IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005145

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	NW
Date of birth:	A date known to the Court
Date of death:	31 August 2024
Cause of death:	1a : Plastic bag asphyxia in the setting of a vitiated atmosphere with inert gas
Place of death:	Mount Waverley, Victoria

INTRODUCTION

1. NW died at home on 31 August 2024 in circumstances suggestive of suicide. At the time of death, NW resided with her husband, FR.

2. NW grew up in California, United States (**the US**) with her parents and her younger sister. She came to Melbourne in 2019 where she married her husband FR, whom she first connected with in 2012 through an online science fiction forum.

3. NW was described by FR as an incredibly smart woman, a description echoed by her father who stated NW was known for her "*academic prowess*".

BACKGROUND

4. NW was noted to be in good health in her freshman year at secondary school, however according to her psychiatrist, she soon developed temporomandibular joint problems,[1] multiple respiratory infections and mouth ulcers.

5. In 2018, during her sophomore year at college, she further developed symptoms suggestive of myalgic encephalomyelitis including fatigue and brain fog.[2] The psychiatrist noted this caused NW to grieve her previous good health, and she was consequently diagnosed with Behçet's disease[3] and depression by her treating doctor in the US.

6. Despite the impact of her multiple conditions, NW successfully completed an internship with Google in Seattle during the summer period of 2019. She then moved to Australia in August 2019 to live with her husband FR and study at Monash University.

7. When NW arrived in Australia, she was able to walk short distances but eventually became reliant on a wheelchair. As her health continued to decline, NW became bedbound and extremely sensitive to light and sound, which easily triggered her migraines. By 2023, she required a stretcher to leave her bedroom. According to FR, this would only be done in exceptional circumstances as the exertion "*posed a high risk of permanent deterioration*".

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[1] The temporomandibular joint, also known as the *TMJ,* is the joint in front of the ear which connects the mandible (the jaw bone) to the skull.

[2] Myalgic Encephalomyelitis, also known as Chronic Fatigue Syndrome (ME/CFS), is a complex disorder characterised by extreme fatigue that does not improve with rest. Diagnosis is difficult as there is no definitive diagnostic test, treatment is aimed at symptom management.

[3] Behçet's disease is a chronic inflammatory disease characterised generally by blood vessel swelling followed by recurrent oral and genital ulcers, skin lesions and eye inflammation.

8. Between November 2022 and June 2024, NW was treated by a General Practitioner (**GP**) for myalgic encephalomyelitis, Behçet's disease, postural orthostatic tachycardia syndrome (**POTS**),[4] fibromyalgia,[5] mast cell activation syndrome,[6] and chronic migraines. The GP noted NW's disease processes were severe and she required 24-hour nursing support at home with the assistance of her husband and father to try and manage her symptoms. This included matters of self-care and activities of daily living (**ADLs**), medication, and at-home oxygen therapy for relief of headaches.

9. While multiple diagnoses and treatment plans were discussed, the GP described NW as highly knowledgeable about her conditions. This led NW to be hesitant about starting new medications or treatments due to possible reactions and sensitivities.

10. In July 2024, NW underwent a tooth extraction and implant following a chipped tooth. While the initial procedure was successful, she later developed an infection and sepsis and was treated with intravenous antibiotics.

THE CORONIAL INVESTIGATION

11. NW'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.

12. 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.

13. 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.

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[4] A condition characterised by increased heart rate and low blood pressure on standing.
[5] A chronic disorder characterised by widespread musculoskeletal pain, fatigue and issues with sleep, memory and mood.
[6] Repeated episodes of symptoms of allergy and anaphylaxis with symptoms such as hives, swelling and low blood pressure due to mast cell activation. Mast cells are cells responsible for immediate allergic reactions and release mediators such as histamine.

14. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of NW's death. The Coronial Investigator conducted inquiries on the court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. Coroner Kate Despot originally held carriage of this investigation. I assumed carriage of this investigation on 28 August 2025 for the purposes of conducting additional investigation, finalising the case, and making findings.

16. This finding draws on the totality of the coronial investigation into the death of NW 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.[7]

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

Circumstances in which the death occurred

17. On the evening of 30 August 2024, NW asked FR to assist with setting up the regulator for her oxygen. By 10.00pm, NW was comfortable and had several alerts set to request assistance during the night.

18. At about 6.00am on 31 August 2024, FR went to help NW with her next round of antibiotics. Upon entering her bedroom, FR discovered NW unresponsive with a plastic bag over her head. He immediately removed the bag and was unable to locate a pulse.

19. FR contacted Triple Zero and Ambulance Victoria arrived shortly after. Responding paramedics were unable to find signs of life and declared NW deceased. Paramedics also identified that the cylinder connected to her regulator was nitrogen, not oxygen.

20. Victoria Police also attended and inspected the scene. They observed an empty nitrogen cylinder as well as the plastic bag and facemask beside NW. Also located at the scene was a handwritten note written by NW to her family, detailing her desire for self-determination due to her suffering and recent infection.

[7] 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.

Identity of the deceased

21. On 31 August 2024, NW, born on a date known to the Court, was visually identified by her father.

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

Medical cause of death

23. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of NW on 2 September 2024 and provided a written report of his findings dated 24 October 2024.

24. The post-mortem examination revealed no unexpected signs of trauma.

25. Toxicological analysis of post-mortem samples identified the presence of diazepam, nordiazepam, zopiclone, doxepin, gabapentin, nimodipine, prochlorperazine, metoclopramide, cimetidine, diphenhydramine, hydroxyzine and cetirizine. The VIFM laboratory was unable to test for the presence of nitrogen.

26. Dr Young provided an opinion that the medical cause of death was appropriately formulated as '*1a Plastic bag asphyxia in the setting of a vitiated atmosphere with inert gas'*.

27. I accept Dr Young's opinion.

CORONERS PREVENTION UNIT REVIEW

28. The Court requested that the Coroners Prevention Unit (**CPU**) review the medical care provided to NW in the period proximate to her death.

29. As part of its review, the CPU considered the medical examiner's report, toxicology report, coronial brief of evidence, the medical records of Medi7 Clayton and Reedy Creek Medical Centre, and the Medicare and Pharmaceutical Benefit Scheme (**PBS**) records.

30. The CPU noted NW was a young woman with complex health issues and was bedbound. Many of her conditions did not have specific diagnostic tests and limited treatment options, with the management of NW's conditions having been focused on symptom control. The CPU further noted that NW's healthcare was fractured, with the vast majority delivered by telehealth, some from interstate and the US.

31. The CPU did not identify any areas of concern with NW's care as there was no evidence to suggest that an acute condition in the time proximate to NW's death caused or contributed to her death.

FINDINGS

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

    a) the identity of the deceased was NW, born on a date known to the Court;

    b) the death occurred on 31 August 2024 at an address known to the Court in Mount Waverley, Victoria from 1(a): *Plastic bag asphyxia in the setting of a vitiated atmosphere with inert gas*; and

    c) the death occurred in the circumstances described above.

33. Having considered all the circumstances, including the chronic illnesses suffered by NW, the prospect of continued infection, the lethality of the means chosen, and the suicide note addressed to her husband and family, I am satisfied that NW intentionally took her own life.

34. NW had profound illnesses as set out above and her health and mobility were clearly impacting on her quality of life. She was cared for not only by nursing staff in the home, but her husband and father who ensured her environment was optimal for her needs. I acknowledge this level of care as it afforded NW the human dignity she deserved throughout the last years of her life.

35. I refer to NW's suicide note, in which the rationale for her decision is clear. That is, her quality of life had deteriorated to such an extent that it was no longer acceptable for her and she preferred to be in control and to end her suffering.

COMMENTS

Pursuant to section 67(3), I make the following comments connected to the death:

<u>Voluntary assisted dying</u>

36. While the extent of NW's knowledge of the *Voluntary Assisted Dying Act 2017* (Vic) provisions are not known, and the evidence before me does not indicate a history of suicidal ideation nor any discussions with family, friends or clinicians about accessing voluntary

assisted dying (**VAD**), her note makes it clear that she had been suffering for many years with a plan in place that was not '*sudden*'.

37. To be eligible for VAD, NW would have needed to meet *all* the eligibility criteria.[8] That includes the requirement that an individual have an advanced disease that will cause their death and is likely to do so within six months (or within 12 months for neurodegenerative diseases like motor neuron disease) and the requirement that the disease will cause suffering that is unacceptable to the individual.[9]

38. NW's lack of terminal prognosis would have been a barrier to accessing the scheme, despite the gradual diminution of her quality of life.

39. The coronial investigation of NW's death provides a human example of one member of the Victorian community who chose to end their life rather than endure a reduced quality of life they deemed unacceptable. Whether VAD should be available to people in such circumstances is ultimately within the remit of the legislature.

Chronic illness and suicidality

40. The intersection of chronic health conditions and mental ill health, particularly depression, has long been studied and acknowledged globally. An Australian study in 2022 documented that *'mental illnesses, particularly depressive disorders, often co-occur with chronic diseases'*.[10] Depressive disorders disproportionately affect females and individuals aged between 35 and 44 years.[11]

41. The study estimated that, as of 2022, 2.4 million Australians (9.3%) live with a mental health condition and a chronic disease. The presence of comorbid mental and physical health conditions often complicates treatment, given that one often exacerbates the other. This leads to poorer health outcomes and places a greater strain on the healthcare systems, particularly primary health providers who are vital to providing first-line treatment and managing these comorbidities. These pressures are more acutely felt in rural communities which experience

[8] *Voluntary Assisted Dying Act 2017* (Vic) s 9.
[9] Ibid s 9(1)(d).
[10] Chronic Pain-Induced Depression: A Review of Prevalence and Management, by R Meda et al. *Cureus* (2022) 14(8) and accessible at: Chronic Pain-Induced Depression: A Review of Prevalence and Management - PMC.
[11] Ibid.

workforce shortages, limited infrastructure and potentially increased stigma around mental ill health.[12]

42. In this connection, the Royal Commission into Victoria's Mental Health System (**RCVMHS**), finalised in March 2021, commented that *'poor physical health can lead to worsening mental health outcomes, as well as poorer life outcomes'*.[13] It also discussed that there was a poor integration of healthcare services provided to individuals with mental ill health and concurrent poor physical health, disability or substance use or addiction, contributing to a difficulty to access appropriate services. The Commission heard evidence regarding the difficulty of accessing multi-disciplinary healthcare for patients with dual diagnoses and stated: *'these services are often not sufficiently integrated to respond to people's needs and preferences'*.[14]

43. The RCVMHS made several recommendations regarding the provision of mental health care in the State and in the context of comorbid mental and physical health I note Recommendation 14 which aims to secure the adequate funding of mental health consultation liaison services for patients admitted for physical health conditions.[15]

44. As of December 2024, the Victorian Government committed itself to implementing all recommendations arising from the RCVMHS.[16]

45. Suicide in persons with chronic physical conditions has also been closely monitored by the Court. The Coroners Prevention Unit (**CPU**)[17] conducted a pilot analysis of data from the Victorian Suicide Register[18] and identified evidence of a chronic or persistent pain condition proximate to death in 979 (23.7%) of the 4132 Victorian suicides that occurred between 2009 and 2015. These included 366 deaths where the pain was associated with an injury, and 737 deaths where the pain resulted from illness (there was some overlap between these two groups).

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[12] Ibid.
[13] RCVMHS, Volume 3: Promoting inclusion and addressing inequalities, page 465 and accessible at: Final Report – Volume 3 – Promoting inclusion and addressing inequities.
[14] RCVMHS, Summary and recommendations, page 11 and accessible at: Final Report – Summary and recommendations.
[15] RCVMHS, Volume 2: A new approach to mental health and wellbeing in Victoria, page 582 and accessible at: Final Report – Summary and recommendations.
[16] Victorian Government website, Department of Health, *Recommendation 14,* dated 9 December 2024 and accessible at: Recommendation 14 | health.vic.gov.au.
[17] 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.
[18] The Victorian Suicide Register is a database built and maintained by the Coroners Court of Victoria, which contains information on suicide deaths investigated by Victorian Coroners.

46. The CPU pilot analysis data is consistent with the broader literature examining pain and suicide,[19] and suggests that understanding how chronic or persistent pain intersects with suicidality may be a crucial area of inquiry for those working in both suicide prevention and clinical pain management in the state of Victoria.

47. The connection between poor physical health and mental ill health, namely depressive disorders, and ultimately suicide, is well established and illustrated in the current tragic circumstances. I am hopeful that recommendations from the RCVMHS and increased Government funding to the mental health and wellbeing services will see improved outcomes for individuals with dual diagnoses.

Pursuant to section 73(1A) of the Act, I direct that this finding be published in accordance with the *Coroners Court Rules 2019.*

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

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

FR, Senior Next of Kin

NW's Father

Reedy Creek Medical Centre

Dr Ken Cheng, c/- Avant Law

Sergeant Shane Macdonald, Coronial Investigator

[19] See for example Stenager EN and Stenager E, "Physical illness and suicidal behaviour", in Hawton K and van Heeringen K (eds), *The International Handbook of Suicide and Attempted Suicide*, 2000, pp405-420; Tuckman J, Youngman W, Kreizman G, "Suicide and physical illness", *The Journal of General Psychology*, 1966, no 75, p.291; Ilgen M, "Pain, Opioids, and Suicide Mortality in the United States", *Annals of Internal Medicine*, 2 October 2018.

Signature:





Coroner Therese McCarthy

Date: 09 November 2026

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.