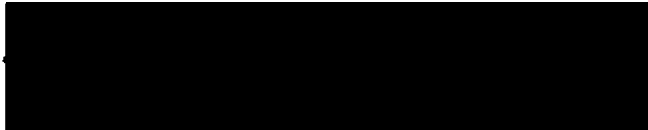
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Similar issues and concerns relating to the sale and use of helium gas in suicide have been raised in previous Regulation 28 cases. The most recent case dealt with by the Department concerned the death of Matthew Satterthwaite.

The information we provided in our response to the Matthew Satterthwaite Regulation 28 report is still pertinent. I have therefore enclosed a copy of our earlier reply to the Manchester Coroner, Nigel Meadows, and trust that this fully addresses the concerns you raise in your Regulation 28 report regarding the death of David Giles.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr Giles's death to my attention.

*Yours sincerely,*



NORMAN LAMB