IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005213

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	*Geoffrey Paul McConachy*
Date of birth:	15 July 1941
Date of death:	18 September 2023
Cause of death:	1a: Incised injury to right leg
Place of death:	Unit 19/205 Dandenong Road Windsor Victoria 3181
Keywords:	Suicide, voluntary assisted dying

INTRODUCTION

1. On 18 September 2023, Geoffrey Paul McConachy was 82 years old when he was found deceased at his home. At the time of his death, Geoffrey lived by himself at Unit 19/205 Dandenong Road, Windsor, Victoria.

2. Geoffrey was married to his wife, Faye, for 56 years before she passed away in 2016, also on 18 September. Together they had two sons, Simon and Mark.[1]

3. In late 2022, Geoffrey visited Mark and his grandchildren in Switzerland. During this trip, he suffered a stroke that profoundly affected his speech and contributed to his developing a serious depressive illness. He lost interest in life and no longer wanted to go for walks, play backgammon or do things he had previously enjoyed. He openly spoke about suicide, stating he had nothing to live for and was 'done'. In this context he requested that one of his sons obtain a pamphlet for him on voluntary assisted dying. He also discussed with his sons the possibility of flying to Switzerland where he could legally access euthanasia.[2]

THE CORONIAL INVESTIGATION

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

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Geoffrey's death. The Coronial Investigator conducted inquiries on my behalf, including

[1] Statement of Brad Tasker, Coronial Brief.
[2] Statements of Simon McConachy and Brad Tasker, Coronial Brief.

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Geoffrey Paul McConachy 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.[3]

9. In considering the issues associated with this finding, I have been mindful of Geoffrey's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 18 September 2023 at approximately 2:15 pm, Geoffrey's son Simon attended at Geoffrey's unit to collect a bag of clothing. Simon knocked and called out, then texted and called his father multiple times, with no response. Simon left the address and returned at around 4:00 pm, but again had no answer.[4]

11. Simon contacted a family friend, Brad Tasker, who had a spare key to Geoffrey's unit, and they agreed to meet at the address after Mr Tasker had finished work. Simon contacted Mark, who advised that he too could not get through to Geoffrey, but that his geolocation was at his unit.[5]

12. At approximately 5:20 pm, Mr Tasker arrived at the address and used his spare key to gain access to Geoffrey's unit. Simon also went into the unit and found Geoffrey deceased in his bed with a large amount of blood underneath him. Simon checked for a pulse but found Geoffrey stiff and cold to the touch.[6]

[3] 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.
[4] Statement of Simon McConachy, Coronial Brief.
[5] Ibid.
[6] Statements of Simon McConachy and Brad Tasker, Coronial Brief.

13. Mr Tasker called 000 and emergency services arrived a short time later. Paramedics performed a verification of death and Geoffrey was formally pronounced deceased at 7:12 pm.[7]

14. Attending police examined and photographed the scene and found no suspicious circumstances. A sharp, black handled knife was located within Geoffrey's reach on the bedside table with the handle closest to him, consistent with his having used it. There were no signs of a struggle or any defensive injuries.[8]

Identity of the deceased

15. On 18 September 2023, Geoffrey Paul McConachy, born 15 July 1941, was visually identified by his son, Simon McConachy.

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

Medical cause of death

17. Forensic Pathologist Trainee Dr Kaitian Yeo, supervised by Forensic Pathologist Dr Gregory Young, both from the Victorian Institute of Forensic Medicine, conducted an examination on 20 September 2023 and provided a written report of their findings dated 26 September 2023.

18. The post-mortem external examination revealed a horizontally oriented, linear incised wound measuring 6 cm in length on the inner aspect of the right leg just below the knee. The wound extended deep into the underlying soft tissues and incised a large-bore artery.

19. No other signs of trauma were seen and there were no defence-type or restraint-type injuries.

20. A post-mortem CT scan showed bronchiectatic[9] changes in the lungs, coronary artery calcification, and multiple large renal cysts.

21. Toxicological analysis of post-mortem blood samples identified the presence of citalopram[10] and mirtazapine[11] at therapeutic levels, and did not otherwise identify the presence of alcohol or any other common drugs or poisons.

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[7] Exhibit 3 – Ambulance Victoria verification of death form, Coronial Brief.
[8] Statement of Anthony Trigg, Coronial Brief.
[9] Bronchiectasis is a lung disease that occurs when the walls of the breathing tubes or airways widen due to chronic inflammation and/or infection.
[10] n antidepressant medication.
[11] Mirtazapine is an antidepressant used in the treatment of major depression. Unlike many other antidepressants, it has sedating properties and is therefore chosen by some practitioners to treat patients for whom sleep disturbance is a feature of their depression.

22. Dr Yeo and Dr Young provided an opinion that the medical cause of death was 1(a) incised injury to right leg, and I accept their opinion.

CPU REVIEW – VOLUNTARY ASSISTED DYING

23. The available evidence indicates that Geoffrey would not have been eligible to access voluntary assisted dying (**VAD**) in Victoria. The eligibility criteria to access VAD include that the person is suffering from an incurable, advanced and progressive disease; the person is experiencing intolerable suffering that cannot be relieved satisfactorily; and the disease is expected to cause death within six months (or 12 months in the case of neurodegenerative conditions). Geoffrey had a greatly reduced quality of life but no terminal prognosis.

24. Because of this context, I directed the independent practitioners in the Research and Policy Team of the Coroners Prevention Unit (**CPU**)[12] to review Victorian coroners' previous findings and comments regarding the scope of eligibility to access VAD under the *Voluntary Assisted Dying Act 2017* (Vic) (**the VAD Act**).

Scope of eligible diseases

25. Nine cases were identified in which the coroner found the deceased had tried to access VAD but was determined not to be eligible because their disease did not meet all the relevant VAD criteria. In eight of these nine cases the deceased took their own life; in the other case, the coroner was unable to determine the deceased's intent, but suicide was a possibility. The most common scenario across these nine cases was that the deceased experienced an irreversible decline in health and very low quality of life (invariably accompanied by persistent pain), but a doctor was unable to give a prognosis of death within six months.

Scope of eligible people

26. One case was identified in which the deceased was refused access to VAD because, despite having resided in Victoria for 40 years and meeting the clinical criteria for VAD, he had never taken Australian citizenship and therefore was ineligible. In that matter, Coroner Phillip Byrne

[12] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

quoted at length from the statement of an experienced doctor who tried to assist the deceased, Mr Bareuther, to access VAD:

> *'I knew Julian for a short time. He was hugely relieved when I told him I could act as his coordinating doctor for VAD, and it was as if an enormous burden had been lifted from him. When I discovered that he had never taken out Australian citizenship, we went to great lengths to see if he might still be eligible for VAD. When I finally had to tell him that there was nothing more we could do, that he was not eligible, he was very upset and stopped seeing me. When I last rang him on September 21, 2019, he seemed resigned to the situation.*
>
> *[…]*
>
> *'Because of this citizenship technicality, he was denied VAD. I had to tell him that I was unable to help him in the only way he wanted and as a result he ended up committing suicide. I do not believe that this was what any of those who framed the law would have wanted to happen.'*[13]

27. Coroner Byrne commented:

> *Although one can understand the rationale behind the denial of the VAD process to Mr Bareuther, I must say I have found it difficult not to feel sympathy for Mr Bareuther' s plight and wonder whether there could be built into the process some level of discretion. I do not however propose to 'sail into a maelstrom'.*[14]

28. Coroner Byrne's reference to the 'maelstrom' (being the fraught atmosphere within which the VAD legislation was developed and debated) appears to be a major reason why Victorian coroners have not made recommendations to date specifically relating to how the VAD Act functions and whether it meets the needs of the Victorian community. Supporting this, some variant of the following comment appears in more than half a dozen findings:

> *The circumstances of [the deceased's] death illustrate a common theme encountered by Victorian coroners. It is well understood that people who have lived a full, productive, and loving life, but who experience an irreversible deterioration in their physical health, can develop a determination to end their own lives. The Coroners Court of Victoria investigates a number of such intentional deaths each year.*
>
> *The debate regarding the dignified end to life is primarily a matter for the executive and legislative arms of government, and involves conflicting legal, ethical, and clinical considerations. In November 2017, the Victorian Parliament passed the Voluntary Assisted Dying Act 2017 (Vic) following the recommendations of a state parliamentary inquiry and a subsequent Ministerial Advisory Panel. The Voluntary Assisted Dying Act 2017 provides a legal framework for Victorians who are at the*

[13] Coroner Byrne, P. (2020) *Finding into death without inquest of Julian Bareuther* (COR 2019 005236), [10].
[14] Ibid [11].

end of their life, and suffering, to request access to voluntary assisted dying. The Act came into force on 19 June 2019.

The Act provides strict eligibility criteria for access to voluntary assisted dying. Such criteria includes that a person must be diagnosed with a disease, illness, or medical condition that is incurable, is advanced, progressive and will cause death, that causes intolerable suffering to the person, and that is expected to cause death within six months or, in the case of a neurodegenerative condition, within 12 months.

It is not clear whether [the deceased] considered requesting access to voluntary assisted dying or whether his medical condition would have been within the definition of the Act. However, I acknowledge the intent of this legislation is to provide an access to means to those who suffer from an irreversible deterioration to their physical health and wish to end their lives in a dignified manner at a time of their choosing.[15]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Geoffrey Paul McConachy, born 15 July 1941;

    b) the death occurred on 18 September 2023 at Unit 19/205 Dandenong Road, Windsor, Victoria 3181, from 1(a) incised injury to right leg.

    c) the death occurred in the circumstances described above.

30. Having considered all of the circumstances, I am satisfied that Geoffrey intentionally took his own life.

COMMENTS

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

31. Victorian coroners have a longstanding interest in voluntary assisted dying as a means to assist people who suffer from an irreversible deterioration in their physical health. The original (26 August 2015) Court submission to the *Inquiry into End of Life Choices* included a data summary on 'suicide cases where the deceased took his or her life after experiencing an irreversible deterioration in physical health'. The cases were not restricted to terminal illness but also included (for example) irreversible chronic disease not expected to cause death, and permanent physical incapacity and pain resulting from injury. When Coroner English and

[15] Deputy State Coroner English, C. (2022) *Finding into death without inquest* (COR 2021 000829) (unpublished), [34]-[37].

Coroner Olle subsequently appeared to assist the Standing Committee on Legal and Social Issues in person on 7 October 2014, the scope of deaths discussed included:

> *[…] there is a cancer group; there is a group with multiple, non-terminal health issues that combined mean that they have reached a point where the treatment is not having any further effect on them; there are smaller groups with pain disorders and a smaller group with incurable conditions such as motor neuron disease.*[16]

32. As is now well known, the Victorian Parliament subsequently resolved to restrict voluntary assisted dying access only to people diagnosed with a disease, illness, or medical condition that is incurable, advanced, progressive, causes intolerable suffering, and is expected to cause death within six months (or 12 months in the case of a neurodegenerative condition).

33. Following this decision and the *Voluntary Assisted Dying Act 2017* (Vic) (**the VAD Act**) coming into effect, I am aware of at least nine Victorian suicides (not including the death of Geoffrey McConachy) where the investigating coroner found the deceased was experiencing an irreversible decline in their health, greatly reduced quality of life and/or unrelieved suffering, but their efforts to access the voluntary assisted dying process were rebuffed because they did not meet the strict criterion of suffering a specific disease expected to cause death within six months (or 12 months in the case of neurodegenerative conditions).

34. A recurring theme throughout many of these deaths was the impact that voluntary assisted dying refusal had on the deceased. Family members often reported that when people believed they would have access to voluntary assisted dying they maintained hope that they would be able to exercise control over how they died; when their access to voluntary assisted dying was refused, their consequent despair and frustration contributed to their decision to take their own life.

35. In addition, I am aware of my colleagues' investigations into Victorian suicides among seriously ill people who did not attempt to access voluntary assisted dying because they knew they would not meet the eligibility criterion of disease expected to cause death within six or 12 months. In one such case, where the deceased had multiple serious medical conditions with none of them clearly terminal, Coroner Hawkins described the impact succinctly as follows:

> *Despite his multiple health problems, [the deceased] would not have met the criteria for medically assisted dying in Victoria. As such, he made his choices and preparations alone, without input and comfort from, or notice to, his family. I*

[16] Standing Committee on Legal and Social Issues, *Transcript: Inquiry into end-of-life choices*, 7 October 2015, p.10.

> *acknowledge that this is a source of additional sadness to his loved ones and I wish to express my sincere condolences to [the deceased's] family.*[17]

36. Victoria's coroners are among the very few people in a position to identify and investigate when the voluntary assisted dying process does not meet the needs of Victorian community members, including people like Geoffrey who are experiencing irreversible decline in their health and who wish to exercise choice over the timing and manner of their deaths. I believe I therefore have a duty and responsibility to notify such instances to the bodies responsible for administering Victoria's voluntary assisted dying process.

37. I therefore distribute this finding to the Voluntary Assisted Dying Review Board in case it is of use in understanding areas where the voluntary assisted dying process in Victoria falls short of meeting the expectations of Victorians who are experiencing irreversible decline in their health and wish to exercise choice over the timing and manner of their deaths.

38. I understand that the *Voluntary Assisted Dying Act 2017* (Vic) was the result of a thorough process through which the executive and legislative arms of government debated conflicting legal, ethical, and clinical considerations. The circumstances of an individual suicide, or even 10 suicides, may not carry much weight in comparison. However, I would ask the Voluntary Assisted Dying Review Board to remain open to considering this finding as part of a developing body of evidence about where there may be opportunities to improve the operation of voluntary assisted dying in the state.

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

[17] Coroner Hawkins, J. (2020) *Finding into death without inquest* (COR 2019 003761) (unpublished), [27].

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

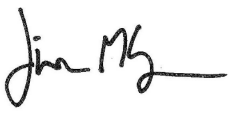
Simon McConachy, Senior Next of Kin

Voluntary Assisted Dying Review Board

Rita Drivelegas, Alfred Health

Senior Constable Bridget Facey, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 16 December 2024

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.