MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Kylie Anne Breen

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Kylie Anne Breen;
b) Ms Breen died in the circumstances set out below with the intention of ending her life;
c) The cause of death is hypoxic brain injury and lung injury, being the effects of drug toxicity and gas inhalation; and
d) Ms Breen died on 2 December 2017 at Launceston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Kylie Anne Breen's death. The evidence includes the Police Report of Death; an opinion of the pathologist who conducted the autopsy; toxicological evidence; identification and life extinct affidavits; family, police and witness affidavits; evidence from the attending paramedic and Ambulance Tasmania; medical records and reports; notes and writings of Ms Breen; forensic evidence; opinion from medical specialists regarding Advance Care Directives and Goals of Care documentation.

Kylie Anne Breen was born in Launceston on 27 September 1977 and was aged 40 years at her death. She was a well-loved primary school teacher at Mole Creek Primary School. She lived with her partner, Scott O'Leary, at their property in Jackeys Marsh.

At the age of 21 years, Ms Breen was diagnosed with multiple sclerosis, a condition which had been deteriorating over the last five years of her life. Her mother, Rosemary Breen, said that her precious and dearly loved daughter had battled the disease stoically over the years. She described her daughter suffering multiple fractures and chronic neuropathic pain as well as undergoing many medical procedures.

Ms Breen was comprehensively treated, monitored and medicated in an attempt to slow the progression of the disease. Although her outlook was remarkably positive, the condition became progressive and led to eventual incapacity. She was unable to continue work during the second half of the 2017 school year, and was effectively house bound. She had also relinquished her driver's licence as she could not drive safely on the roads.

Ms Breen told Mr O'Leary many times that she wanted to end her life at an appropriate time due to her poor quality of life, although he did not consider that she would actually take this step.

On Friday 1 December 2017 Mr O'Leary went to work, with Ms Breen remaining at their property. When he arrived home at 8.00pm, Mr O'Leary could smell gas in the house. After opening the door to Ms Breen's bedroom he was confronted with the smell of gas. Ms Breen was in her bed, still alive, although she was unconscious and barely breathing. Mr O'Leary could see a gas bottle near the foot of the bed. There were also detailed typed and handwritten notes and instructions from Ms Breen indicating that she had ended her own life due to an inability to tolerate her physical condition. In her writing, she said that she had overdosed on a variety of sleeping tablets. She also expressly stated that she had not undertaken an act of suicide but of "euthanasia".

Mr O'Leary called an ambulance and performed CPR until emergency personnel arrived. At the scene, the intensive care paramedic noted the presence of numerous empty blister packets of assorted medications, including benzodiazepines and some narcotic-based analgesics. When police officers attended the residence to investigate, they found no suspicious circumstances or evidence that any person assisted in her death. They concluded that the gas bottle had been opened by Ms Breen and that she had placed it in the room to increase the likelihood of her successful suicide.

Ms Breen was transported to the Launceston General Hospital and arrived at 10.41pm. Medical assessment of her condition and resuscitation commenced, including a CT scan, intubation, ventilator-initiated oxygen and a number of medications. However, it was apparent at the outset that, due to her prolonged down time period (with GCS score of 3) that her prognosis was very poor.

Almost 12 months before her death, Ms Breen had put in place with her general practitioner an *Advance Care Directive for Care at End of Life (Tasmania)* ("ACD"). A copy of this document was given to the Launceston General Hospital for inclusion on her medical record to inform any future treatment and care. Ms Breen signed the document in the presence of a witness. Included in the ACD was an express request that she not be revived or have her life prolonged if she could not speak, hear, move, or if she should have to be fed through a tube.

As will be discussed below, Ms Breen's initial medical intervention at the LGH arguably took place contrary to her request expressed in the ACD. That document was not initially known or accessed by hospital staff and, when it was sighted, the treating doctor was reluctant to cease medical intervention. However, after further consideration of the terms of the ACD and consultation with the family, active treatment ceased. She then passed away at 1.35am on 2 December 2017.

Ms Breen's death by apparent suicide was reported to the coroner. Dr Rosa Devadas, pathologist, performed an autopsy upon Ms Breen for the coronial investigation. Dr Devadas had regard to a toxicological sample of blood indicating that there was elevated levels of oxycodone and chlorpheniramine, as well as a range of other sedating medications present in the blood of Ms Breen. In Dr Devadas' opinion the cause of death was multiple drug toxicity with hypoxic brain injury and acute lung injury. I accept her opinion as to the cause of death.

It is clear that, upon the evidence, Ms Breen intended to end her life by ingesting large quantities of medication. She made a rational decision to do so due to her constant pain combined with the fact that her health was rapidly declining to the point of requiring care at home.

Comments and Recommendations

Ms Breen's mother, Rosemary Breen ("Mrs Breen"), has expressed concerns that her daughter was subject to active medical treatment upon arriving at the hospital with an obviously poor prognosis. Mrs Breen was primarily concerned that the initial resuscitation and treatment efforts were contrary to her daughter's own wishes as expressed in her ACD, which was signed by her on 14 December 2016 and placed upon the hospital record, specifically for the purpose of informing treatment in a situation similar to that which occurred; that being where recovery to consciousness was highly unlikely or the outcome of treatment would be a permanent coma.

Ms Breen felt very strongly about choosing the time and manner of her death, in light of her debilitating medical condition. In one of her notes left before her death she stated:

"I feel really strongly about suicide being vastly different to euthanasia, and it is euthanasia that I have chosen. Considering the powers that be haven't yet legalised it, I took matters into my own hands. I hope people can understand why I have made such a choice. I had enough of the pain and indignities of MS many, many years ago. But sometimes you just have to say enough is enough".

Mrs Rosemary Breen was present in the hospital during the attempts to resuscitate her daughter. The events were distressing to her. She described initially bringing the existence of her daughter's ACD to the attention of a nurse. She said that she subsequently emphasised to the treating doctor that her daughter did not wish for medical intervention and asked the doctor to sight the ACD for *"proof of its existence".* She said that the ACD was then accessed by the doctor and, after further consultation with the family, Ms Breen's intubation was removed and she passed away.

I have received documentation from Dr Peter Renshaw, Executive Director of Medical Services, Launceston General Hospital, who reviewed issues arising in respect of Ms Breen's end-of-life care, specifically regarding issues surrounding respecting her wishes in the ACD contained on the hospital file.

Dr Renshaw firstly noted that a Medical Goals of Care (GOC) Plan, as well as an ACD, was present on Ms Breen's medical record. This document was completed by a doctor and related to a previous medical admission for Ms Breen in August 2017, some three months before her death. A brief description of both documents is required.

An Advance Care Directive (ACD) is an individual's own written wishes regarding health care decisions at the end of life if they lack decision-making capacity at some future time.[1] The Tasmanian Health Service recognises the legal validity of an ACD, which is based upon common law principles concerning the individual's right to self-determination.[2] This written document helps to provide clarity and accountability for a patient, their family and health professionals. An ACD will be used when the individual lacks decision-making capacity. It is the responsibility of doctors to check for an ACD, take into account the wishes expressed, and to discuss these wishes with the responsible family member/s.

By contrast, a Medical Goals of Care (GOC) Plan is a standard form document completed by medical staff, (and *not* the individual patient), communicating to treating health professionals any planned treatment limitations in respect of a particular episode of care. Although the document is written by medical staff, it is based upon the patient's wishes concerning any limitation upon their treatment. It is essential that a new GOC Plan is made when the situation changes or at the patient's next hospital admission. This ensures that the patient's GOC Plan is always applicable to the current episode of treatment.

Ms Breen wrote in her ACD, which remained current, that she did not wish be revived or have her life prolonged if she could not speak, hear, move, or if she should have to be fed through a tube. The August 2017 GOC Plan, however, related to an admission for a specific medical procedure. It indicated no limitation of treatment and specified a requirement for life-sustaining treatments in that particular episode of care. It was not applicable to inform Ms Breen's care on 1 December 2017.

Upon examining the medical record and reviewing the circumstances of care, Dr Renshaw noted that the treating doctor, in deciding to actively treat her, appeared to place some reliance upon the existence of the GOC plan, which indicated no limitation of treatment, rather than the applicable

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[1] Advance Care Directive, *Department of Health – Specialist Palliative Care Service* <https://www.dhhs.tas.gov.au/palliativecare/advance_care_planning_for_healthy_dying>.
[2] *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

ACD requesting no life-prolonging treatment. In his medical notes, the doctor recorded *"no clear advance care directive available, last GOC on file from this year indicates Kylie is for full resuscitation"*. This approach represented a misunderstanding of the purpose of the GOC plan. However, it is quite clear that the doctor believed he was acting in Ms Breen's best interests and in accordance with what was lawfully required. I also observe that, for the purpose of observing the patient's requirements as set out in an ACD, a treating team will be required to assess the patient's condition using appropriate means so as to form a considered opinion regarding whether, upon stabilisation, significant recovery is highly unlikely. The records indicate that Ms Breen's treating team was, at least initially, engaging in this assessment process. The issue is a difficult one, as there may be serious legal consequences for doctors who fail to properly assess a condition, regardless of the existence of an ACD.

Fortunately, Ms Breen's wishes as per the ACD were established within a relatively short time and she passed away three hours after her arrival in hospital.

I have also sought information from a palliative care specialist, Dr Michael Ashby, Clinical Director Cancer, Chronic and Sub-Acute Care, Tasmanian Health Service, regarding any wider issues flowing from the facts of this case surrounding end of life decision-making. Dr Ashby identified that work is required to encourage more members of the community to make their end-of-life wishes known in an ACD and also to inform their family and / or friends and health professionals (particularly general practitioners) of their wishes. He is of the view that that an ongoing health and education campaign is needed to achieve this goal of increasing the rate of ACD completion.

In this case, Ms Breen *had* completed an ACD and *had* made her wishes known to her family members, general practitioner and the hospital. Relevantly, Dr Ashby was also of the view that systematic and ongoing work with clinicians should occur in this area, particularly to reinforce the primacy of patient wishes in their decision-making as well as to assist with general communication skills regarding end-of-life issues. Dr Ashby indicated that, unfortunately, previous valuable initiatives in this area have not continued and have suffered from a lack of funding.

This investigation, therefore, highlights the following issues:

- The importance of an individual completing an ACD as well as making their wishes for end-of-life medical care known to their loved ones and treating doctors (who may advocate for their wishes in the event of loss of capacity); and
- The importance of treating health professionals being alerted to the existence of an ACD, understanding its significance and then giving effect to the patient's wishes expressed within it.

Both Dr Ashby and Dr Renshaw are of the view that initiatives in these areas would be of great assistance in both ensuring correct end-of-life care and prevention of unnecessary distress to family members and loved ones.

I **recommend** that all hospitals in this state take any necessary steps to ensure that a patient's ACD is readily accessible within the patient's medical records so that timely compliance with a patient's wishes as expressed in this document can be achieved when the circumstances arise.

I convey my sincere condolences to the family and loved ones of Kylie Anne Breen.

Dated: 2 September 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner