SUICIDES, ASSISTED SUICIDES AND 'MERCY KILLINGS': WOULD VOLUNTARY ASSISTED DYING PREVENT THESE 'BAD DEATHS'?

Katrine Del Villar, Lindy Willmott and Ben White[1]

This article may be cited as: (2020) 46(2) Monash University Law Review (forthcoming)

Abstract

Voluntary assisted dying (VAD) has recently been legalised in Victoria, and legalisation is being considered in other Australian States. One argument advanced in favour of legalisation of VAD is that terminally and chronically ill people are committing suicide, or asking friends or relatives to assist them to die, because they feel that they have no alternative. This article evaluates whether the Voluntary Assisted Dying Act 2017 (Vic) will prevent these 'bad deaths' from occurring. The article evaluates two important sources of evidence: coronial evidence from Victoria and Western Australia concerning suicides in the chronically and terminally ill; and Australian cases on assisted suicide and "mercy killings". It concludes that many of these cases would not have met the eligibility criteria for VAD under the Victorian model, and thus 'bad deaths' will continue to occur.

Key words: suicide; assisted suicide; mercy killings; voluntary assisted dying; coronial data; criminal prosecutions; parliamentary debates; law reform

[1] Katrine Del Villar, BA (Hons) (ANU), LLB (Hons) (ANU), PhD Candidate and Postdoctoral Research Fellow, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology; Lindy Willmott, BCom (UQ), LLB (Hons) (UQ), LLM (Cambridge), PhD (QUT); Professor, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology; Ben White, LLB (Hons) (QUT), DPhil (Oxford), Professor, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology. We disclose that Lindy Willmott and Ben White were engaged by the Victorian Government to design and provide the legislatively mandated training for doctors involved in voluntary assisted dying. Lindy Willmott also discloses that she is a Board member of Palliative Care Australia, but the views she expresses in this article are her own views, not those of the organisation. The authors thank Emily Bartels for her research assistance with this article.

SUICIDES, ASSISTED SUICIDES AND 'MERCY KILLINGS': WOULD VOLUNTARY ASSISTED DYING PREVENT THESE 'BAD DEATHS'?

I INTRODUCTION

Voluntary assisted dying ('VAD') is a topic of widespread debate in Australian parliaments, media and the community. There has been considerable media attention given to recent cases of individuals, such as 104 year old botanist Professor David Goodall,[2] and 54 year old firefighter Troy Thornton,[3] who chose to travel to Switzerland to end their lives.[4] There has also been media reporting of family members assisting terminally ill relatives to commit suicide. Most recently, in July 2019, Penelope Blume's husband was charged with assisting his wife,[5] who was terminally ill with motor neurone disease, to commit suicide, although the charges were later dropped by the prosecution on public interest grounds.[6]

Against the background of this ongoing media attention, parliamentary committees in five Australian jurisdictions[7] have recently considered or are in the process of considering whether to permit VAD. In

[2] David Goodall was not ill, but was frail, and tired of living: Charlotte Hamlyn and Lisa McGregor, 'David Goodall's Final Hour: An Appointment with Death', *ABC News* (online, 12 July 2018) <https://www.abc.net.au/news/2018-07-10/david-goodalls-appointment-with-death-and-his-final-hour/9935152>.

[3] Troy Thornton suffered from multiple systems atrophy: Tracey Ferrier, 'Australian firefighter Troy Thornton dies after lethal injection in Swiss clinic', *Sydney Morning Herald* (online, 23 February 2019) <https://www.smh.com.au/national/australian-firefighter-troy-thornton-dies-after-lethal-injection-in-swiss-clinic-20190223-p50zr9.html>.

[4] Dignitas statistics record that 27 Australians travelled to Dignitas between 2003–2017: Dignitas, *Accompanied Suicides per Year and Residence* (Report, 2017) <http://dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2017.pdf>. Other clinics in Switzerland also provide treatment to foreign residents.

[5] We adopt his description of their relationship, although the couple were not legally married.

[6] DPP (ACT), 'Police v O - CC2019/3260 Charge of Aiding Suicide under section 17(1) *Crimes Act 1900'*, (Media Release, 28 June 2019) <https://www.dpp.act.gov.au/__data/assets/pdf_file/0007/1382353/Police-v-O-DPP-Statement-of-Reasons.pdf> ('*Police v O*'). The provision of public reasons for this decision was unusual. For a discussion of prosecutorial discretion in this area, including the desirability of providing such reasons, see Ben White and Jocelyn Downie, 'Prosecutorial guidelines for voluntary euthanasia and assisted suicide: Autonomy, public confidence and high quality decision-making' (2012) 36 *Melbourne University Law Review* 656.

[7] Victoria, Western Australia, the Australian Capital Territory, Queensland and South Australia.

2017, following an extensive process of parliamentary inquiry and community consultation,[8] Victoria became the first Australian State[9] to enact legislation permitting VAD under strictly controlled conditions.[10] In December 2019, the Western Australian Parliament also legislated to authorise VAD,[11] following a similar process of a parliamentary committee of inquiry,[12] and recommendations of a Ministerial Expert Panel as to the content of such legislation.[13]. In the ACT, a parliamentary inquiry noted that, while unable to recommend legislation for constitutional reasons,[14] a majority of the committee supported considering legalising VAD in future should the constitutional position change.[15] At the time of writing, Queensland[16] and South Australia[17] are both conducting parliamentary reviews of end of life issues, including VAD.

One argument advanced in favour of legalising VAD is that legislation will prevent 'bad deaths': that is, people taking their own lives in 'desperate, determined and violent ways',[18] because they feel that

[8] A parliamentary committee of inquiry recommended the enactment of VAD legislation: Legal and Social Issues Committee, Parliament of Victoria Legislative Council, *Inquiry into end of life choices: Final Report* (Parliamentary Paper No 174, 9 June 2016) ('Victorian Committee Report'). A multidisciplinary Ministerial Advisory Panel provided expert advice on the form of the legislation: Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 21 July 2017) ('Victorian Advisory Panel Report'). See also Margaret O'Connor et al, 'Documenting the process of developing the Victorian voluntary assisted dying legislation' (2018) 42 *Australian Health Review* 621.

[9] VAD was briefly legal in the Northern Territory, until the *Rights of the Terminally Ill Act 1995* (NT) was overturned by the Federal Government pursuant to its constitutional power to legislate for the territories: *Euthanasia Laws Act 1997* (Cth). The first attempt at law reform occurred in 1993, with the Voluntary and Natural Death Bill 1993 (ACT). Since then, over 60 Bills have been introduced in various Australian jurisdictions seeking to legalise assisted dying: Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser, and Andrew McGee "(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics" (2016) 39(1) *University of New South Wales Law Journal* 1.

[10] The *Voluntary Assisted Dying Act 2017* (Vic) ('Victorian Act') commenced on 19 June 2019.

[11] The *Voluntary Assisted Dying Act 2019* (WA) was enacted on 10 December 2019, and is expected to commence mid-2021.

[12] Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (First Report, 23 August 2018) ('WA Committee Report').

[13] Department of Health, Government of Western Australia, *Ministerial Expert Panel on Voluntary Assisted Dying* (Final Report, June 2019) ('WA Expert Panel Report').

[14] Select Committee on End of Life Choices, Parliament of the ACT, *Select Committee on End of Life Choices in the ACT* (Report, March 2019) 89.

[15] Ibid 94. For this to occur, the Commonwealth would need to repeal the *Euthanasia Laws Act 1997* (Cth).

[16] In Queensland, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the Queensland Parliament released an Issues Paper: Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Parliament, *Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying* (Paper No 3, 14 February 2019). The inquiry is due to report in March 2020.

[17] In South Australia, the Joint Committee on End of Life Choices was established on 4 April 2019, and received submissions until 2 August 2019: Parliament of South Australia, *End of Life Choices* (Web Page) <http://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=2&CId=366>.

[18] The phrase is Coroner Caitlin English's: Victorian Committee Report (n 7) 197.

they have no alternative but to commit suicide when faced with irremediable pain and suffering or irreversible physical decline. Both the Victorian and Western Australian parliamentary committees were deeply affected by coronial evidence, as well as anecdotal reports, of suicides committed by people with terminal illnesses or suffering physical pain or deterioration.[19] In many of these cases, the death is violent, and some are unsuccessful. In addition to these suicides, they were also influenced by the prospect of friends or relatives, in cases such as Penelope Blume's, facing criminal prosecution for unlawfully assisting a loved one to die.

This paper aims to evaluate whether, had VAD been legal, these terrible deaths – some in lonely isolation, and others exposing family members or friends to the risk of criminal prosecution – might have been prevented. As the Victorian Parliament's Legal and Social Issues Committee stated: 'While it is impossible to know whether people would have availed themselves of the option of assisted dying if it existed, the evidence suggests that decisions to suicide are desperate and occur in the absence of a less devastating alternative.'[20]

Section 2 of this paper outlines the claim that legalising VAD is necessary to prevent 'bad deaths', whether by suicide, assisted suicide or 'mercy killing'. Next, section 3 provides an overview of the circumstances in which VAD is permitted in Victoria under the *Voluntary Assisted Dying Act 2017* (Vic) ('Victorian Act'), and Western Australia under the *Voluntary Assisted Dying Act 2019* (WA) ('WA Act).

Sections 4 and 5 then test the claim whether the availability of VAD could address these bad deaths. These sections evaluate two important sources of evidence advanced in debates leading up to the Victorian Act and the WA Act. In section 4, the coronial evidence from Victoria and Western Australia relating to suicides in the chronically and terminally ill is summarised and compared with the criteria for eligibility requirements under the Victorian Act and the WA Act. Section 5 considers Australian cases on assisted suicide and 'mercy killings', and evaluates these cases against the

[19] Victorian Committee Report (n 7) 173–180, 193–200; WA Committee Report (n 11) 138–146.
[20] Victorian Committee Report (n 7) 200.

eligibility criteria in the Victorian Act and the WA Act. 'Mercy killing' is not a legal term, but refers to 'an intentional killing which is prima facie murder but which is carried out for compassionate motives, often by a member of the family or a friend of the victim'.[21] It encompasses both cases where the person has decision-making capacity and requests to die, and where the person does not request assistance to die, but the act intended to cause death is motivated by a desire to relieve the person's pain or suffering. These cases are generally prosecuted as murder, or sometimes manslaughter (where a mitigating factor such as diminished responsibility or a suicide pact is present).[22]

The paper concludes that many of these cases of suicide, assisted suicide and mercy killing would not be eligible for VAD under the Victorian or Western Australian models. This is for two main reasons: because people with a variety of illnesses - not just terminal illness - have requested assistance to die; and because of the prevalence of mercy killings when the person lacks capacity or does not request assistance to die. 'Bad deaths' therefore may continue to occur in Victoria and Western Australia despite their VAD legislation, and are also likely to persist in other Australian jurisdictions if similarly narrow VAD laws are enacted.

II THE NEED TO PREVENT 'BAD DEATHS'

It is sometimes suggested that legalising VAD is necessary to prevent terminally or chronically ill people from committing suicide,[23] or from asking friends or family to assist them in their wish to die. Writing in 1993, Margaret Otlowski stated:

---

[21] Otlowski, Margaret, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17 *Criminal Law Journal* 10, 10.

[22] In other cases, facts amounting to murder or attempted murder have been prosecuted as lesser offences, such as manslaughter or assisting suicide, according to plea bargaining principles or in the exercise of prosecutorial discretion: Ibid 16–18. See also Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17 *Journal of Law and Medicine* 532, 547.

[23] Studies of suicide in the medically and terminally ill, or in the elderly, have not generally suggested this. See Phillip Kleespies, Douglas Hughes and Fiona Gallacher, 'Suicide in the Medically and Terminally Ill: Psychological and Ethical Considerations' (2000) 56(9) *Journal of Clinical Psychology* 1153; Yu Wen Koo, Kairi Kõlves and Diego De Leo, 'Suicide in older adults: differences between the young-old, middle-old, and oldest old' (2017) 29(8) *International Psychogeriatrics* 1297; D Lawrence et al, 'Suicide and attempted suicide among older adults in Western Australia' (2000) 30(4) *Psychological Medicine* 813.

> [I]f active voluntary euthanasia and doctor-assisted suicide were legalised, many cases of mercy killing by family or friends would be unnecessary. In quite a number of the cases dealt with in this study the deceased was either terminally or incurably ill, had expressed a wish to die, and had requested assistance in bringing about death. The defendant's response in complying with that request was, in most instances, a desperate act, reluctantly performed in the absence of any other perceived alternatives … If medically administered euthanasia or assisted suicide were an option for terminal or incurable patients, the defendants in these cases would probably not have felt compelled to take the matter into their own hands.[24]

It is asserted that regulating VAD will allow these people a 'good death': that is, a painless and quick death at the time of their choosing, rather than resorting to a desperate and often unlawful act, with a significant risk of failure, which must either be performed in the absence of any support from friends or family, or runs the risk of criminal prosecution and conviction of those providing support or assistance. This perspective received support in the Victorian and Western Australian parliamentary committees, and during the parliamentary debates in Victoria and Western Australia.

A *Parliamentary committees*

Both committees referred to evidence that significant numbers of people in their States were dying 'bad deaths'. Two types of bad deaths identified. First, some people chose suicide rather than dying in pain (whether pain from a terminal and degenerating condition such as cancer, or from a chronic condition such as arthritis) or experiencing ongoing deterioration and loss of function from progressive conditions such as motor neurone disease or dementia.[25] Secondly, some people unlawfully sought the assistance of relatives to die rather than commit suicide alone.[26]

[24] Otlowski (n 20) 38–39.
[25] Victorian Committee Report (n 7) 197–200.
[26] Ibid 173–180.

1 *Suicides*

Coronial evidence was presented to both the Victorian and Western Australian parliamentary inquiries concerning suicides committed by people suffering terminal and chronic illnesses.[27] Many of these people were elderly and frail, and frequently ended their lives alone, in secret, often by drastic or violent means.[28] The Victorian committee cited 'particularly disturbing evidence that around 50 Victorians a year are taking their lives after experiencing an irreversible deterioration in physical health.'[29] Victorian Coroner John Olle expressed the opinion that palliative care or support services could not reduce these deaths and that only making VAD legally available would assist: '… the people we are talking about in this small cohort have made an absolute clear decision. They are determined. The only assistance that could be offered is to meet their wishes, not to prolong their life.'[30] The Victorian committee accepted the Coroner's opinion.[31]

Similarly, coronial information in Western Australia indicated that over 10% of suicides are committed by people with a terminal, chronic or neurological condition.[32] The Western Australian parliamentary committee opined that some of these suicides were preventable if VAD were available. Finding 33 of the committee's report stated that the 'prohibition of a peaceful, assisted death has driven some terminally or chronically ill individuals to suicide using violent means'.[33]

The Western Australian committee went further than the Victorian parliamentary committee. It found that some people with terminal or chronic illnesses are choosing to take their lives early for fear of

[27] Coronial data prepared for the Queensland parliamentary inquiry does not differentiate between terminal or chronic conditions: National Coronial Information System, 'DATA REPORT DR19-26 Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland, 2016–2017' (Report, July 2019) <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2018/AgedCareEOLPC/cor-23Jul2019.pdf>.
[28] Victorian Committee Report (n 7) 169. An extreme example is the elderly man who committed suicide using a nail gun: Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy). Similarly, the WA Committee found that several elderly people had died by hanging or gunshot wound, and one had ingested a fatal quantity of weed killer: WA Committee Report (n 11) 141–142.
[29] Victorian Committee Report (n 7) 197.
[30] Ibid 172.
[31] Ibid 200.
[32] 199 out of 1720, or 11.5%: WA Committee Report (n 11) 140.
[33] Ibid 146.

losing physical or mental capacity to do so at some later stage,[34] or after receiving an unfavourable diagnosis.[35] This argument has also been accepted by courts in Canada and New Zealand.[36] Internationally, evidence supports the claim that this does occur in a percentage of suicides every year,[37] although reliable data on this point is unavailable domestically.

Police and coroners also reported community perceptions that some suicides in cases of terminal and incurable illness occur because VAD is not a lawful option. Victorian Coroner Caitlyn English referred to a case where a 93-year-old woman with crippling arthritis and back pain slit her wrists after she was admitted to an aged-care facility 'and she died of exsanguination with her arm dangling over the toilet bowl'.[38] Her daughter's view, which the Coroner found 'very compelling' was that there should be 'a better way that their loved ones did not have to die in such violent circumstances and alone.'[39] Acting Commander of the Victorian Police, Rod Wilson, also described the 'desperation' and 'frustration' felt by family that their loved ones were forced to commit suicide in violent, lonely circumstances because there was no alternative.[40]

2 *Assisted suicides and mercy killings*

The Victorian committee also detailed a number of Victorian cases where family or friends had been prosecuted for killing or assisting a loved one to die. It noted that a consistent theme of the cases is the 'remarkable degree of leniency shown to offenders, even though there was a clear violation of the criminal law'.[41] Unlike Otlowski, the Victorian committee stopped short of explicitly recommending VAD as a mechanism to render these cases unnecessary. However, the Committee did note the

[34] Finding 34, ibid xxiv. See also ibid 144–145.
[35] For example, William Philip gave evidence about his wife's attempt to commit suicide by overdose of prescription morphine when she received her diagnosis of adenoma: ibid 142–143.
[36] See *Seales v A-G* [2015] 3 NZLR 556, [29] (Collins J); *Carter v Canada (Attorney General)* [2012] BCSC 886, [1322] (Lynn Smith J); *Carter v Canada (Attorney General)* [2015] 1 SCR 33, [57]–[58].
[37] *Seales v A-G* (n 34) [51]–[52] (Collins J); *R (on the application of Nicklinson and another) v Ministry of Justice* [2015] AC 657, [14] (Lord Neuberger).
[38] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 7 (Caitlin English, Coroner).
[39] Ibid.
[40] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 15 (Rod Wilson, Acting Commander, Victorian Police).
[41] Victorian Committee Report (n 7) 173.

unsuitability of the law to achieve a just outcome in cases of mercy killings,[42] and questioned whether the law 'reflects the contemporary values of the Victorian community'.[43]

The Western Australian parliamentary committee's report did not expressly address mercy killing cases, possibly because—unlike Victoria—no cases of mercy killing have been reported in the last 20 years in that State.

B *Parliamentary debates*

Perhaps because of the coronial evidence and the findings of the parliamentary committees, these 'bad deaths' were considered at length during both the Victorian and Western Australian parliamentary debates.

1 *Suicides*

During debate on the Voluntary Assisted Dying Bill 2017 (Vic), numerous Members of Parliament ('MPs') mentioned terrible examples of individuals who had committed suicide rather than endure terminal or chronic illness.[44] Some were personally known to the MPs, others were told to them by constituents, and still others came from media reports or the evidence of the coroners. A particularly tragic example, mentioned by several MPs, was the case of a 90 year old man with brain cancer who killed himself with a nail gun.[45]

In Western Australia, a similar theme of suicide in the terminally and chronically ill was prominent in the parliamentary debate.[46] In particular, many MPs referred to the death of Clive Deverall, the former president of the Cancer Council of Western Australia, and a long-term sufferer of non-

[42] Ibid 176.
[43] Ibid.
[44] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy); 3056 (Daniel Andrews, Premier); 3081 (Martin Foley).
[45] Ibid 3054 (Emma Kealy); 3056 (Daniel Andrews, Premier); Victoria, *Parliamentary Debates*, Legislative Assembly, 18 October 2017, 3230–3231 (David Morris).
[46] See, eg, Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 5988–5989 (Mark McGowan, Premier); 6069 (Lisa Baker); 6076 (Matthew Hughes); 29 August 2019, 6139 (Yaz Mubarakai); 6158 (Jessica Shaw); 3 September 2019, 6313 (Roger Cook).

Hodgkin's lymphoma, who committed suicide on the day of the Western Australian election in 2017, making the statement 'suicide is legal, euthanasia is not'.[47] Several MPs commented that they were supporting the WA Bill in honour of Deverall's memory.[48]

Some MPs in both States had personal experience as emergency first responders attending the suicides of people with terminal and chronic illnesses. The Victorian member for Frankston, Mr Edbrooke, spoke of his personal experience serving as a firefighter, and attending trauma scenes of botched suicide attempts by terminally ill people. His evidence was graphic and compelling:

> They have lungs filled with fluid and are at risk of drowning in their own fluids. They have been unable to take a breath for a long time and are literally suffocating. They may be a fraction of their former weight. They may be in unimaginable pain and unmanageable pain. These are people begging their families to help them die, starving themselves to death over a month, stopping their dialysis or hoarding tablets to take a lethal dose.[49]

In Western Australia, Mr Folkard, the member for Burns Beach and a former senior police officer, similarly stated he had attended so many deaths over the years relating to chronic illness that they were too numerous to quantify: 'I have seen simple suicides after individuals have been advised that they have a terminal illness. Some have jumped in front of trains. I have even been to situations in which individuals have created complicated machines and used them to take their own lives.'[50]

The coronial evidence and anecdotal reports of suicide among terminally ill people deeply affected many MPs and influenced their desire to legalise VAD.[51] As member for Williamstown, Mr Noonan, stated: 'I cannot accept in those circumstances that maintaining the status quo, whilst people with

---

[47] Claire Moodie, 'Cancer pioneer Clive Deverall's death puts spotlight on voluntary euthanasia laws', *ABC News* (online, 22 March 2017) <https://www.abc.net.au/news/2017-03-22/cancer-pioneer-clive-deveralls-death-spotlight-on-euthanasia/8376890>.
[48] Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 5995 (John McGrath); 5989 (Mark McGowan, Premier); 6073 (Simone McGurk); 29 August 2019, 6093 (John Quigley); 6106 (Peter Rundle); 6138 (Yaz Mubarakai).
[49] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3133 (Paul Edbrooke). The member for Gippsland East had heard similar stories from police and paramedics: at 3135 (Timothy Bull).
[50] Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6132 (Mark Folkard).
[51] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3100 (Janice Edwards). See also at 3118 (Marsha Thomson).

incurable health conditions are killing themselves at a rate of one a week, is in any way acceptable. … The only sensible conclusion to draw from this is that the end-of-life care legal framework must be changed.'[52]

Several MPs, both in Victoria and Western Australia, made a clear link with VAD laws, which would prevent these types of desperate suicides, and give an individual the option 'to die peacefully at a time of his [sic] choosing, surrounded by loved ones and on his own terms'.[53] Some appeared to erroneously believe that all the suicides referred to by the coroners were of people with terminal illness who would be eligible for VAD,[54] whereas in fact these statistics (as will be discussed in section 4 below) included people who were both terminally and chronically ill (the latter not being eligible).

Not all MPs made the same link between these deaths and VAD. A smaller number of MPs considered the coronial evidence showed a problem with other underlying issues, such as mental illness,[55] loneliness and isolation,[56] inability to pursue enjoyable activities,[57] or chronic and unrelieved pain.[58] The member for Burwood, Mr Watt, was concerned about the use of suicide statistics to justify VAD, and observed that less than half of the suicides referred to by the coroners involved people with terminal illness.[59]

---

[52] Ibid 3097 (Wade Noonan).
[53] Ibid 3069 (Gabrielle Williams); 3097 (Wade Noonan); 3132 (Timothy McCurdy); 3118 (Marsha Thomson). Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6095 (Donald Redman) 6109 (Lisa O'Malley); 6110 (Amber-Jade Sanderson); 6134 (Cassandra Rowe); 3 September 2019, 6310 (David Michael).
[54] Western Australia, *Parliamentary Debates*, Legislative Assembly, 28 August 2019, 6069 (Lisa Baker); 6076 (Matthew Hughes); 29 August 2019, 6114 (Elizabeth Mettam); 3 September 2019, 6283 (Antonio Krsticevic).
[55] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3088 (Graham Watt).
[56] Ibid.
[57] Ibid.
[58] Ibid 3058 (Robert Clark). See also at 3088 (Graham Watt).
[59] Mr Watt observed that 119 of 240 relevant Victorian suicides between 2009 and 2013 had chronic health issues or pain, but were not terminally ill:

> Of the remaining 121 with cancer or degenerative brain disorders, it is unclear how many had a prognosis of 12 months or less to live at the time of their suicide. So perhaps 24 suicides per year were of terminally ill Victorians. The Minister for Health should be careful about her facts on such an important issue. She has at least doubled the numbers in her count.

Ibid 3087 (Graham Watt).

2 *Assisted suicides and mercy killings*

Some MPs also mentioned people who were assisted to die by family members or medical professionals outside the law. 'There are people who are having all kinds of interventions by untrained family members, by doctors acting in a way that they would rather not and by nursing staff to take their lives in ways not contemplated by this Parliament and without any of the safeguards.'[60]

In Western Australia, Mr Folkard, the member for Burns Beach, stated that as a senior police officer, he had attended

> countless sudden death scenes that related to people passing from chronic illness. ... I have attended murder-suicides where partners have killed sick loved ones and then taken their own lives. I have attended scenes when partners have attempted to kill their sick loved ones and then taken their own lives, but have failed in taking the life of the sick partner, resulting in that partner dying in loneliness. I have attended scenes at which a partner has taken the life of a sick loved one but has been unsuccessful in taking their own life and has become nothing more than a living vegetable.[61]

Although there are no reported cases of people being prosecuted for their part in these murder-suicides in Western Australia, this evidence demonstrates that mercy killings are occurring in that State as they are in other States where prosecutions are recorded.

Many MPs felt that regulating VAD was a preferable way to 'monitor and manage this existing practice [of VAD]'.[62] This sentiment is best expressed in the submission of Dr Julia Anaf, who stated:

> Pre-emptive suicide, often by horrendous means, and so-called 'mercy killings' are both tragic consequences of the legal status-quo, and are an indictment on a civilised society. Until the law is changed there is a terrible legacy; both for the patient and their loved ones who face a complicated grief process.[63]

[60] Ibid 3060 (Martin Pakula, Attorney-General); 3062 (Samuel Hibbins).
[61] Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 August 2019, 6132 (Mark Folkard).
[62] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy).
[63] Dr Julia Anaf, personal submission, quoted in Victorian Committee Report (n 7) 197.

III ELIGIBILITY AND VOLUNTARINESS REQUIREMENTS FOR VAD

In Victoria and Western Australia, VAD is (or will be) lawful in a narrow set of circumstances. As outlined in more detail below, a person must be an adult,[64] with decision-making capacity,[65] who is a resident of the State[66] and has a condition that is advanced, progressive and will cause death within six months or 12 months for a neurodegenerative condition.[67] In Victoria, the condition is also required to be 'incurable'.[68] The condition must also cause suffering that cannot be relieved in a way that the person considers tolerable.[69] In addition to being eligible, the person must make a voluntary request for assistance to die.[70] Providing assistance to a person with capacity who has not requested it, or who lacks capacity, is not permitted, and remains a criminal offence in all jurisdictions.[71] Although the primary mode of death authorised under the Victorian Act is self-administration by the person,[72] administration of a lethal substance by a medical practitioner is also lawful if the person lacks the ability to physically ingest or swallow a lethal medication themselves.[73] The term VAD encompasses both of these practices. The WA Act also proposes self-administration as the default approach but more readily permits administration by a medical practitioner on grounds that self-administration would be considered 'inappropriate'.[74]

[64] Victorian Act s 9(1)(a); WA Act s 16(1)(a).
[65] Victorian Act s 9(1)(c); WA Act s 16(1)(d).
[66] Victorian Act s 9(1)(b); WA Act s 16(1)(b).
[67] Victorian Act s 9(1)(d), 9(4); WA Act s 16(1)(c)(i) and (ii).
[68] Victorian Act s 9(1)(d)(i).
[69] Victorian Act s 9(1)(d)(iv); WA Act s 16(1)(c)(iii).
[70] Victorian Act ss 20(1)(c), 29(1)(c), s 65(2)(a)(ii), 66(1)(c); WA Act s 16(1)(e).
[71] In both Victoria and Western Australia, intentional killing of another person is murder: *Crimes Act 1958* (Vic) s 3; *Criminal Code Act 1913* (WA), s 279(4). However, it may be prosecuted as manslaughter if extenuating circumstances, such as diminished responsibility, exist: *Crimes Act 1958* (Vic) s 5; *Criminal Code Act 1913* (WA), s 280(1). In Victoria, the specific statutory crime of manslaughter by suicide pact also exists: *Crimes Act 1958* (Vic) ss 6B(1), 6B(1A).
[72] Victorian Act ss 45, 47.
[73] Referred to as 'practitioner administration': Victorian Act ss 46, 48.
[74] WA Act s 56(2).

A *Eligibility requirements*

1 *Adult*

Only a person aged 18 years or over is eligible to access VAD in Victoria or Western Australia.[75]

2 *Capacity*

To be eligible, a person must have decision-making capacity specifically in relation to VAD.[76] In Victoria, decision-making capacity is defined as comprising four abilities: to understand relevant information, to retain that information for the purposes of making a decision about VAD, to use or weigh that information in making a decision, and to communicate the decision.[77] In Western Australia, the criteria are broadly similar, although there is no explicit requirement to retain information to make a decision about VAD.[78]

3 *Condition is incurable, advanced, progressive and will cause death*

The Victorian Act permits a person to receive assistance to die if the person has an incurable disease, illness or medical condition that is advanced, progressive and is expected to cause death within six months.[79] The WA Act follows the Victorian approach but does not require the condition to be incurable.[80] The timeframe to death is extended in both models to 12 months for neurodegenerative conditions.[81]

Disability and mental illness alone are not grounds to request VAD,[82] but a person with a disability or mental illness who is also suffering from a terminal medical condition may be eligible for VAD if he or she meets the other eligibility criteria.

---

[75] Victorian Act s 9(1)(a); WA Act s 16(1)(a).
[76] Victorian Act s 9(1)(c); WA Act s 16(1)(d).
[77] Victorian Act s 4(1).
[78] The WA Act also sets out in more detail the information and matters that must be understood: WA Act s 6(2).
[79] Victorian Act s 9(1)(d).
[80] WA Act s 16(1)(c)(i) and (ii).
[81] Victorian Act s 9(4); WA Act s 16(1)(c)(ii).
[82] Victorian Act s 9(2)-(3); WA Act s 16(2).

4 *Suffering*

Both the Victorian Act and the WA Act require that the person must be experiencing suffering caused by the condition that cannot be relieved in a manner that the person considers tolerable.[83] Whether this eligibility requirement would have been met in the cases of suicides, assisted suicide or mercy killing considered in sections 4 and 5 will not be discussed further in this paper. That is, we will consider whether the other VAD eligibility requirements would be met *on the assumption that the person is experiencing intolerable suffering*. We take this approach for two reasons. Firstly, it is reasonable to assume that a person who chooses to suicide in the circumstances discussed in section 4 would be suffering, as they would not otherwise take such action. The same assumption is reasonable for cases of assisting a suicide. For cases of mercy killing, the accused would have at the very least perceived the person to be suffering, although the authors accept that this perception may not correspond to the person's actual suffering. Secondly, and more importantly, it is not possible to make a categorical determination of whether intolerable suffering was present in the suicide, assisted suicide, or mercy killing cases, as such determinations were not needed from the coronial review or in the criminal law cases.

5 *Residence requirement*

A final criterion under both the Victorian Act and the WA Act is that the person requesting VAD must have been ordinarily resident in the State for at least 12 months before making the first request.[84] The residence requirement raises issues which are distinct from the central argument of this paper, so will not be discussed further.

B *Voluntary request for VAD*

Even if the person is eligible to access VAD under the Victorian Act or WA Act, the person must make a voluntary request for assistance to die. Under the Victorian model, each medical practitioner

[83] Victorian Act s 9(1)(d)(iv); WA Act s 16(1)(c)(iii).
[84] Victorian Act s 9(1)(b); WA Act s 16(1)(b).

assessing a person's eligibility must certify that the request was made 'voluntarily and without coercion'.[85] A medical practitioner administering VAD must also certify that the request for practitioner administration was made voluntarily and without coercion.[86] In Western Australia, this requirement of voluntariness is specifically included as part of the eligibility criteria.[87]

IV SUICIDES IN THE TERMINALLY AND CHRONICALLY ILL

As mentioned, evidence was presented to both the Victorian and Western Australian parliamentary committees concerning suicides committed by terminally and chronically ill people. The Victorian and Western Australian Coroners provided statistical estimates of the scale of the problem, broken down according to the condition from which the person was suffering. The Coroners also provided case reports detailing the circumstances of particular cases, to provide a human context for the problem. This was supplemented by reports from individual relatives and friends recounting the suicides of loved ones. This section considers that evidence and whether the cases reported would be eligible for access to VAD under the Victorian and Western Australian models outlined above.

At the outset, it is important to note that this analysis is inevitably limited, because it depends on the Coroners' summaries of cases, and statistics prepared by the Coroners and their researchers. Without access to coronial files, this analysis can only be partial and conclusions can only be tentative. The following analysis depends on two data sets from Victoria and one data set from Western Australia, each of which was generated by researchers by reference to their own guidelines. The publicly available data includes the Coroners' submissions to the Parliamentary committees in both Victoria[88]

[85] Victorian Act ss 20(1)(c), 29(1)(c).
[86] Victorian Act s 66(1)(c). For practitioner administration, the independent witness must also attest that the request for VAD was made voluntarily and without coercion: Victorian Act s 65(2)(a)(ii).
[87] WA Act s 16(1)(e).
[88] Coroner's Court of Victoria, Submission No 755 to Legal and Social Issues Committee, *Inquiry into End of Life Choices* (26 August 2015) ('Victorian Coroner's Court Submission 755'); Coroner's Court of Victoria, Submission No 1037 to Legal and Social Issues Committee, *Inquiry into End of Life Choices* (20 May 2016) ('Victorian Coroner's Court Submission 1037').

and Western Australia;[89] and the oral evidence given by Coroners to the committees.[90] The data are not directly comparable across jurisdictions, and indeed, there are inconsistencies evident even within a jurisdiction.[91] Nonetheless, this analysis is important, because the publicly available summaries of the coronial data were relied on by many members of Parliament in reaching the conclusion that law reform to permit VAD was necessary and desirable.[92]

A *Victoria*

In Victoria, the Coroners Prevention Unit, an internal research group within the Coroners Court, conducted an analysis of all suicides between 2009 and 2012. The data was prepared at the request of Coroner Caitlin English, who had carriage of a number of suicide cases where the deceased experienced an irreversible decline in physical health.[93] The Coroner did offer to make full versions of the findings in all these cases available to the committee, but this offer was not taken up.[94] Supplementary summary statistics were later prepared by the Coroners Prevention Unit at the request of the parliamentary committee, after two of the Coroners gave oral evidence before the committee.[95]

The initial data from 2009-2012 identified a cohort of suicides committed by people suffering "irreversible deterioration in physical health".[96] The criteria for inclusion were:[97]

---

[89] Coroner's Court of Western Australia, Submission to Joint Select Committee on End of Life Choices, Parliament of Western Australia, *Questions on Notice from Public Hearing* (11 April 2018) ('Coroner's Court of Western Australia Submission').
[90] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015; Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018.
[91] An example of this is that the National Coronial Information Service initially reported that 240 cases over the period 1 January 2012 to 5 November 2017 involved a terminal or debilitating illness: National Coronial Information Service, *Intentional Self-harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012–2017* (Coronial Report: CR17-61, 6 November 2017) 4 ('NCIS Nov 2017'). It later reported that 41 cases were erroneously included, and there were in fact 199 cases which involved either a terminal or debilitating illness: National Coronial Information Service, *Intentional Self-harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012–2017* (Coronial Report: CR17-61.1, 24 May 2018) ('NCIS May 2018').
[92] See section 2 above.
[93] Victorian Coroner's Court Submission 755 (n 88) 3. The research was requested to assist in making a submission to the inquiry: ibid 6.
[94] Ibid, 5.
[95] Victorian Coroner's Court Submission 1037 (n 88) 1.
[96] This term was not defined in the Coroner's submissions, but the inclusion and exclusion criteria provide some indication of the scope of the term.
[97] Victorian Coroner's Court Submission 755 (n 88) 3.

- Deterioration in physical health as a result of a diagnosed terminal disease (the period of time considered to be 'terminal' was not specified);
- Deterioration in physical health as a result of an incurable chronic disease that was not expected to cause death; and
- Permanent physical incapacity and pain, as a result of an injury, that could not be relieved.

Cases were excluded where:[98]

- the deterioration in physical health was a symptom or manifestation of mental ill health;
- there was insufficient evidence to conclude the disease was incurable;
- there was insufficient evidence to conclude that the deterioration was irreversible; or
- the deceased was elderly and feared future loss of independence, isolation or deterioration, but there was insufficient evidence to conclude that the deterioration had already occurred.

There were 197 of these cases, representing 8.6% of suicides over that period.[99] Table 1 summarises the information provided by the Victorian Coroner.

Table 1: Victorian suicides for irreversible physical decline 2009–2012[100]

Percentage of suicides[101]	**Condition**	**Examples**
40%	Cancer	
24%	Multiple medical interrelated issues which are incurable and deteriorating	• heart disease, prostate issues and lumbar spinal osteoarthritis • diabetes, stroke, hypertension and heart disease

[98] Ibid 3-4.
[99] Evidence to Standing Committee on Legal and Social Issues, Inquiry into End-of-Life Choices, Parliament of Victoria, Melbourne, 7 October 2015, 3 (John Olle, Coroner).
[100] Ibid 5 (Dr Jeremy Dwyer). Dr Dwyer leads the Coroners Prevention Unit, a specialist research unit within the Coroners Court of Victoria.
[101] Dr Dwyer divided these suicides into physical illness (80%) and physical injury (20%), then subdivided the cases of physical illness into 50% cancer cases, 30% with multiple medical issues, 15% incurable conditions and 5% unrelievable pain. We have re-calculated these numbers as a percentage of the total number of suicides attributable to irreversible decline, whether from physical illness or physical injury, which accounts for the divergence from Dr Dwyer's figures.

		• breast cancer, hypertension, spondylosis, pancreatic cyst and shingles
12%	Advanced and incurable conditions	• cerebral palsy • Parkinson's disease • multiple sclerosis • muscular dystrophy • degenerative brain and nerve disorders
4%	Unrelievable pain disorders	
20%	Major physical injury followed by long-term slow decline in quality of life	• motor vehicle accident • workplace injury

The Coroners Prevention Unit provided a supplementary submission to update this information to include cases from 2013 (making a total of 240 deaths from irreversible physical decline between 2009 and 2013).[102] Unfortunately the presentation of the data does not allow for Table 1 to be updated, but information was provided about means of death for this updated cohort. The greatest number, approximately one third, of these deaths occurred by poisoning due to drug overdose,[103] but many of these deaths occurred by violent methods, such as hanging,[104] gunshot wound, or stabbing. Nineteen deaths occurred by a threat to breathing, most of which used the 'Exit bag method championed by Exit International, usually using helium or nitrogen as the irrespirable atmosphere'.[105]

B *Western Australia*

The Western Australian Coroner also provided a report in relation to suicides in Western Australia where the deceased had a 'terminal or debilitating illness'.[106] This report was prepared by the National Coronial Information System (NCIS), an independent national repository of coronial data, at the request of the State Coroner, to assist in the preparation of a submission to the parliamentary

[102] Victorian Coroner's Court Submission 1037 (n 88) 4.
[103] 74 deaths out of 240: ibid 6. See also Victorian Committee Report (n 7) 171–2.
[104] 64 out of 240: Victorian Coroner's Court Submission 1037 (n 88) 6.
[105] Ibid 5.
[106] NCIS May 2018 (n 91). Neither the term 'terminal' nor the term 'debilitating' is defined in the NCIS report, so it is unclear what criteria the researchers used to include or exclude cases on this basis.

inquiry.[107] Cases were identified for manual screening by searching 37 key words, most of which were specific physical or mental conditions (such as cancer, tumour, bipolar, or schizophrenia).[108] The criteria for inclusion or exclusion by the researcher conducting the manual screening were not specified. However, cases were excluded where the suicide was primarily as a result of a mental illness rather than a physical illness.[109]

Based on the report of 199 cases over a period of nearly 6 years, the parliamentary committee estimated that approximately 10% of all suicides in Western Australia are committed by persons suffering from a terminal or debilitating illness.[110]

Suicides occurred in relation to a variety of conditions, and many people suffered from multiple physical conditions. Those most commonly represented were the same as in Victoria, although in different proportions, namely:

- cancer, in approximately 21% of cases (42/199)
- cardiovascular disease, in approximately 32% of cases (64/199)
- diabetes, in approximately 14% of cases (28/199)
- arthritis, in approximately 12% of cases (23/199), and
- Parkinson's disease, in approximately 5% of cases (10/199).[111]

In 100 cases, the deceased person experienced a noted physical decline prior to their death. Of these cases, 48% were considered to be suffering from a terminal condition,[112] whereas 52% had a debilitating but not terminal condition.[113] Of the 99 cases in which there was no physical decline

[107] NCIS Nov 2017 (n 91) 2.
[108] Ibid 3.
[109] Ibid 4. The NCIS noted that in some cases where the deceased had both a physical and a mental illness, it was difficult for the researcher to identify which condition made a more significant contribution to a person's suicide: ibid 4; NCIS May 2018 (n 91) 5. Although this inevitably affects the reliability of the numerical data, it does not significantly impact the qualitative conclusions.
[110] WA Committee Report (n 11) 140.
[111] NCIS May 2018 (n 91) 3. Although the NCIS data are reported as a proportion of 240 cases, 41 cases were erroneously included which involved neither a terminal nor a debilitating illness. The figures provided above are a proportion of the 199 cases which involved either a terminal or debilitating illness. It should also be observed that these statistics are significantly different from those presented in the original NCIS report: NCIS November 2017 (n 91) 4.
[112]NCIS May 2018 (n 91) 8.
[113] Ibid 9.

evident prior to suicide, no breakdown as to the proportion of people suffering from a terminal condition is provided.

As in Victoria, these deaths were carried out by a variety of means, predominantly poisoning (including 17 cases using pentobarbitone),[114] Nineteen cases of plastic bag asphyxiation,[115] and more violent means such as hanging, gunshot, knife injuries, carbon monoxide poisoning and fire related deaths.[116]

C *Will VAD laws prevent these suicides?*

The evidence presented to the parliamentary committees suggests that a significant number of terminally or chronically ill people are committing suicide because they perceive no other alternative is available. However, it is important to consider whether the Victorian Act or the WA Act will address these concerns. While it is difficult to conclusively answer this question, given the incomplete set of publicly available data mentioned earlier, the analysis below suggests that the VAD system may be less effective in reducing suicides than some may have contemplated.

Some of the eligibility criteria would appear to be met. All of the cases of suicide in those with terminal or debilitating illness reported on by the Victorian and Western Australian Coroners involved adults. The decision to commit suicide in each case appeared to be voluntary and not the subject of coercion: indeed, the suicide was often (but not always) an unwelcome shock to those closest to the deceased. Although some of those committing suicide experienced mental illness in addition to their physical conditions, there is no evidence that the mental illness was such as to compromise the decision-making capacity of the deceased or the voluntariness of the decision. Both the Victorian and

[114] 19 cases involving pentobarbitone were manually counted, but two (cases 13 and 25) were excluded as not involving terminal or debilitating illness: ibid.
[115] Table 3 states that 17 cases involved plastic bag asphyxiation, but a manual search of the case summaries reveals 20 cases, of which case 41 was excluded as the person did not have a terminal or debilitating illness.
[116] See generally Table 3: NCIS May 2018 (n 91) 7. Note, however, that these figures include the 41 cases erroneously included (see n 91).

Western Australian data sets employed case selection criteria which specifically excluded cases of suicide where mental illness was a dominant factor.[117]

However, many of these people would not qualify for VAD because they did not have a terminal illness. In Western Australia, of 100 cases involving a person whose physical condition was noted to have declined prior to suicide, less than half had a terminal condition. (In this regard, the authors note that the phrase 'terminal illness' was not defined, so it is unclear whether those who committed suicide would have been diagnosed as having less than six months to live.[118]) Of the remaining 99 cases, where there was no evidence of decline prior to suicide, no data is available on the proportion of people who were suffering from a terminal illness.[119] In Victoria, the coronial data did not expressly distinguish between those whose conditions were terminal and those whose were not.[120] It was noted that 40% of the relevant suicides involved persons with cancer, but it is not stated that all were incurable and that the disease had progressed to a stage where they were expected to have less than six months to live. In cases involving multiple chronic conditions, or a progressive incurable condition such as Parkinson's disease or multiple sclerosis (together 36% of suicides), it is again not clear from the data whether the person's condition had progressed sufficiently to constitute a terminal illness with the relevant 6 or 12 month life expectancy. Those with chronic pain or suffering from a major disability or injury would not qualify for VAD, as neither of those conditions is a terminal illness.

Evidence presented to the Victorian and Western Australian parliamentary committees further demonstrates that people commit suicide for a variety of reasons, only some of which may be

[117] Ibid 4; Victorian Coroner's Court Submission 1037 (n 88) 3.
[118] As is required under the WA Act s 16(1)(c)(ii) unless the terminal condition is neurodegenerative, in which case the time period is 12 months.
[119] The Western Australian Coroner was specifically asked to provide information as to how many people would have a terminal illness and be expected to die within 6 months: Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018, 15. However, the Coroner's office was unable to provide detailed information about the medical diagnosis: Coroner's Court of Western Australia, Submission (n 89) 2.
[120] The criteria for the suicides included in the Coroners Prevention Unit's report used three distinct categories: a diagnosed terminal illness, an incurable chronic disease not necessarily expected to cause death in the near future, and permanent physical incapacity and pain as a result of an injury or accident. These data would have enabled a clearer picture but the number of cases in each of these categories was not reported.

addressed by VAD legislation. The most commonly cited reasons were terminal illnesses such as cancer;[121] progressive degenerative illnesses such as motor neurone disease,[122] multiple sclerosis[123] or Parkinson's disease; severe pain;[124] and pre-emptive death after a diagnosis of dementia.[125]

Neither the Victorian Act nor the WA Act will assist those with debilitating chronic illnesses, such as diabetes, arthritis or chronic pain, or those experiencing progressive decline from an illness which will not on its own lead to death (such as most cases of multiple sclerosis, Parkinson's disease, or loss of abilities consequent on major physical injury). Accordingly, while the Victorian Act or WA Act may lead to a decline in the number of 'bad deaths' by suicide, the above discussion demonstrates that there will still be many cases which fall outside the legal framework.

V CASES ON ASSISTED SUICIDES AND MERCY KILLINGS

Cases where a relative or friend assisted another to die, or took active steps to bring about the death of a loved one, are rarer than the cases of suicide described above. Over a similar period to that in which the Victorian Coroner reported 240 relevant suicides, the Victorian police database recorded only 5 cases of aiding and abetting suicide,[126] none of which were prosecuted.[127]

Nevertheless, assisted suicides and mercy killings do occur in Australia, despite the criminal prohibitions on homicide and assisting suicide. Over the last few decades, there have been several

[121] See Victorian Committee Report (n 7) 194-199. Some of these are pre-emptive deaths after a cancer diagnosis, for example WA Committee Report (n 11) 141–143.
[122] Including pre-emptive suicide rather than endure continued degeneration: WA Committee Report (n 11) 145.
[123] For example, Mark Brennan, suffering from multiple sclerosis, killed himself pre-emptively, alone and in a violent manner, to avoid the risk of being unable to do so at a later stage when his illness had deteriorated: Victorian Committee Report (n 7) 199; WA Committee Report (n 11) 144–145.
[124] Case 7.2 describes a 93 year old woman with crippling pain and arthritis who slit her wrists and died alone in an aged care facility: Victorian Committee Report (n 7) 198. Several cases reported by the Western Australian Coroner also described people in severe and chronic pain who took their own lives: Cases 87, 126, 134, 162 in WA Committee Report (n 11) 141.
[125] Laura Gaal explained how a friend diagnosed with dementia committed suicide by driving head on into a truck: Victorian Committee Report (n 7) 199.
[126] Evidence to Standing Committee on Legal and Social Issues, Parliament of Victoria, Melbourne, 7 October 2015, 15 (Rod Wilson, Acting Commander, Victorian Police). The police records cover the 5 year period from 2010–2014, whereas the coronial evidence relates to the 5 years from 2009–2013. Nevertheless, the comparison is stark.
[127] Acting Commander Wilson observed that in his entire career in homicide squad he had only ever seen one prosecution for aiding and abetting suicide, and that was in the 1980s: ibid 16. (The case referred to is probably *R v Larkin* [1983] Vic SC 122).

prosecutions brought against family and friends for assisting with or causing the death of a loved one.[128] Like the suicides discussed in section 4 above, these cases directly raise the issue that 'bad deaths' are occurring because of the absence of a lawful alternative. Some of the deceased persons,[129] or those who assisted in a suicide[130] were members of Exit International or other pro-euthanasia organisations. Some had received assistance from such organisations, including information on how to import prohibited euthanasia drugs from Mexico,[131] instructions about methods of asphyxiation,[132] email support[133] or visits from Exit members to discuss end-of-life options.[134]

In some of the cases, judges made observations apparently accepting that killing occurred in an environment of increasing societal tolerance or even acceptance of euthanasia. In *Pryor*, for example, where a 45 year old nurse was convicted for assisting her terminally ill father to die, and had earlier attempted to kill her demented mother due to her quality of life in a residential aged care facility, the judge observed: 'Euthanasia was a subject openly discussed in the Grant household'.[135] In *Sutton*, parents killed their son who had severe disabilities and was due to undergo surgery which would deprive him of most of his remaining senses. The father in this case commented that this was necessary 'because there was no euthanasia'.[136]

---

[128] These cases have previously been the subject of detailed analysis in Otlowski (n 20); Bartels and Otlowski, (n 21), and are briefly discussed in Jocelyn Downie, 'Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions' (2016) 16 *QUT Law Review* 84, 103–4. Similar cases have been reported in Canada and New Zealand: see Downie at 100–103; Andrew Geddis 'The case for allowing aid in dying in New Zealand' [2017] *New Zealand Criminal Law Review* 3.

[129] Mrs Rijn was a member of Exit International, and Mrs Godfrey had been 'an outspoken member of first, the Victorian, and later, the Tasmanian, Euthanasia Society': *R v Rijn* (Melbourne Magistrates Court, Mag Lethbridge, 23 May 2011); *R v Godfrey* (Supreme Court of Tasmania, Underwood J, 26 May 2004), 1.

[130] Shirley Justins' friend, Caryn Jenning, was an office holder of Exit International: *Justins v The Queen* [2008] NSWSC 1194, [8].

[131] *R v Nielsen* [2012] QSC 29, 1–7; *Justins v The Queen* (n 130) [16].

[132] Rijn and Maxwell killed themselves in accordance with the helium balloon method they had read about in the 'Final Exit' book: *R v Rijn* (n 129); *R v Maxwell* [2003] VSC 278, [21]. Penelope Blume attended an information evening run by a euthanasia organisation on how to die painlessly: *Police v O* (n 5).

[133] Klinkermann had been in email contact with Exit International: *R v Klinkermann* [2013] VSC 65, [8].

[134] Graeme Wylie was visited by Dr Philip Nitschke, the founder of Exit International in Australia, to assess his capacity for the purposes of applying to Dignitas: *Justins v The Queen* (n 130) [14]–[15]. Frank Ward had two visits from members of Nancy's Friends, a group within Exit International, to discuss end-of-life options and explain how to obtain pentobarbital from Mexico: *R v Nielsen* (n 131) 1–7.

[135] *R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005), 1. Pryor was sentenced to 12 months wholly suspended for assisting her father's suicide, and 18 months wholly suspended for the attempted murder of her mother.

[136] *R v Sutton* [2007] NSWSC 295, [16]. The Suttons were convicted and sentenced to a five year good behaviour bond for the murder of their son.

At times, judges themselves intimate their concern about the harshness of the criminal law in the context of such deaths. In *Klinkermann,* King J commented*:*

> Our law does not permit people to behave in that manner towards other human beings. It is permissible of course to end the life of a suffering animal but in terms of a human being that remains an exceedingly contentious issue in our community and as a result you have been charged with the offence of attempted murder of the wife that you loved and adored.[137]

Some judges have referred to the broader law reform movement in passing sentence. In *Nielsen*, Dalton J compared the facts of that case to 'theoretical legal models that are proposed … for medically-assisted suicide, and the laws in countries where medically assisted suicide is possible'.[138] In *Riordan* and *Rolfe*, Cummins J went so far as to consider academic writings on euthanasia by Glanville Williams and Margaret Otlowski, as well as law reform proposals in England and Victoria, before passing sentence on two elderly gentlemen convicted of the mercy killings of their wives.[139] Nevertheless, judges have been at pains to emphasise that in pronouncing sentence they are not ruling on the merits of VAD law reform: 'the Court's role is to impose a sentence according to the law and not involve itself in any debate on the difficult topic of euthanasia.'[140]

While the case law provides examples of sympathetic statements regarding an accused's motivations for actions[141] as well as lenient sentences, for the purpose of this paper it is important to identify and examine the facts of these cases to determine if the deceased would have been eligible to receive assistance to die under the Victorian Act or the WA Act.

A *Method for identification of cases*

[137] *R v Klinkermann* (n 133) [11], [26].
[138] Ibid.
[139] *DPP v Riordan* (Supreme Court of Victoria, Cummins J, 20 November 1998), 33–34; *DPP v Rolfe* [2008] VSC 528, [28].
[140] *R v Pryor* (n 135) 2; *R v Nestorowycz* [2008] VSC 385, [5]; *DPP v Rolfe* (n 139) [27]–[28]; *R v Nielsen* (n 131) 1–17.
[141] See, eg, *R v Maxwell* (n 132) [2]; *R v Mathers* [2011] NSWSC 339, [85]; *DPP v Riordan* (n 139) 35; *R v Hollinrake* [1992] VSC 289, 40.

This component of the research aimed to identify all publicly available Australian cases (reported or unreported) concerning assisted suicide and mercy killings, and for which there were sentencing remarks or some other formal set of reasons. The departure point for this review was the group of cases identified by Bartels and Otlowski in 2010.[142] Searches were then conducted on Jade Case Citator, seeking to identify all subsequent cases which referred to any of the cases in the Bartels and Otlowski study. The review also included wider and systematic searches for any relevant cases about assisted suicide or mercy killing. Databases searched were Austlii, Jade Case Citator and the unreported judgments repositories of each of the State and Territory Supreme Courts. A range of search terms were employed including 'mercy killing', 'euthanasia', 'compassion NEAR death', 'assisting suicide' and variations of these terms. As noted, the focus of this review was on cases where sentencing remarks or other formal reasons were available, as they contain an authoritative description, at least from a legal perspective, of the facts of a case. However, a small number of matters not available as reported or unreported judgments were included when there was reliable, publicly available information contained in secondary sources[143] or media reports[144] that provided sufficient details to enable those cases to be included in the proposed analysis. For reasons of convenience, we have only included cases where no judgment is available if they occurred after 2000.[145]

Further criteria for inclusion were that family or friends were prosecuted for murder, manslaughter, attempted murder, attempted manslaughter, or assisting suicide, in circumstances where the offender knowingly caused or assisted in the death of another person motivated solely by a compassionate desire to end their suffering. Cases were excluded when:

[142] Bartels and Otlowski (n 21).
[143] *R v Thompson* (Local Court of NSW, Mag Railton, 21 February 2005) reported in Nick Cowdery, 'Dying with Dignity' (2011) 86 *Living Ethics* 12 and Sarah Steele and David Worswick, 'Destination death: a review of Australian legal regulation around international travel to end life' (2013) 21 *Journal of Law and Medicine* 415, 420.
[144] See, eg, the recent case of *R v Nixon* (Supreme Court of Queensland, 7 December 2017) resulted in an acquittal, hence there was no record of judgment and no sentencing remarks. Information concerning this case is derived solely from newspaper reports.
[145] Otlowski's research details a long line of similar cases stretching back to at least the 1960s: Otlowski (n 20) 17, 18, 20, 28. However, as sentencing remarks are not publicly available for these and other older cases, they are not part of this review.

- the motive for the killing appears to be a mistaken conception of mercy caused by psychiatric disturbance[146] or personality disorder in the offender;[147]
- the killing was not pre-meditated but appears to have been a reaction *in extremis* to circumstances of stress, including the burden of care;[148]
- the offender's motivation appears to be malice or self-interest, rather than compassion for the condition of the victim;[149] or
- the killing was claimed to be a mercy killing but this was found not to be established on the evidence.[150]

A further three cases were excluded because, although the motive appeared to be to comply with the expressed wishes of the person seeking assistance to die, the cases involved pre-existing drug users supplying (and in some cases using) heroin to cause death. The involvement of drug users rendered these cases more complicated than traditional mercy killings.[151]

Twenty-seven cases were identified using this method, salient features of which are included in Table 2 below. Whether the deceased in these cases would have been eligible for VAD is explored in more detail below, however at the outset it is important to observe two main points. Firstly, although all cases of assisted suicide involve a person who wishes to die, the mercy killing cases encompass both voluntary requests to die, as well as cases where a person knowingly caused the death of another who had not requested assistance to die, albeit from motives of mercy or compassion towards the victim.

---

[146] See, eg, *R v Cheatham* [2002] NSWCCA 360, where the offender killed his wife and daughter while suffering from the delusional belief that he had infected them with AIDS; *R v Duthie* [1999] NSWSC 1224, where the offender was a prisoner suffering from the effects of drugs when he formed a suicide pact with his cellmate.

[147] An example is the paranoid and anti-social personality of the offender in *R v Howard* [2009] VSC 9.

[148] See, eg, *R v Dawes* [2004] NSWCA 363, where a mother strangled her 10 year old autistic son, affected by numerous personal stressors such as her marriage breakdown, the death of her father, sexual abuse of her daughter, and major depression.

[149] See, eg, *R v Davis* [2016] NSWSC 1362, and *Haines v R* [2018] NSWCCA 269, where nurses in two separate aged care facilities administered large doses of insulin to residents, resulting in their deaths. They were charged with murder.

[150] See *R v McGrath* [2000] NSWSC 419, where the offender initially claimed he killed the victim at his request, and that he had only 6 weeks to live, but he later admitted that he murdered him because of allegations the victim had sexually abused children of friends.

[151] *Carter v A-G* [2003] 2 Qd R 402; (2003) 141 A Crim R 142; [2014] 1 Qd R 111 and *Walmsley v The Queen* (2014) 253 A Crim R 441 involved assisting the suicide of depressed drug addicts. In *R v Cooper* [2019] NSWSC 1042, a woman in chronic physical pain asked her partner to give her a heroin overdose to end her life.

Secondly, these assisted suicide and mercy killing cases involve people suffering a wide range of conditions including those that are not terminal including chronic pain, degenerative illnesses, dementia, mental illness, and disability.

Table 2 below summarises the facts of the cases reviewed that are relevant to assessing eligibility for VAD. Because of the significance of a person's condition in making that assessment, the cases have been grouped by condition. The authors note that in some cases, the victim had more than one type of condition: these cases have been included under a primary condition but are noted with an asterisk below.

Table 2: Assisted Suicide and Mercy Killing Cases

CASE	MEDICAL CONDITION	METHOD OF DYING	CHARGE
TERMINAL ILLNESS GENERALLY			
***R v Maxwell* [2003] VSC 278**	Mrs Maxwell, age 59, was terminally ill with painful and debilitating cancer.	Asphyxiation with helium balloon	Aid and abet suicide
***R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005)**	Ms Pryor's father was a retired doctor who had terminal colon and bowel cancer.	Injections of pethidine and insulin, then asphyxiation	Assisted suicide
***R v Attenborough* (NSW District Court, Graham AJ, 30 May 2019)**	Attenborough's father was in palliative care suffering a twisted stomach, hiatus hernia and heart condition	Overdose of morphine, other drugs and alcohol	Administer a poison with intent to murder
***Police v O* CC2019/3260[152]**	Ms Blume was terminally ill with motor neurone disease, and wanted to commit suicide.	Not stated, but following a method prescribed by a euthanasia organisation	Aiding suicide (charges were later dropped by the prosecution on public interest grounds)

[152] *Police v O* (n 5).

DEMENTIA			
***DPP v Riordan*, (Supreme Court of Victoria, Cummins J, 20 November 1998)**	Mrs Riordan had had advanced Alzheimer's disease for more than a decade, and was in a residential aged care facility. She had no control over her bodily functions, could not feed herself, was barely able to chew, and continuously cried out in a loud and pitiful way.	Not stated	Attempted murder
***R v Pryor* (Tasmanian Supreme Court, Hill AJ, 19 December 2005)**	Ms Pryor's mother had severe dementia and was very difficult to care for. She was discovered by ambulance officers and revived, and died several months later of unrelated causes	Insulin injection (did not succeed)	Attempted murder
R v Klinkermann* [2013] VSC 65	Mrs Klinkermann had severe dementia and Parkinson's disease. Mr Klinkermann did not want to place her in full-time palliative care.	Gassing in bedroom (both survived)	Attempted murder
***DPP v Rolfe* [2008] VSC 528**	Mrs Rolfe had vascular dementia, needed assistance to walk and could no longer communicate. She needed to go into a care home. Mrs Rolfe died but Mr Rolfe was resuscitated by paramedics.	Gassing in bedroom (husband survived)	Manslaughter by suicide pact
***Justins v The Queen* [2008] NSWSC 1194**	Graeme Wylie suffered from advanced Alzheimer's disease. He had made two previous suicide attempts, and had applied to go to Switzerland to access VAD, but his application was rejected due to concerns about his capacity.	Drank Nembutal	Manslaughter (1st trial); Assisting suicide (re-trial)
***R v Nixon* (Supreme Court of Queensland, 7 December 2017)**	Nixon's father, aged 88, had dementia and was unable to walk, or go to the toilet independently.	Drank a dissolved mixture of Valium and oxycodone.	Assisting suicide
CHRONIC PAIN			
***R v Marden* [2000] VSC 558**	Mrs Marden suffered constant pain from severe rheumatoid arthritis. Mr Marden had heart problems and a pacemaker inserted. Their only son's marriage broke down and they lost regular contact with their grandsons.	Electrocution, then suffocation. Mr Marden attempted overdose of pills (survived).	Manslaughter by suicide pact

R v Godfrey **(Tasmanian Supreme Court, Underwood J, 26 May 2004)**	Godfrey's 88 year old mother was chronically ill. She had undergone a bowel resection for colon cancer. She had chronic back pain, severe rheumatic joint pain and was doubly incontinent.	Suffocation with plastic bag	Assisting suicide
R v Mathers **[2011] NSWSC 339**	Mathers' partner, Eva Griffiths, had severe back pain arising from osteoporosis, arthritis and sciatica, and wished to die rather than ending up in a residential aged care facility.	Suffocation with pillow and plastic bag, after overdose of pills	Manslaughter (diminished responsibility)
R v Rijn **(Melbourne Magistrates Court, Mag Lethbridge, 23 May 2011)**	Mrs Rijn suffered chronic hip pain, which could not be relieved by surgery or pain relief.	Suffocation using kit purchased from Exit International	Inciting suicide
DEGENERATIVE CONDITION			
R v Thompson **(Local Court of NSW, Mag Railton, 21 February 2005)**	Thompson's wife had multiple sclerosis. She had been repeatedly saying she did not want to go into a residential aged care facility, or to have palliative care.	Suffocation with pillow after overdose of pills	Aid and abet suicide
STROKE			
R v Tait **(Supreme Court of Victoria, Winneke CJ, 8 August 1972)**	Tait's mother suffered a stroke, leaving her virtually helpless and disoriented in mind. She needed care in a residential aged care facility, which upset her greatly.	Tait slit his mother's throat while she slept	Murder
R v Hollinrake **[1992] Vic SC 289**	Mrs Hollinrake, age 77, had suffered a major stroke.	Mr Hollinrake cut his wife's wrist, then slit his own wrists (both survived).	Attempted murder
DISABILITY			
R v Nicol **[2005] NSWSC 547**	Mrs Nicol had a foot amputated, then developed infection and gangrene and had half her leg amputated. She did not adjust well to the prosthetic limb so became dependent on her husband.	Beating with an iron bar, then suffocating her, before attempting suicide via overdose	Murder (pleaded guilty to manslaughter)

***R v Sutton* [2007] NSWSC 295**	The parents of 29 year old adult man with severe disabilities (Trisomy 13 syndrome) killed him to avoid future planned surgery that would leave him substantially deaf and unable to speak.	Not stated	Manslaughter
R v Nestorowycz* [2008] VSC 385	Mr Nestorowycz was a double amputee with dementia and diabetes. He resided in a nursing home, because his wife could no longer care for him.	Stabbed in stomach then stabbed herself (both survived).	Attempted murder
***R v Dowdle* [2018] NSWSC 240**	Dowdle was the mother of a man who had acquired severe disabilities as a result of a car accident. He had become an alcoholic and drug user and was abusive towards her.	Suffocation with a plastic bag	Manslaughter (substantial impairment)
R v Nielsen* [2012] QSC 29	Mr Ward, a 76 year old man, earlier suffered a minor stroke. He had a subsequent medical event (details unknown) that impaired mobility but not significantly. He did not want medical care or to become dependent on anyone.	Drank Nembutal Nielsen bought for him in Mexico	Assisting suicide
MENTAL ILLNESS			
***R v Larkin* [1983] Vic SC 122**	Larkin's lover had manic depression, and had made several suicide attempts.	Overdose of sleeping pills Larkin then injected him with a fatal dose of insulin	Aiding and abetting suicide
***The Queen v Johnstone* (1987) 45 SASR 482**	Mrs Johnstone had suffered from severe bipolar disorder for 30 years of their 36 year marriage, as well as prolonged alcoholism. She was miserable and suicidal.	Electrocution	Murder
***R v ANG* [2001] NSWSC 758**	ANG's uncle suffered depression and wanted to end his life.	Overdose of pills. Then ANG rolled his body into the river, where he drowned	Manslaughter by criminal negligence
***R v Hood* (2002) 130 A Crim R 473**	Hood's flatmate and former lover had depression and decided to commit suicide, because he had lost his job and his relationship had ended. He arranged a farewell party, at which he told his friends and family (untruthfully) that he had a serious brain tumour, and would rather die with dignity than become a vegetable.	Overdose of pills	Aiding and abetting suicide

***DPP v Karaca & Price* [2007] VSC 190**	Bruce Levin suffered serious depression. He put pressure on Karaca and Price to assist him with his planned suicide.	Levin overdosed on pills. Price then hit him twice over the head with an iron bar (he survived)	Attempted murder

B *Eligibility requirements*

In this section, the cases above are reviewed to determine whether the deceased would have satisfied the individual eligibility requirements of the Victorian Act or the WA Act. While this analysis considers each criterion separately, it is noted that all eligibility criteria must be met to access VAD and this is discussed further below.

1 *Adults*

All cases involved adults, so this criterion of the Victorian Act and WA Act would have been satisfied.

2 *Capacity*

It is not possible to make a categorical determination of whether the deceased would have had capacity in all cases. This is because the focus of a criminal trial is on the actions of the offender. Accordingly, the following conclusions are tentative only, based on the comments made in judicial sentencing remarks, and assumptions about the ordinary impact of illnesses such as cancer and dementia on capacity. Nevertheless, these tentative conclusions are illustrative of the broader point. A review of the above 27 cases reveals the following:

- the deceased appeared to have decision-making capacity in 12 cases;[153]

[153] *R v Maxwell* (n 132); *R v Pryor* (n 135) (assisting the suicide of the father); *R v Attenborough* (NSW District Court, Graham AJ, 30 May 2019); *Police v O* (n 5); *R v Marden* [2000] VSC 558; *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129); *R v Thompson* (n 143); *R v Nicol* [2005] NSWSC 547; *R v Nielsen* (n 131); *R v Dowdle* [2018] NSWSC 240. Although Dowdle's son had sustained a severe disability in a car accident, there was no indication that he lacked decision-making capacity, at least when not under the influence of alcohol and drugs. In *R v Attenborough*, there was 'no suggestion that [the deceased] was suffering from any particular or

- the deceased appeared to lack decision-making capacity in 9 cases; and
- in 6 cases, it could not be reasonably determined whether the deceased had decision-making capacity at the time of death.[154]

Of those cases where the deceased appeared to lack capacity, six involved elderly adults with severe dementia or advanced Alzheimer's disease,[155] two involved elderly women who had suffered a major stroke which significantly affected their cognitive functioning and ability to communicate,[156] and one concerned the death of a severely intellectually impaired young adult at the hands of his parents.[157] While it is not explicitly stated in most of the cases[158] that any of these people lacked decision-making capacity, the description of their level of functioning appears to indicate that they did. For example, Mrs Riordan had advanced Alzheimer's disease causing severe dementia, and was unable to talk or communicate at all.[159]

There were a further six cases where the decision-making capacity of those who made a voluntary request to die may also have been questioned. For example, Mrs Rolfe had vascular dementia, and was unable to communicate, although medical evidence suggested she retained the ability to understand what was being said to her and assent to her husband's suicide pact plan.[160] Similarly, a number of cases involved the deaths of younger people with severe mental illness, whose suicidal ideation may have cast doubt on their decision-making capacity.[161]

3 *Condition is incurable, advanced, progressive and will cause death*

impairing form of mental condition, whether dementia or other mental health issues', although he was in significant pain and at times distressed on account of the pain: at 3.

[154] *DPP v Rolfe* (n 139); *R v Larkin* (n 127); *R v Hood* (2002) 130 A Crim R 473; *DPP v Karaca & Price* [2007] VSC 190; *R v ANG* [2001] NSWSC 758; *The Queen v Johnstone* (1987) 45 SASR 482.

[155] *R v Nestorowycz* (n 140); *DPP v Riordan* (n 139); *R v Pryor* (n 135) (in respect of the mother); *R v Klinkermann* (n 133); *Justins v The Queen* (n 130); *R v Nixon* (n 144).

[156] *R v Tait* (Supreme Court of Victoria, Winneke CJ, 8 August 1972); *R v Hollinrake* (n 141).

[157] *R v Sutton* (n 136).

[158] The exception is *Justins v The Queen* (n 130). In that case, Graeme Wylie's lack of capacity was demonstrated by the fact that some months earlier his application for VAD in Switzerland was rejected by Dignitas, due to concerns about his cognitive capacity. Specifically, the evidence stated that during capacity assessment he was unable to recall his date of birth or the number, age or sex of his children: at [10]–[11].

[159] *DPP v Riordan* (n 139) 28.

[160] *DPP v Rolfe* (n 139) [10].

[161] *R v Larkin* (n 127); *R v Hood* (n 154); *DPP v Karaca & Price* (n 154); *R v ANG* (n 154); *The Queen v Johnstone* (n 154).

Under the Victorian Act, only those who suffer from a condition which is incurable, advanced, progressive and is expected to cause death within 6 months, or a neurodegenerative condition which is expected to cause death within 12 months, will be eligible to seek medical assistance to die.[162] As outlined earlier, the criterion in the WA Act is the same except there is no requirement for the condition to be 'incurable'.

However, the case review reveals that only a small minority of deaths involved a person suffering from a progressive terminal condition. Maxwell's wife and Pryor's father both suffered terminal cancer,[163] Attenborough's father was in palliative care for a range of health concerns and was estimated to have one to three months left to live,[164] and Penelope Blume was in the final stages of motor neurone disease.[165]

Dementia is also a progressive and terminal medical condition for which there is no cure,[166] and seven cases involved the intentional killing of an elderly spouse or parent with dementia.[167] These killings were motivated by compassion for the deceased's perceived poor quality of life, or out of respect for previously expressed wishes.[168] Although dementia is incurable, progressive and will cause death, we cannot state with certainty whether the patients in these cases would have satisfied the criterion of causing death within the prescribed 12 month period set out in the legislation for neurodegenerative conditions.[169]

[162] Victorian Act s 9(1)(d).
[163] *R v Pryor* (n 135); ***R v Maxwell*** (n 132).
[164] *R v Attenborough* (n 153).
[165] ***Police v O*** (n 5).
[166] Mari Lloyd-Williams and Sheila Payne, 'Can multidisciplinary guidelines improve the palliation of symptoms in the terminal phase of dementia?' (2002) 8(8) *International Journal of Palliative Nursing* 370–375.
[167] Five cases involved an elderly spouse: *DPP v Riordan* (n 139); *R v Nestorowycz* (n 140); *R v Klinkermann* (n 133); *Justins v The Queen* (n 130); *DPP v Rolfe* (n 139) [10]. Two cases involved an elderly parent: *R v Nixon* (n 144); *R v Pryor* (n 135) (in relation to Pryor's mother).
[168] See, eg, *R v Pryor* (n 135) (in relation to Pryor's mother); *Justins v The Queen* (n 130).
[169] Further, as noted above, six of these seven adults would be unlikely to have satisfied the capacity criterion for VAD under the Victorian Act or the WA Act. The exception is *DPP v Rolfe* (n 139), as described above: at [10].

Of the 27 cases, 4 involved requests for assistance to die from people who were suffering from chronic pain in some form.[170] Two cases involved a person suffering from a degenerative but not imminently fatal illness: Thompson's wife had multiple sclerosis, and Mrs Klinkermann suffered from Parkinson's disease in addition to advanced dementia.[171] These people, although also suffering serious and incurable conditions, would not be eligible for VAD under the Victorian Act or WA Act.[172]

Some of the cases involved people with disabilities who found their situation sufficiently intolerable that they sought to end their lives. For example, disability was the primary reason for Mrs Nicol asking her husband to 'put me out of my misery'[173] as she was not adjusting to the dependency she experienced as an amputee, and did not want to go into care.[174] Fear of future disability or dependence was also the primary motivation of the deceased in *R v Nielsen* in seeking assistance to commit suicide, despite having earlier had only a 'relatively minor' stroke and currently experiencing a loss of function, the cause and duration of which was unknown because of an unwillingness to seek medical advice.[175]

The review also identified cases involving a disability where there was no request to die made by the deceased. Two cases involved elderly people with physical and intellectual impairment following a major debilitating stroke.[176] Mrs Nestorowycz's attempt to murder her disabled husband, who had become a double amputee as a result of diabetes, arose because of concerns about his quality of life. Mr Nestorowycz also had dementia. Similarly, the Suttons, although described as devoted and loving parents, chose to end the life of their severely disabled son because they found it intolerable that he required further surgery which would have deprived him of the ability to communicate. In Victoria

[170] *R v Marden* (n 153); *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129).
[171] Parkinson's disease and multiple sclerosis are progressive and degenerative but are not generally considered terminal, although in some cases they may be when accompanied by other co-morbid conditions: *R v Thompson* (n 143); *R v Klinkermann* (n 133).
[172] Victorian Advisory Panel Report (n 7) 69.
[173] *R v Nicol* (n 153) [10].
[174] Ibid.
[175] *R v Nielsen* (n 131) 1–4.
[176] *R v Hollinrake* (n 141); *R v Tait* (n 156).

and in Western Australia, people with disabilities are not eligible for VAD in the absence of terminal illness.[177]

Five of the people who sought assistance to die were suffering from mental illness, without a terminal condition.[178] While having a mental illness is not an exclusionary factor under the Victorian Act or the WA Act if all the other eligibility criteria are met,[179] mental illness on its own is not sufficient to meet the eligibility criteria for VAD.[180] These five people therefore would not have been eligible under the Victorian or Western Australian legislation.

Based on the above analysis, of the 27 cases described in Table 2, only 11 meet the criterion in the Victorian Act or WA Act of an advanced, progressive and incurable disease, illness or medical condition which is expected to cause death. However, 7 of these 11 cases involved people with dementia so, although terminal, death may not have resulted within 12 months (and in at least 6 of those cases it is unlikely that the person would have had the requisite capacity). Clearly, cases of assisted suicide and mercy killings in Australia have not been restricted to people suffering as a result of terminal illnesses such as cancer or progressive degenerative diseases. Many more involved an elderly person in considerable suffering due to chronic pain,[181] or suffering loss of abilities due to stroke,[182] amputation[183] or other disability.[184] In many of these cases, part of the impetus for suicide or seeking assistance to die was the fear of ending up incapacitated in a residential aged or disability care facility.[185] Thus, enacting legislation which permits VAD only for people suffering from a terminal illness would not prevent the majority of these unlawful deaths from occurring.

---

[177] Victorian Act s 9(3); WA Act s 16(2).
[178] *R v Larkin* (n 127); *The Queen v Johnstone* (n 154); *R v ANG* (n 154); *DPP v Karaca & Price* (n 154); *R v Hood* (n 154). See also *Carter v A-G* (n 151); *Walmsley v The Queen* (n 151).
[179] Ministerial Panel Recommendation 5, see Victorian Advisory Panel Report (n 7) 80–82 (in respect of mental illness).
[180] Victorian Act s 9(2); WA Act s 16(2).
[181] *R v Marden* (n 153); *R v Godfrey* (n 129); *R v Mathers* (n 141); *R v Rijn* (n 129).
[182] *R v Hollinrake* (n 141); *R v Tait* (n 156).
[183] *R v Nestorowycz* (n 140); *R v Nicol* (n 153).
[184] *R v Thompson* (n 143).
[185] This was a significant factor in *R v Godfrey* (n 129); *R v Justins* [2011] NSWSC 568, [23]; *R v Marden* (n 153); *R v Nicol* (n 153) [9]; *R v Mathers* (n 141) [17]; *R v Nielsen* (n 131); *DPP v Rolfe* (n 139) [7], [13], [14]; *R v Tait* (n 156) 3. In *R v Klinkermann* (n 133), this factor was significant to the husband, who refused to countenance his wife going into care, although she was no longer competent to express her own views on the

C *Voluntary request for assistance*

The Victorian Act and WA Act, like VAD regimes around the world, only apply to voluntary requests for assistance to die. Many, but by no means all, of the Australian mercy killing cases involved a voluntary request to die.

In five of the cases set out in Table 2, the deceased person wished to die and had taken active steps to bring about his or her death, and the offender's role was to provide assistance in a manner requested by the deceased.[186] That is, the action of the accused was assisting the suicide rather than bringing about the death themselves. In one case, this involvement was restricted to the provision of emotional support. In *R v Hood*, the offender sat by his friend's bedside after he took an overdose of pills, and read tributes from his condolence book until his friend lost consciousness.[187] In four other cases, the accused assisted to prepare the means for suicide, such as handing the deceased a glass of Nembutal[188] or purchasing or preparing the equipment used to cause death.[189]

In a further five cases, the accused took active steps to complete a suicide attempt after the deceased had begun the process.[190] Examples include suffocating a person who has taken an overdose and is already unconscious;[191] Larkin injecting her lover with insulin, at his request, to ensure his overdose was successful;[192] and Price complying with his flatmate's demands to bludgeon him with an iron bar, after he took an overdose of sleeping tablets.[193]

---

issue. The husband in *R v Nestorowycz* (n 140) and the mother in *R v Pryor* (n 135) were already in residential care, and the evidence was that this distressed them, which influenced the actions of the relatives in attempting to end their lives to end that suffering.

[186] *R v Hood* (n 154) (overdose of pills); *R v Maxwell* (n 132) (helium balloon asphyxiation); *R v Rijn* (n 129) (asphyxiation); *R v Nielsen* (n 131) (dose of Nembutal); *Police v O* (n 5) (mode of death not stated).

[187] Hood had briefly attempted to suffocate his friend once he became unconscious, by placing his hand over his nose and mouth, but this act made him feel ill, so he desisted, and there was no suggestion that this caused the victim's death. This is why he was convicted of assisting suicide, for being present while his friend died, rather than murder: *R v Hood* (n 154) [23]–[24].

[188] *R v Nielsen* (n 131).

[189] *R v Rijn* (n 129); *R v Maxwell* (n 132); *Police v O* (n 5).

[190] These cases in law technically constitute murder, as the act of the defendant (rather than the unsuccessful suicide attempt of the deceased) was the direct cause of death. However, we have categorised them as actions taken to complete a suicide, recognising that the deceased had instigated the process of causing death, which the offender then completed.

[191] *R v Godfrey* (n 129); *R v Mathers* (n 141).

[192] *R v Larkin* (n 127).

[193] *DPP v Karaca & Price* (n 154).

Seven of the cases involved prosecutions for murder or manslaughter rather than assisting a suicide. In these cases, the accused took action to bring about the person's death, in order to end their pain or suffering, albeit at the request of the deceased. Three of these cases involved a suicide pact between husband and wife,[194] two involved individuals suffering mental illness who persuaded a relative to assist them to die,[195] one involved a terminally ill man,[196] and one involved a woman with multiple sclerosis whose condition had been progressively deteriorating and who wished to avoid going into nursing care.[197]

In the 17 cases considered above, the requirement under the Victorian Act or the WA Act that a person's request for assistance to die is voluntary and not the product of undue influence or coercion[198] would have been satisfied.

However, there were also several mercy killing cases in Australia which would not satisfy the voluntariness criterion. In these cases, a friend or relative acted to cause the death of a loved one for compassionate motives, seeking to end their suffering, but without any explicit request to do so. Four of these cases involved a victim with severe dementia whose spouse or adult child killed them to end their suffering.[199] There were also two cases where a person had suffered a severe stroke, and the act causing death occurred in the context of previous discussions about not wanting to be dependent or to be institutionalised.[200] And there were also two reports of parents who killed their adult children with disabilities in order to ease their suffering.[201] In addition to these cases, in two instances a person with

[194] *R v Marden* (n 153); *R v Nicol* (n 153); *DPP v Rolfe* (n 139). In both *Marden* and *Nicol*, the husband took the actions which killed the wife before attempting his own suicide, and the wife did not actively participate in the acts causing death, although both wives had requested their lives to end. In *DPP v Rolfe* (n 139), the husband attempted to gas both himself and his wife, but he was found unconscious and revived by paramedics.
[195] *R v Johnstone* (n 154); *R v ANG* (n 154).
[196] *R v Attenborough* (n 153). In that case, the charge was the statutory offence of administering a poison, not murder: *Crimes Act 1900* (NSW) s 27.
[197] *R v Thompson* (n 143).
[198] It should be noted that under the Victorian Act, a medical practitioner is permitted to actively perform an act causing death (termed practitioner administration) only when a person's medical condition prevents them from physically administering or digesting a VAD substance. However, for the purposes of this discussion, it is presumed that a person who otherwise met the eligibility criteria for VAD would have chosen to perform VAD in accordance with the method authorised under the Victorian Act.
[199] *DPP v Riordan* (n 139); *R v Pryor* (n 135) (in relation to Pryor's mother); *R v Nestorowycz* (n 140); *R v Klinkermann* (n 133).
[200] *R v Tait* (n 156); *R v Hollinrake* (n 141).
[201] *R v Sutton* (n 136); *R v Dowdle* (n 153).

advanced dementia voluntarily drank a lethal substance prepared for him by relatives, but the assistance to die appears to have been provided at the initiative of the relative, rather than as a response to a voluntary request from the person concerned.[202] Legalising VAD in accordance with the Victorian or Western Australian models, both of which require voluntariness as a key precondition, will not prevent the unlawful killing of a person who has not requested to die.

In summary, of the cases set out in Table 2, 17 involved a voluntary wish to die sufficient to satisfy the voluntariness requirement. However, 10 cases involved the death of a person who had not expressed a voluntary request to die (9 of whom are likely to have lacked capacity).[203] None of these latter cases would have been eligible for VAD.

D *Will VAD prevent these bad deaths?*

Given the narrow eligibility criteria in the Victorian Act and WA Act, and the broad range of circumstances in which assisted suicides or mercy killings have occurred in Australia, it appears unlikely that enactment of VAD legislation based on the Victorian model will address the situations raised in these cases. Table 3 presents a summary of the findings from the cases relating to each *individual* VAD eligibility criterion, noting of course, as discussed below, that eligibility to access VAD depends on fulfilling *all* criteria. While all cases involved an adult and the majority made a voluntary request to die, a major issue was that just over one-third involved people with an advanced and progressive terminal illness.

Table 3: Assisted Suicide and Mercy Killing Cases: Summary of Findings

Criterion of VAD	Yes	No	Unsure
Adult	27	0	0
Capacity	12	9	6
Terminal illness[204]	11	16	0

[202] *Justins v The Queen* (n 130); *R v Nixon* (n 144).
[203] With the probable exception of *R v Dowdle* (n 153).
[204] This figure includes seven cases of people with dementia. As noted above, it is not possible to accurately ascertain from the case reports whether each of them would have satisfied the requirement that death was

Voluntary	17	10	0

It can be seen that, of the 27 cases described in this paper, all involving adults, 10 concerned a death which was not at the voluntary request of the person concerned. In 9 cases, the person clearly lacked capacity to make a request to die, by reason of severe dementia, disability or stroke. In a further 6 cases there was at least some unresolved question of decision-making capacity. Finally, and most significantly, only 11 of the 27 cases involved people with terminal illness (some of whom may not have died within the required statutory period).

The key finding from this analysis, however, relates to how many of the cases would have satisfied *all* of the criteria for eligibility for VAD in Victoria or Western Australia. On our assessment, these criteria were met in only 4 of the 27 cases: *Maxwell*, *Pryor* (in relation to Pryor's father not mother), *Attenborough* and *O*.[205] In the remaining 23 cases where the offender has acted out of compassion for the suffering of the deceased rather than at their request, or the deceased was not suffering from a terminal illness, , the offenders' actions would fall outside the statutory VAD statutory regime.

This is arguably a striking conclusion. The authors acknowledge that these cases provide only a partial picture of the operation of the criminal justice system. As noted earlier, some cases of assisted suicide or mercy killings are not prosecuted and so fall outside the methodology of this review. While it is unknown, it is possible that those cases which were not prosecuted involved a greater proportion of fact scenarios that would be eligible for VAD under the Victorian Act or the WA Act. Nevertheless, the finding that only 4 out of 27 cases considered in this analysis would have been eligible for access to VAD raises important questions about the role of this argument in the VAD reform debate.

expected within 12 months. Further, as already noted, even if they were to meet the terminal illness requirement, if their dementia had progressed to that point, it is very likely they would lack decision-making capacity.

[205] ***R v Maxwell*** (n 132); *R v Pryor* (n 135); *R v Attenborough* (n 153); ***Police v O*** (n 5).

VI CONCLUSION

With Victoria and Western Australia recently enacting legislation permitting VAD, other Australian States are likely to follow.[206] The purpose of this paper was to examine two key sources of evidence that informed the debates surrounding these laws: coronial data about suicides in the chronically and terminally ill, and information about prosecuted cases of assisted suicide or mercy killings. Both sources of evidence were advanced as reasons supporting VAD reform. It was proposed that changing the law to permit VAD could decrease the number of suicides of individuals who are chronically or terminally ill, and could decrease the number of cases where families or friends take the law into their own hands to facilitate or cause a loved one's death. To test these claims, we evaluated whether cases from these two sources of evidence would be eligible to access VAD under the Victorian Act and the proposed WA Bill.

Our conclusions were mixed. Although the suicide statistics provided by the Victorian and Western Australian coroners are not conclusive, many of the deaths reported do not appear to involve people with a terminal illness. Given the eligibility requirements of both the Victorian Act and the WA Act require a person to have a condition expected to cause death within 6 months (or 12 months for neurodegenerative conditions), this means many of the 'bad deaths' identified would not be addressed by this legal model.

The findings in relation to prosecutions of assisted suicide or mercy killings were more conclusive. Although cases may have satisfied various individual eligibility criteria, only 4 of the 27 cases would have satisfied all the criteria to be eligible to access VAD under the Victorian Act or the WA Act. It is important to note, though, that such cases do not provide a full picture of the criminal justice system's response to this issue, as in some instances the prosecution may exercise a discretion not to proceed, or to discontinue a case, or a jury may choose to acquit against the weight of the evidence.

[206] Ben White and Lindy Willmott, 'Future of assisted dying reform in Australia' (2018) 42 *Australian Health Review* 610.

These findings have implications for debates about VAD and law reform. One is about the scope of an appropriate VAD law. Both the suicide data and the cases on assisted suicide and mercy killings provide evidence that, for many people, the desire to die stems from intractable chronic pain[207] or a degenerative but non-terminal illness.[208] The mercy killing cases also include several examples where a friend or relative became involved in assisting or completing the suicide of a person with mental illness.[209] Some may use this evidence to argue that the 'bad deaths' in these non-terminal situations should be addressed by widening access to VAD. In other words, this evidence could be said to demonstrate a need for broader eligibility criteria, such as those contained in VAD systems in countries such as the Netherlands and Belgium.[210] This, however, is not an argument the authors endorse. Limiting VAD to those with a terminal illness is justifiable by reference to a number of fundamental societal values,[211] and the model proposed elsewhere by two of the authors confines VAD to circumstances where a person has a condition that will cause his or her death.[212]

Another implication of these findings is that a VAD law may not bring the expected degree of benefit in terms of preventing people dying 'bad deaths'. The system of VAD in existence in the Victorian Act, and in the WA Act, is likely to provide a lawful alternative option for only some of the suicides, assisted suicides and mercy killings discussed in this paper. This demonstrates the need for precise evidence to inform law-making in this complex and contested area.[213] Given the engagement by the parliamentary committees and MPs outlined above, it is reasonable to conclude that the coronial evidence about suicide statistics had at least some influence on the decision to recommend VAD reform. For some of the cases of suicide outlined in that data, this was appropriate. Those cases

[207] See *R v Marden* (n 153); *R v Godfrey* (n 129), *R v Mathers* (n 141); *R v Rijn* (n 129).
[208] See statistics discussed above in sections 4 A and B. See also the cases of *R v Klinkermann* (n 133); *R v Thompson* (n 143).
[209] See *R v Larkin* (n 127); *The Queen v Johnstone* (n 154); *R v ANG* (n 154); *DPP v Karaca & Price* (n 154); *R v Hood* (n 154). See also *Carter v A-G* (n 151); *Walmsley v The Queen* (n 151). Cases of suicide where mental illness was a factor were specifically excluded by the coroners when compiling evidence about suicide in the chronically and terminally ill.
[210] Willmott, Lindy and Ben White, 'Assisted dying in Australia: A values-based model for reform' in Ian Freckelton and Kerry Petersen (eds), *Tensions and traumas in health law* (Federation Press, Sydney, 2017) 479, 484–486.
[211] Ibid.
[212] Reference removed for anonymity reasons.
[213] See Ben White and Lindy Willmott, 'Evidence-based law making on voluntary assisted dying' (2020) Australian Health Review (available early online, forthcoming).

involved 'bad deaths' that could have been prevented if VAD had been lawful, because they would be eligible under the Victorian Act or WA Act. But many of the cases fell outside the scope of that law and so do not provide support for the reform that occurred. Based on the data examined in this article, it cannot be claimed that legalising VAD in accordance with the Victorian or Western Australian legislation would avoid all 'bad deaths'. Optimal law-making occurs when there is precision about data such as this and when parliaments consider which cases support reform and which do not.

A further implication is that there remains an urgent need for detailed research and accurate evidence to inform the parliamentary and community debate about VAD law reform. For example, the coronial evidence was not able to identify the percentage of suicides which involved a person who was terminally ill, compared with those which involved a person with chronic illness. Although these distinctions had not been precisely conceptualised until the Victorian model of VAD was formulated,[214] when asked directly to provide an indication, the Western Australian Coroner stated that their data does not contain the information, as it requires a detailed medical prognosis prior to death.[215] Further, the Coroner's Court of Western Australia stated that it did not have the capacity to produce detailed reports, as it does not have research staff embedded within its office.[216] Another point on which further research is required is the number of cases of assisted suicide and mercy killings which are not prosecuted or are discontinued, and what criteria are employed by prosecutors in making decisions in these cases. A further matter worthy of investigation is the prevalence of jury acquittals in such cases, although the reasons for jury verdicts are inscrutable.

A final observation is that this review highlights the ongoing role that criminal law will need to play even if VAD legislation is enacted. While the majority of the prosecuted cases identified here involved a voluntary desire to die, 10 of the 27 Australian cases involved mercy killings of people who lacked capacity, including those with dementia, stroke victims and people with disabilities. As

[214] This was particularly a challenge for the Victorian Coroner, providing evidence to the parliamentary committee prior to the drafting of proposed VAD legislation.
[215] Coroner's Court of Western Australia Submission (n 89) 2.
[216] Evidence to Joint Select Committee on End of Life Choices, Parliament of Western Australia, Perth, 1 March 2018, 13 (Rosalinda Fogliani, Coroner).

Bartels and Otlowski have observed, there is a need for safeguards in any law permitting VAD, to prevent the deaths of people who lack capacity.[217] Even with the legalisation of VAD in Victoria, and possibly other Australian jurisdictions, there will remain an important role for the criminal law. It protects vulnerable people from the unilateral unlawful killing by a trusted family member, sending a message to the community that it is not for others to judge that a person's quality of life is intolerable.

VAD is an important and complex social policy issue and there will be diverse views about the desirability for reform. This paper has highlighted one key argument in these debates: whether VAD reform could help address a cohort of identified 'bad deaths'. The evidence demonstrates that while some of these deaths may be addressed by VAD laws, under the model of VAD adopted in Victoria and Western Australia, many will not. Not all mercy killings are carried out at the voluntary request of the deceased person, and many deaths—whether by suicide, assisted suicide or mercy killing—do not involve a person with a terminal illness. To return to the media reports with which this paper began, while Penelope Blume and Troy Thornton would have qualified for VAD once they were assessed as having less than 12 months to live, Professor Goodall would not have been eligible for VAD (even if the WA Act had commenced or he was resident in Victoria at the time of his death), and he would still have had to travel to Switzerland.[218] A more nuanced understanding of this evidence is important for the Australian state parliaments currently, and in the future, considering VAD reform.

[217] Bartels and Otlowski (n 21) 549.
[218] Frailty or being 'tired of living' does not fall within the terminal illness criterion in the VAD Act.