IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5494

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**PATRICIA SHAW**, born 26 October 1928
Delivered on:	11 September 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	11 September 2017
Counsel assisting the Coroner:	Leading Senior Constable Remo Antolini

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HER HONOUR:

BACKGROUND

1. Mrs Patricia Shaw was 87 years old and resided with her husband Mr Peter Shaw (**Mr Shaw**) in Brighton at the time of her death. Mr and Mrs Shaw were married for 60 years until their deaths on 27 October 2015. Mrs Shaw is survived by her children Judith, Annie and Kate.

2. Mrs Shaw was one of the first women to study biochemistry at the University of Melbourne, and over the course of her working life she was employed as a nutritionist and later as as a lecturer in the medical faculty at Monash University.

3. Mrs Shaw was a long-term patient of general practitioner Dr Paul Molloy, who remembers Mrs Shaw as an intelligent and articulate woman. Mrs Shaw did not have what Dr Molloy considered to be major health problems, and he reported that Mrs Shaw did not present with features of depression or any other mental health disorder, did not discuss an intent to end her own life at any time, and did not display impaired cognitive function. In September 2014, Mrs Shaw had provided Dr Molloy with an Advanced Care Directive. In the two years prior to her death, he said that Mrs Shaw had shown deterioration in her mobility. Mrs Shaw declined offers of further assessment by a neurologist in relation to this matter.[1]

4. Mrs Shaw's husband Mr Shaw was a member of Exit International,[2] an end-of-life choices information and advocacy organisation. Mrs Shaw's family had been aware for approximately 10 years that Mr and Mrs Shaw desired to end their lives before they became incapacitated and unable to care for themselves, as they did not wish to live in a care home or be hospitalised. Mr and Mrs Shaw discussed their wishes with their daughters on numerous occasions over a number of years.

5. In her statement to the Court, Kate Shaw made the following statement regarding her parents' plan to end their own lives:

> "*Their plan was that my mum would take the Nembutal and that my dad would sit with her till he was sure she was gone, then he would go down to the shed and take his own life with the Nitrogen cylinder and a plastic bag.*"[3]

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[1] Coronial brief, statement of Dr Paul Molloy, dated 18 April 2016, 22.
[2] *Ibid*.
[3] Coronial brief, statement of Kate Shaw, dated 27 October 2015, 14.

6. Mr and Mrs Shaw's children were aware that they had ordered Nembutal from China approximately three years prior to their death, and had purchased a nitrogen cylinder in preparation to end their lives at a time of their choosing.

7. Despite being aware of Mr and Mrs Shaw's wishes, their daughters always encouraged them to continue living.[4]

8. In November 2015, Annie Shaw had been booked to come out to Melbourne from Germany to say goodbye to her parents. On 18 October 2015, Annie spoke with her parents on the telephone. Mr Shaw told Annie that he could not wait for 6 November 2015 and that he had to end his life. Annie told him to hold on, and Mr Shaw promised he would wait. However on 19 October 2015 Annie's sister Kate called and told her she should come home. Annie booked a flight for the following day, and called Mrs Shaw to advise she was coming home. Mrs Shaw told Annie she was glad as she did not think Mr Shaw would last until November.[5]

9. On 21 October 2015, Annie arrived in Melbourne. She noted a big difference in her parents' appearance from when she saw them last in March 2015, saying that they were "*frail and old looking*"[6].

10. Between 23 and 25 October 2015, Mr and Mrs Shaw told their daughters that they were intending to end their lives on 27 October 2015.

THE PURPOSE OF A CORONIAL INVESTIGATION

11. Mrs Shaw's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected and not from natural causes.[7]

12. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

[4] Above n 2, 17.
[5] Ibid, 18-19.
[6] Ibid, 19.
[7] Section 4 *Coroners Act 2008.*
[8] Section 89(4) *Coroners Act 2008.*

13. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[9] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

14. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

15. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

16. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

17. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

18. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[10] 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 that they caused or contributed to the death.

19. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was

[9] *Keown v Khan* (1999) 1 VR 69.
[10] (1938) 60 CLR 336.

as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

20. While Mrs Shaw's identity was not in dispute and she was not a person placed in "*custody or care*" as defined by section 3 of the Act, her death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of her death as no person or persons have been charged with an indictable offence in respect of the death.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

21. On 27 October 2015, Ms Kate Shaw identified the body of the deceased to be that of her mother Mrs Patricia Shaw, born 26 October 1928.

22. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the Act

23. On 29 October 2015, Dr Victoria Francis, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mrs Shaw's body. Dr Francis provided a written report, dated 3 February 2016, which concluded that Mrs Shaw died from the combined effects of pentobarbitone, oxazepam, amlodipine and zopiclone ingestion with circumstantial evidence of external airway obstruction due to smothering and plastic bag asphyxia.

24. Dr Francis commented that the cause of death had been formulated based on available toxicological results and the circumstances described in the notes written by Mr Shaw.

25. Post-mortem toxicological analysis of blood specimens detected the presence of pentobarbitone[11] (~7mg/L), zopiclone[12] (~0.02mg/L), oxazepam[13] (~0.03mg/L) and amlodipine[14] (~0.06mg/L).

26. I accept the cause of death proposed by Dr Francis.

[11] Pentobarbitone is a drug which is used as a sedative and for the treatment of insomnia (hypnotic).
[12] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia.
[13] Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.
[14] Amlodipine, a derivative of dihydropyradine, is an anti-hypertensive drug and a treatment for angina.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

27. On the morning of 27 October 2015 Mr and Mrs Shaw spent time with their children. The family ate breakfast together and spent time talking.

28. At an unknown time Mrs Shaw consumed an antiemetic medication. [15]

29. At approximately 12.00pm, Mr and Mrs Shaw said goodbye to their children in the backyard of their home. Ms Judith Shaw took a video of the farewell, which showed Mr and Mrs Shaw as being in good spirits. After saying their farewells, Ms Annie Shaw, Ms Kate Shaw, and Ms Judith Shaw left the property and went to Brighton Beach where they spent two hours walking.

30. At an unknown time, Mrs Shaw consumed a quantity of pentobarbitone and lay down on the bed in the master bedroom of their home. After Mrs Shaw took the pentobarbitone Mr Shaw monitored her, observing that she took several breaths, fell unconscious and then took many deep laboured breaths. Mr Shaw put a pillow over Mrs Shaw, and then held a plastic bag over her mouth and throat for ten minutes.

31. Once Mrs Shaw was deceased, Mr Shaw went to the kitchen where he wrote a note explaining that Mrs Shaw's death had gone "*not entirely according to plan*".[16] In the note, Mr Shaw confirmed that he had assisted in Mrs Shaw's death.

32. After Mrs Shaw passed away, Mr Shaw exited the house and walked to the rear shed at the property where he had set up a cylinder of compressed nitrogen gas connected to an exit bag.[17] He sat in a recliner chair, placed the exit bag hood over his head and turned on the nitrogen gas bottle.

33. Mr and Mrs Shaw's daughters returned to the home at approximately 2.00pm. On entering the family home, Ms Judith Shaw and Ms Kate Shaw found Mrs Shaw lying on her bed unresponsive. Ms Judith Shaw checked for a pulse or signs of breathing, but found Mrs Shaw to be deceased.

34. Ms Judith Shaw and Ms Kate Shaw found Mr Shaw slumped in the recliner chair in the shed on the property. On checking for a pulse Ms Judith Shaw found Mr Shaw to be deceased.

[15] A drug used to prevent nausea and vomiting.
[16] Coronial brief, handwritten note of Peter Shaw, undated, 41.
[17] A plastic hood that enables inert gas asphyxiation.

35. Mr and Mrs Shaw's daughters located a hand written note on the kitchen table explaining the manner of Mrs Shaw's death.

36. Following instructions previously provided by Mr and Mrs Shaw, Ms Judith Shaw called the practice of Mr and Mrs Shaw's general practitioner Dr Paul Molloy. She was advised to call 000. Ambulance Victoria paramedics attended and confirmed Mrs Shaw and Mr Shaw were deceased.

37. Victoria Police members undertook an investigation at the scene, locating suicide notes written by Mrs Shaw and Mr Shaw, and a further handwritten note left by Mr Shaw.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

38. The circumstances of Mrs Shaw's death illustrates a common theme encountered by Victorian coroners. In her statement to the Court, Ms Judith Shaw made the following comment:

> "*I love my parents very much, I am very grateful to them for everything. I am very sad that they are gone but I am glad they went peacefully in a manner of their own choosing."*[18]

39. 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, often in circumstances of desperation, loneliness and fear.

40. The Coroners Court of Victoria investigates a number of deaths each year in which a person suffering an irreversible decline in physical health, has made the decision to end their own life. Such deaths raise a number of moral and social issues, which fall outside the jurisdiction of the Court.

41. One of the purposes of the *Coroners Act 2008* is to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.[19] Further, section 7 of the Act requires that I avoid unnecessary duplication of inquiries and investigations.

42. In 2015, the Parliament of Victoria conducted an Inquiry into End of Life Choices, which produced its Final Report in 2016. This Report contains 49 recommendations, including a

[18] Coronial brief, statement of Judith Shaw, dated 27 October 2015, 12.
[19] *Coroners Act 2008* (Vic) s 1(c).

recommendation for a legal framework for assisted dying. In December 2016, the Victorian Government responded to this recommendation, advising that it was under review.

43. A Ministerial Advisory Panel was formed, and its work has built upon the recommendations of the Inquiry into End of Life Choices. The Panel has developed a framework to provide access to assisted dying to persons who are at the end of their lives, who are suffering and who wish to choose the time and manner of their deaths. The Panel made 66 recommendations to the Victorian State Government. Victorian Premier Daniel Andrews and the Honourable Jill Hennessy, Minister for Health, have indicated that legislation will be developed and considered by the Victorian Parliament in the second half of 2017.

44. In the context of the purposes of the Act, the current progress of development of a Voluntary Assisted Dying Bill, together with the likelihood that such a bill will be considered by the Victorian Parliament by the end of 2017, it is unnecessary for me to make any further comments or recommendations in this matter.

FINDINGS AND CONCLUSION

45. Having investigated the death of Mrs Shaw and having held an Inquest in relation to her death on 11 September 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Mrs Patricia Shaw, born 26 October 1928;

    (b) that Mrs Patricia Shaw died on 27 October 2015, at 21 Wolseley Grove, Brighton, from the combined effects of pentobarbitone, oxazepam, amlodipine and zopiclone ingestion with circumstantial evidence of external airway obstruction due to smothering and plastic bag asphyxia; and

    (c) that the death occurred in the circumstances set out above.

46. I convey my sincerest sympathy to Mrs Shaw's family and friends.

47. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

(a) Ms Kate Shaw, Senior Next of Kin; and

(b) Senior Detective Scott Martin, Coroner's Investigator, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 11 September 2017