Dying with Dignity Tasmania (Inc)

ANALYSIS OF THE VICTORIAN CORONERS COURT EVIDENCE TO THE VICTORIAN INQUIRY INTO END OF LIFE CHOICES – with some updates as at August 2017

- The Victorian Coroners evidence was provided in a submission[1] and evidence at a hearing[2]. A subsequent submission was provided following a request by the Parliamentary Committee[3]. All are essential reading.

Analysis

- Reported on a study of 2281 suicides investigated by the Coroners Court between 1 January 2009 and 31 December 2012.
- 240[4] suicides (8.6% of total) involved clear evidence of decline/deterioriation in physical health due to incurable and irreversible conditions. Excluded were any suicides that were "a symptom or manifestation of mental health", or where there was "insufficient evidence" of incurable condition, or of irreversible decline, including among elderly people with failing health.
- Unlike other suicides, the most frequently used method for this group was poisoning (eg overdose or combining medication) and a greater proportion than of other suicides used a firearm (21 deaths, approximately 11%)
- Suicides were divided into 3 groups where deterioration was due to:
  - diagnosed terminal illness where "expected to die within a specified period of time" (eg "metastasized cancer, end-stage chronic obstructive airways disease")
  - "incurable chronic disease that was not expected to cause death in the foreseeable future" (eg Huntington's, Parkinson's, MS, diabetes, MN, osteoarthritis)
  - permanent physical incapacity and pain that could not be relieved as a result of injury (eg motor vehicle, workplace incident).
- Of the 5 case studies in the submission, one appears to be in the first category, three were clearly in the latter two categories, and in one case it is unclear. Methods used in the case

[1] http://www.parliament.vic.gov.au/images/Submission_755_-_Coroners_Court_of_Victoria.pdf
[2] http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/ELC_Transcripts/SCLSI_-_Coroners_Court_-_FINAL_-_End-of-life_choices_7_October_2015.pdf
[3] http://www.parliament.vic.gov.au/images/stories/committees/lsic/Submissions/Submission_1037_-_Coroners_Court_of_Victoria_further_submission.pdf
[4] Reported in second submission and in the final report of the inquiry. The first submission had the figure 197 which was included in an earlier version of this paper and is the basis for this summary.

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studies included one hanging, two from blood loss from self-inflicted lacerations and two from medications (one a fatal overdose from stockpiled medication; one from fatal combination).

Evidence at hearing on 5 October (All italicised material is quotes from the transcript of the hearing. Comment in square brackets is by DwDTas.)

- *These are people who are suffering from irreversible physical terminal decline or disease, and they are taking their lives in desperate, determined and violent ways. They are the category of suicides we want to talk to you today about*.

- *I suppose my motivation initially some time ago to refer several cases that I was investigating to our coroners prevention unit was really would I want a member of my family to die in the circumstances of loneliness, fear and the horror of some of these cases we are privy to — would I want that? The answer was a resounding no. People who have invariably lived a long, loving life surrounded by family die in circumstances of fear and isolation. That was the motivation.*

- *So a total of 197 deaths not in palliation at the time of death. It is important to point that out. We are not talking about this wonderful palliation. We do not in any way, shape or form undermine that. That role is so important, but we are not talking about that. We are talking about the people who unlikely would qualify, would meet the criteria of palliation.*

- *… highlight the absolute determination of these individuals — their desperation, their plight*.

- More details were given on the analysis of the 197 suicides where the deceased was suffering an irreversible deterioration in their physical health show that in up to 60% of cases the person's death may not be terminal and/or predictable in terms of weeks or months. Some were described as not having a "terminal illness" and it is assumed this means that the illness would not cause death or would not cause it within a foreseeable timeframe like 12 months [5]. The details also show how understandable it was that the people would have found their situations intolerable, and why they should be considered eligible for voluntary assisted dying.

- Direct quotes are in italics. Where bold text used, it is my emphasis.

[5] This factor has become relevant due to the recommendation of the Expert Panel and accepted by the Victorian Government for the Voluntary Assisted Dying Bill that eligibility should be more restricted than originally recommended by the inquiry into end of life choices. The inquiry had recommended that a person must be "suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable". The Panel's recommendation is that a person must "be diagnosed with an incurable disease, illness or medical condition that: is advanced, progressive and **will cause death** …within weeks or months, but not longer than 12 months and is causing suffering that cannot be relieved in a manner the person deems tolerable." (our emphasis).

- Key points are:
  - *about 80 per cent involved physical illness and in about 20 per cent, if you like, the aetiology of the deterioration is physical injury* [assumed not terminal illness and difficult or impossible to predict death in terms of weeks or months].
  - 80% that had physical illnesses –
    - First group*, about 50 per cent are associated with cancer diagnoses,* [that is 40% of total 197; terminal illnesses that will cause the person's death, and probably predictable in terms of weeks or months] *particularly the return of cancer after successful first treatment, the metastasising of cancer, and particular types of cancer such as pancreatic cancer. The themes are that* ***the deceased has been engaged in treatment and has usually been through multiple periods of treatment and has reached a point in most cases where they feel that the treatment is, I guess, detracting from their quality of life to the point where they make the decision that they do****.*
    - *The second group — around 30 per cent of these deceased* [24% of total, deaths possibly unpredictable in terms of months (?)]*— are people who* ***do not actually have a terminal illness but who usually suffer a range of different physical illnesses from which they are no longer able to recover****. I have a list by deceased of the ranges. I will just give you an idea — for example, someone suffering heart disease, prostate issues and lumbar spinal osteoarthritis. A very common combination is diabetes, stroke, hypertension and heart disease. One suffered breast cancer, hypertension, spondylosis, pancreatic cyst and shingles. There are things like that. So they have* ***multiple medical issues****, and a lot of them are interrelated.* ***They have been engaged in treatment for a long time, they are not getting any better and the drugs are not doing them any good, and they have come to a realisation that their physical health is not going to improve****.*
    - *The third group here — about 15 per cent of the deceased* [12% of total; death foreseeable but some not predictable with any certainty until last weeks (?)]*— are those who have what I guess, for want of a better term, we would classify as* ***incurable conditions, usually very well advanced****: cerebral palsy, Parkinson's, multiple sclerosis, muscular dystrophy and so on — degenerative brain and nerve disorders.*
    - *The last group, a small group — about 5 per cent* [4% of total; definitely not predictable deaths in terms of weeks or months] *— have illness-related pain disorders.* ***Usually they have been in treatment for a very long time. They are not getting relief from opioids. They are not getting relief from the more exotic forms of pain treatment such as direct spinal stimulation and so on. They end up in a situation where every day is distressing for them****.*

- More details were given on case histories that demonstrate not only the harrowing circumstances of the person involved but hint at the "hidden damage" for their families, the people who found them, and beyond them paramedics, doctors who would have to provide death certificates, police and the Coroner's Court personnel:
  - *Another case I have seen was an 82-year-old lady. She lived on her own and was survived by her children, again with whom she shared a loving lifelong relationship. Her documented medical history: hypertension, insomnia, arthritis, gastro-oesophageal reflux disease, gout and on and on and on it goes. She was feeling very poorly about it*

and depressed about her lot. Her vision was nearly gone. Her love of reading books, her quality of life was greatly diminished. She was described by her doctor as lonely, isolated, frustrated, impatient. Her daughter was informed by a neighbour who had told her she could not read anymore. It was the most important part of her life. She also informed her on a number of occasions she wanted to die.

She was found on the couch in her lounge room. This 82-year-old lady had a stained towel wrapped around her left hand. There was a knife on the floor in front of her, an open wound on her left wrist. There was a white-handled knife that measured 14 centimetres on the floor beside her. In the bathroom was found two pairs of scissors, and another white-handled serrated knife, about 30 to 40 centimetres in length, was located on a table. There were traces of dried blood on all of these items. She died of exsanguination — she bled to death.

- *Another, 89-year-old. Again, a man. He lived with his wife of 61 years and enjoyed a long and loving relationship with his family. He had a very lengthy medical history — no hint of mental illness. His son stated his dad's lucidity, memory and eyesight were failing. He could not listen to music, watch TV or read, which he was known to enjoy. He ended up alone, grinding various tablets with either a mortar and pestle or food processor and died of drug toxicity.*

- *Another, 75-year-old — the second last. He lived with his wife, with whom he maintained a good relationship despite their divorce. He is survived by his daughters, with whom he shared close, loving relationships. He had no documented mental health history, and again a very long, complex mental history. Not long before his death, some years, he was diagnosed with prostate cancer, treated — radical treatments — sadly without improvement and increasing pain with poor prognosis. He expressed to others his belief that his life would be so much easier if someone could help him die. He could not face his lot. He ultimately obtained a firearm which he discharged by holding the tip of the barrel against his chest and reaching for the trigger. He was found by family.*

- *Finally, a 90-year-old man, survived by his family, again with whom he shared close, loving relationships. He was described as a delightful gentleman. He was extremely fit for his age and a proficient iPad user. He had no documented mental health history. A very lengthy history included back pain, chronic obstructive pulmonary disease, asbestos exposure and the like. Not long before his death he was diagnosed with a solitary brain metastasis in a setting of metastatic melanoma. He expressed his wishes very clearly to his treating clinicians; he did not wish to have any invasive procedure done. His main priority was quality of life.*

  In the final four weeks of his life, his doctor explained, he remained frail. He had lost approximately 6 kilograms in the previous four weeks. He had a poor appetite. He looked malnourished and had nausea. His family stated that from about mid-December 2014 his wellbeing deteriorated. He felt generally unwell. He was dehydrated and had diarrhoea. He was vomiting uncontrollably. He had fevers. He was wobbly on his feet, even with the assistance of walking aids. He was diagnosed with likely viral gastroenteritis and was commenced on IV fluids for rehydration therapy. He improved as a result of the

rehydration therapy markedly and was discharged home to the care of his grandson in January this year.

The family explained that when he learnt of his cancer he went downhill emotionally. He was depressed and angry that there was no cure. He often told his family he would rather do something to end it straightaway and that if he could no longer drive, he might as well be dead. He mentioned a nail gun. He was subsequently found dying with nail gun wounds to his head and to his chest. He died ultimately from the injuries sustained from the nail gun.

- *I have other cases still before us. The tally is not ending: a lovely lady who had the ability to step off the platform in front of a train; a man with the ability to tie a hessian bag full of sand around his waist and step off a pier. It goes on and on. These are the cases I have sent to Jeremy. This is the information we are privy to.*

Initially prepared in July 2016 by Margaret Sing, President of DwDTas, for MPs, Lara Giddings and Cassy O'Connor, for consideration in the preparation of the Voluntary Assisted Dying Bill 2016. Updating was done for this August 2017 version.