

## CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

**Case Title:** Inquest into the death of Penelope Ann BLUME

**Citation:** [2019] ACTCD 19

**Decision Date:** 10 December 2019

**Before:** Chief Coroner Theakston

**Decision:** See [24], [29].

**Catchwords:** **CORONIAL LAW** – cause and manner of death – assisted suicide

**Legislation Cited:** *Coroners Act 1997* (ACT) ss 15, 52(1), 52(4)(a), 58  
*Crimes Act 1900* (ACT) s 17  
*Euthanasia Laws Act 1997* (Cth) sch 2  
*Australian Capital Territory (Self-Government) Act 1988* (Cth) s 23(1A)

**File Number:** CD 65 of 2019

## **CHIEF CORONER THEAKSTON:**

1. The death of Penelope Ann Blume, a 68 year old woman at the date of her death, was reported to the ACT Coroner on 15 March 2019 in accordance with section 13(1)(a) of the *Coroners Act 1997*, as she was thought to have died unnaturally in unknown circumstances.
2. The initial report made to the ACT Coroner was that Ms Blume, a former nurse, had been diagnosed and was living with Motor Neuron Disease (MND). She had apparently been found deceased in bed by her partner, Stephen Neil O’Riordan, on the morning of 13 March 2019. Mr O’Riordan rang Ms Blume’s usual general practitioner, who rang Police. The GP refused to write a Medical Certificate Cause of Death for Ms Blume, stating to Police that although Ms Blume had a terminal illness, she was not yet at a point at which the GP expected Ms Blume to die from that illness; Ms Blume had also apparently spoken in the past about voluntary euthanasia. I note at this point that the actions of the GP in referring Ms Blume’s death to the Coroner were entirely appropriate.
3. As is normal when gathering information for the Coroner, Police undertook an investigation of the death scene and located a plastic bag with masking tape on it in a rubbish bin. As a result, Mr O’Riordan, was arrested and charged with an offence under section 17 of the *Crimes Act 1900* of assisting Ms Blume’s suicide.
4. At the time Ms Blume died, Her Honour Mrs Campbell was the duty Magistrate and Coroner. Ordinarily this would have meant that Coroner Campbell had carriage of the inquest into Ms Blume’s death. However, when sitting in Saturday court Mrs Campbell (while sitting as a Magistrate) dealt with Mr O’Riordan’s bail application. For this reason, in due course I assumed carriage of the inquest into Ms Blume’s death.
5. Ultimately, on 2 July 2019, the Director of Public Prosecutions Shane Drumgold withdrew the charge against Mr O’Riordan. Mr Drumgold stated that he had formed the view that it was not in the public interest to proceed with the prosecution against Mr O’Riordan for this offence.

6. The fact that Mr O’Riordan had been charged with what amounted under the *Coroners Act 1997* to a “related criminal offence” had certain implications both practical and legal for the coronial process.
  - a. First, having regard to sections 15 and 58 of the Act, other than making decisions and directions in relation to the examination of Ms Blume’s body, the substantive part of the coronial inquest was paused pending the resolution of the related criminal prosecution.
  - b. Secondly, coronial decisions in relation to Ms Blume were made in the context of the related criminal prosecution. As was his right, Mr O’Riordan lodged an objection with the Coroner against the conduct of a post-mortem examination. Quite properly in my view given the circumstances as they were then known, Coroner Campbell denied the objection and ordered that a post-mortem examination was to take place.
  - c. Thirdly, the fact of Mr O’Riordan having been arrested for and charged with a related criminal offence, and being put in custody until he was granted bail, in a practical sense affected his ability to spend time with Ms Blume after her death, and for other family and friends to spend time with her.
7. The decision about whether to arrest someone, or to investigate a potential crime, is a decision for police alone. The decision by Mr Drumgold to withdraw the charge against Mr O’Riordan was made on public interest grounds, and not because there was insufficient evidence. I make no further comment about these issues. I do however acknowledge the detrimental effect of these processes on Mr O’Riordan.
8. Much of the coronial process is focussed on the death of a person and the circumstances immediately prior to the death. I wish here to take some time to acknowledge the life of Ms Blume.
9. Penelope Ann Shaw (as she then was) was born on 23 March 1950. She grew up in Gunning, NSW, to parents Patricia and Gibson (who have both

predeceased her). Ms Blume has a younger brother Stephen, who survives her.

10. Ms Blume attended Goulburn Presbyterian College and then studied at an art school in Melbourne. She then decided to change direction and successfully attained her nursing degree. Throughout her career Ms Blume worked in mental health wards around Australia.
11. In 1977 Ms Blume married Ron Blume. The couple lived on a country property at Tuross River, NSW. They divorced in 1984 but Ms Blume retained the Tuross River property.
12. In 1984 Ms Blume commenced a relationship with Mr O’Riordan. They separated for a time in 1989 but rekindled the relationship a few years after, and the couple remained together until Ms Blume’s death. Mr O’Riordan has a son Liam from a previous relationship and Ms Blume became Liam’s stepmother.
13. Mr O’Riordan is also a nurse working in the alcohol and drugs area. Ms Blume and Mr O’Riordan spent time living and working in Victoria prior to moving to the ACT. In 2002 Mr O’Riordan and Ms Blume purchased their primary residence in Pearce.
14. In 2014 Mr O’Riordan and Ms Blume relocated temporarily to Bangkok where they worked with medical tourism companies. While there, Ms Blume began to display symptoms of muscle weakness. In 2015 tests for MND were inconclusive. However in August 2016, Ms Blume was formally diagnosed with the disease. She and Mr O’Riordan retired but remained in Asia touring. From time to time Mr O’Riordan would return to Australia for short periods to work, but Ms Blume would remain in Thailand.
15. By December 2017, Ms Blume’s mobility had declined. She and Mr O’Riordan decided to return to Australia. Over the next few months, Ms Blume’s mobility decreased to the point where she required a walker, and by January 2019 she permanently required the use of a wheelchair. Ms Blume also required Mr O’Riordan’s assistance with activities of daily

living such as showering, toileting and getting in and out of bed. She was also in significant pain, for which she was prescribed opioid painkillers. She was also prescribed antidepressants.

16. According to Mr O’Riordan, he had many conversations with Ms Blume in the last two years of her life about assisted dying. Ms Blume indicated that she wished to die while she could still make the decision and while she was still capable. She told Mr O’Riordan that she no longer wished to live if she became incapacitated. They researched peaceful suicides and investigated relocating to Switzerland or Victoria, jurisdictions which have legalised voluntary assisted dying, but this was not practical for them.
17. In December 2018, Ms Blume and Mr O’Riordan decided together to take active steps towards hastening her death. They continued to take active steps for the next few months. There is no need for me to detail here what those steps were. However, I note that as a consequence of their decision, Ms Blume commenced making phone calls to friends and relatives that she had not spoken to in some time and dictated letters and made arrangements about her personal property.
18. In early March, Ms Blume began to experience several ‘silent falls’, such as sliding down a wall to break her fall. Additionally, her oxygen saturation levels were dropping, which caused her some distress and anxiety. Ms Blume made the decision to end her life over the weekend of 9 – 10 March 2019 but postponed implementing that decision due to the visit of relatives and first wishing to visit places of childhood memories and the graves of family.
19. On 14 March, Ms Blume indicated to Mr O’Riordan that she wished to end her life that day. Mr O’Riordan purchased champagne and they had a special dinner, reminiscing and listening to music together. At about 2am on 15 March, Ms Blume decided that the time was right. She asked Mr O’Riordan to leave her but he declined to do so; Mr O’Riordan was there when Ms Blume died. After he was sure that Ms Blume had passed, he removed the equipment used to assist Ms Blume’s death, which he discarded in a wheelie bin, and made her comfortable in bed. He

remained at the house until 7:00 am when he called Ms Blume's general practitioner.

20. I am required by section 52(1) of the *Coroners Act 1997* to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death.
21. As noted earlier, Coroner Campbell directed that a post-mortem examination of Ms Blume take place, but to be limited to the extent necessary to determine the cause of Ms Blume's death. Professor Johan Duflou undertook that examination. During the examination, Professor Duflou took the view that it was appropriate to send the brain and spinal cord for specialist neuropathological examination, and Coroner Campbell formally ordered retention of those organs. Due to a national shortage of neuropathologists, and a heavy workload on those working in the area, the report back from the neuropathologist was only received on 7 November 2019. Professor Duflou was then able to complete his report of the post-mortem examination, and it was received at the Court on 10 November 2019.
22. The opinion of Professor Duflou is that Ms Blume died from plastic bag asphyxia with vitiated atmosphere, with MND being a significant condition contributing to her death but not related to the disease or condition causing death. The Professor noted that while there was evidence at autopsy of changes diagnostic of severe MND, he was unable to determine from the autopsy alone if the severity of Ms Blume's disease was such that she was able to independently perform the various actions leading up to her death, or whether she required assistance to complete those actions. He also noted there was an absence of injuries to Ms Blume, suggesting that there was no struggle in the time leading up to death, and there was no medication in her system at a level where it could have been expected to cause significant sedation or incapacitation.
23. In terms of the manner of Ms Blume's death, I consider that her death was the result of suicide, in that she took actions to end her own life intending that death would be the outcome of those actions. On the evidence as it

presently stands, I am unable to find definitively whether Mr O’Riordan took any active steps in the process causing death. It is clear that Mr O’Riordan took steps with Ms Blume to procure items for Ms Blume’s suicide, and that he attempted to destroy evidence after the fact. However, and noting that Mr O’Riordan is the only living witness to the events immediately prior to Ms Blume’s death, the evidence does not rise to a level where I can make a finding of causation in respect of Mr O’Riordan, or any adverse comment.

24. Based on the information above I find as follows:

Penelope Ann Blume died on 15 March 2019 at *[omitted]* in the Australian Capital Territory. She died from plastic bag asphyxia with vitiated atmosphere, with Motor Neuron Disease being a significant condition contributing to her death but not related to the disease or condition causing death. The manner of her death was suicide.

25. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it.

26. I have had the benefit of hearing Mr O’Riordan’s statement at the hearing. I thank him for his statement and the issues he raises. I make the following comments.

27. Mr O’Riordan has said that he, as well as family and friends, wished to say goodbye to Ms Blume but were unable to do so. As I noted earlier, some of this is undoubtedly due to the fact of Mr O’Riordan having been arrested and charged. However, I consider there should be no impediment to families and friends having the opportunity to spend time with a deceased loved one, certainly once all necessary investigations have been completed. The *Coroners Act 1997* expressly provides several rights for families, and rights to request certain things, including a request to see the body and inspect the scene of death. I am aware that in other cases, families and friends have been able to do these things, but perhaps families and friends are unaware of their rights in this matter. I

have asked Police in the Coroners team and staff working at the Court to improve processes in this regard. I understand that the ACT Coroner's Court website is shortly to be updated with more details for families and friends about the coronial process and their place in it. Additionally, I understand that work is presently underway on a fact sheet for families that Police can provide, which will set out the range of rights and options families have in coronial matters.

28. In terms of the broader issue of voluntary assisted dying in the ACT, I observe that since the passage of the *Euthanasia Laws Act 1997* (Cth), the ACT Legislative Assembly "has no power to make laws permitting or having the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life": see the *Australian Capital Territory (Self-Government) Act 1988* (Cth), s 23(1A). Accordingly, this is not a matter that Territorians, through their elected representatives, are permitted to decide for themselves. This is not the case for States. An attempt was made in the Commonwealth Parliament in 2018 to override the effect of the *Euthanasia Laws Act 1997*, but it was narrowly defeated. I note also that on 27 November 2019 the ACT Legislative Assembly passed a motion calling on the Federal Parliament to remove the above amendment.
29. I find that no matter of public safety arises in connection with this inquest.
30. I direct that a copy of my findings, and Mr O'Riordan's statement, be sent to the ACT and Commonwealth Attorneys-General for their information.
31. I direct that these findings be published in due course on the Coroner's Court website. I also direct that any response to my findings and comments that I receive will also be published on the Court website.
32. Finally, I again extend my condolences to Ms Blume's family and friends and in particular Mr O'Riordan, upon whom so much of the burden of dealing with her death and its consequences has fallen.

**DATED** 10 December 2019

**G S THEAKSTON  
CHIEF CORONER**

I certify that the preceding thirty-two [32] numbered paragraphs are a true copy of the reasons for the judgment of his Honour Chief Coroner Theakston.

Associate: Lauren Dreyar

Date: 10 December 2019