IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 001593

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Mrs DA
Date of birth:	28 August 1954
Date of death:	On or about 26 March 2014
Cause of death:	Multiple drug toxicity (propoxyphene, citalopram, oxazepam and others)
Place of death:	Highton

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of Mrs DA without holding an inquest:

find that the identity of the deceased was Mrs DA

born on 28 August 1954

and that the death occurred on or about 26 March 2014

at an address in Highton, Victoria 3219

from:

I (a) MULTIPLE DRUG TOXICITY (PROPOXYPHENE, CITALOPRAM, OXAZEPAM AND OTHERS)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mrs DA was a 59-year old Australian woman of Malaysian Chinese descent who lived in Highton with her husband of 31 years, Mr DA. Mrs DA was known for her dynamism and determination and had operated a successful real estate business for many years. She and her husband had one adult son.

2. In June 2006, Mrs DA suffered a severe right frontoparietal haemorrhage (stroke) secondary to subacute bacterial endocarditis following a dental procedure. The stroke caused sensory impairment along the left side of her body and significant left hemiparesis with a non-functional upper limb and little movement in the lower limb. Following initial management at Geelong University Hospital and St Vincent's Hospital, Mrs DA underwent months of inpatient rehabilitation at the McKellar Centre, a stay that was characterised by sadness and anxiety as she came to terms with the dramatic change in her health.

3. At the time of discharge Mrs DA was able to walk short distances with the aid of a single point stick, an ankle-foot orthosis and supervision, and required assistance with personal care. Mr DA arranged for personal carers to supervise and assist his wife while he was at work and their home was modified to accommodate her disabilities. Mrs DA continued physical rehabilitation with home-based and outpatient services and her progress was reviewed periodically by consultant in rehabilitation medicine, Dr Michael Bennett, and her general practitioner at Newtown Medical Centre, Dr Hugh Seward.

4. By February 2007, despite engaging private occupational therapists and physiotherapists in addition to the outpatient rehabilitation services, Mrs DA's frustration with her disabilities was evident to Dr Bennett at review. She disclosed that she could not 'go on like this' and, on direct questioning, confirmed that she had considered ending her life. Mrs DA declined Dr Bennett's offer to refer her for psychological counselling and refused to consider antidepressant medication and so he reported his concerns about her mental state to Dr Seward, and advised Mr DA about how to manage any acute deterioration of his wife's mood.

5. In mid-2007, Mrs DA trialled returning to work – for two hours a week – but suffered a fall. She also started to experience a decrease in mobility and seizures for which an anticonvulsant was prescribed and produced side effects.

6. In 2007 and 2008, the DAs travelled overseas to seek curative and rehabilitative therapies from a variety of practitioners, but these produced little or no effect.

7. In April 2009, Mrs DA sustained a left neck of femur fracture in a fall from a chair at home. This was repaired surgically at Geelong University Hospital by internal fixation of a dynamic hip screw. Following a further period of inpatient rehabilitation at the McKellar Centre, Mrs DA was discharged home able to mobilise with assistance and required additional assistance with activities of daily life. As a result of her hip fracture, and significant stroke-related muscle spasm, Mrs DA experienced chronic pain, for which Dr Seward prescribed narcotic analgesia (slow and immediate release oxycodone). Mrs DA became increasingly reluctant to leave the house.

8. In late 2009, Mrs DA commenced psychiatric treatment with Dr Gerald Matthews but attended only intermittently. There was difficulty identifying an antidepressant that did not produce adverse side effects; she was also prescribed alprazolam for anxiety.

9. During a review with Dr Bennett in January 2010, Mrs DA expressed a strong desire to die and admitted to having intermittent suicidal ideation since her stroke but did not disclose a definite suicidal plan or any previous attempt. Dr Bennett consulted Dr Matthews because of his concern about Mrs DA's mental state and, though the psychiatrist offered an urgent review, Mrs DA would only 'consider' attending. Mr DA, who appeared exhausted, was provided further advice about managing his wife's deteriorating mood and was counselled to seek support or respite care.

10. Upon review in April 2010, Mrs DA required hands on assistance when walking and reported abandoning hyperbaric oxygen treatment because it was unhelpful. Dr Bennett canvassed Mrs DA's increasing care needs frankly with the couple but she remained opposed to respite care and said she would 'rather die than go into a nursing home'.

11. In August 2011 at Mrs DA's request, Dr Seward substituted propoxyphene (marketed as 'Doloxene') for immediate release oxycodone. Prescriptions for propoxyphene were provided on five occasions, the last in September 2013. Other, slow release, opioid analgesics continued to be prescribed at regular intervals to manage pain. Mrs DA's regular medications included anticonvulsants levetiracetam and valproic acid, citalopram (an antidepressant), the benzodiazepine oxazepam, and an antiemetic metoclopramide.

12. In 2012, Mrs DA became involved with Exit International, a non-profit organization that advocates legalisation of euthanasia. She told her husband that she intended to determine the time and manner of her own death. Mrs DA's siblings, their spouses and her son and his family were also aware of her intention to end her own life and had intervened to prevent her when an attempted suicide appeared imminent in November 2012. Her family persuaded her to delay her plans for 12 months.

13. In September 2013, Dr Bennett noted that Mrs DA required assistance with all activities of daily life, required hands-on assistance and a single point stick when walking short distances but often mobilised in a wheelchair. She spent most of the day in an armchair, was obviously in pain most of the time and remained unhappy and frustrated by her state.

14. Accordingly to one of her brothers, Mrs DA resumed end of life and funeral planning arrangements in early 2014. She had apparently chosen a date in March to die, to coincide with her son and his family's scheduled visit to Melbourne.

15. On the evening of 25 March 2014, Mr and Mrs DA, their son, his wife and their daughter were at home. One of Mrs DA's brothers who also lives in Australia visited that evening. At about 11pm, Mrs DA sought her husband's assistance to go to bed. Once settled in bed and at her request, Mr DA brought his wife a tray laden with two fluid-filled drinking glasses.

16. At about 6am on 26 March 2014, Mr DA woke and found his wife deceased in bed. There was a note addressed to him and a sealed envelope addressed to Dr Seward nearby. At about 7.30am, he spoke to Dr Seward, informing him that Mrs DA had died and that she had taken her own life.

17. Dr Seward attended at about 8am and confirmed that Mrs DA was deceased. Mrs DA's note thanked the GP for his care, indicated that she had been handling her own medication for much of the previous year and had ended her life 'without any help' from family because she was unable to tolerate the severe pain any longer. Dr Seward called the police.

18. Attending police members spoke to members of the DA family, searched the home and, as they considered the circumstances of Mrs DA's death to be suspicious, notified the Geelong Crime Investigation Unit [CIU]. A criminal investigation was instigated during which Mr DA was formally interviewed by police, however, no charges were laid against him in relation to his wife's death.

19. Forensic pathologist, Dr Victoria Francis of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an autopsy. Among Dr Francis' anatomical findings were the absence of any significant recent injury, old

infarct of the right frontoparietal lobe of the brain, mild myocardial fibrosis, atrophic renal changes with intimal proliferation and benign nephrosis, and 200mL of milky fluid within the stomach.

20. Post-mortem toxicology detected propoxyphene at a level consistent with fatal use (~2.0mg/L) in blood and stomach contents, a supra-therapeutic level of citalopram, in addition to oxazepam, levetiracetam, valproic acid, metoclopramide and paracetamol. Dr Francis noted that the toxic effects of propoxyphene include cardiac arrhythmias, hypotension, circulatory collapse and respiratory depression. Dr Francis attributed Mrs DA's death to *multiple drug toxicity (propoxyphene, citalopram, oxazepam and others).*

21. In June 2016, Detective Senior Constable Bruce Sharp of Geelong CIU completed the investigation of Mrs DA's death and compiled the coronial brief of evidence on which this finding is largely based.

22. I find that Mrs DA, late of an address in Highton, died there on or about 26 March 2014 and that the cause of her death was multiple drug toxicity involving propoxyphene, citalopram, oxazepam and others prescribed medications.

23. In light of Mrs DA's clearly articulated suicide pronouncements over a number of years to family and treating clinicians in the context of irreversible serious disability, chronic pain and diminished quality of life, I am satisfied that she intended to take her own life. The available evidence does not enable me to determine with the requisite degree of certainty whether or to what extent Mrs DA may have been assisted, nor by whom.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008***, I make the following comments connected with the death:

1. Mrs DA's death highlights an unfortunate but not uncommon theme arising in this jurisdiction in the investigation of some deaths by suicide. That is, the individual's determination to end his or her life that is generated by the experience of protracted, irreversible deterioration of physical health and the fulfilment of that determination often, though not in Mrs DA's case, in circumstances of violence, loneliness and fear.

2. Notwithstanding this observation, and mindful that one of the purposes of the ***Coroners Act 2008*** is to contribute to the reduction of the number of preventable deaths through the findings of the investigation of reportable deaths and the making of recommendations by coroners, in my view, Parliament is the most appropriate forum for examining the issues raised by Mrs DA's death, commonly referred to as 'end of life choices'.

3. I note that following a ten-month investigation, the Victorian Parliament's Legal and Social Issues Committee tabled its final report on its Inquiry into End of Life Choices in June 2016 [Final Report]. Among its 49 recommendations for improvements to advance care planning, palliative care and end of life choices, the Committee recommended that the Victorian Government should, in certain limited circumstances, legalise assisted dying.

4. The Victorian Government's response to the Final Report was tabled in Parliament in December 2016. The Government restated its commitment to end of life care, unveiled a new framework for end of life and palliative care in Victoria with funding commitments to support the framework's implementation and introduced legislation to establish a framework for medical treatment decision-making for individuals without capacity.

5. The Government indicated that further significant and detailed work was necessary before the legal, clinical and practical implications of introducing assisted dying framework could be sufficiently known to inform further consideration of the Committee's recommendation on this issue.

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

Mr DA

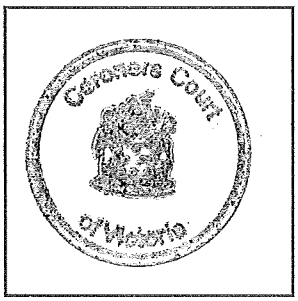
Dr Bennett

Dr Seward

DSC Bruce Sharp

The Secretary, Victorian Parliament's Legal and Social Issues Committee

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 21 June 2017