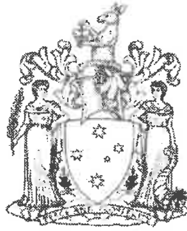

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3002

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Baillee Petra Schneider
Date of birth:	19 February 1993
Date of death:	23 June 2018
Cause of death:	1(a) Compression of the neck
Place of death:	71 Darling Street, Moonee Ponds, Victoria

INTRODUCTION

1. Baillee Petra Schneider was a 25-year-old woman at the time of her death.

2. Ms Schneider was the middle of three children to Sabine and Cameron Schneider. She lived with her parents and her older brother, Ryan, in Moonee Ponds. Her sister, Lilli, lived in Tasmania.

3. Ms Schneider had been an excellent student. After finishing school, she worked in retail fashion and as a dental nurse.

4. Ms Schneider died at home on 23 June 2018 from compression of the neck.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Ms Schneider's death was reported to the Coroner as it appeared to be the result of accident or injury, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. The Coroner's Investigator, Leading Senior Constable (LSC) Katyana Rijks, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers. I also had regard to concerns raised by Ms Schneider's parents in correspondence dated 20 July 2019, 27 August 2019 and 4 November 2019. I requested the Homicide squad review the coronial brief prepared by LSC Rijks and advise me whether there were any suspicious circumstances surrounding Ms Schneider's death. Detective Acting Senior Sergeant Paul Rowe from the Homicide squad conducted the review and provided an advice.

8. I have based this finding on the evidence contained in the coronial brief and the Homicide squad review. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

9. On 23 June 2018, Cameron Schneider visually identified his daughter, Baillee Petra Schneider, born 19 February 1993.

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

BACKGROUND

11. Ms Schneider was born in Queensland but grew up in in Tasmania when her family moved there when she was aged five.

12. In 2013, at the age of 19, Ms Schneider moved to Melbourne. She was studying to be a dental nurse and worked full time as visual merchandiser for a clothing chain. Ms Schneider also did some modelling work and became involved in the Melbourne night club scene. She started using cocaine and drinking heavily on weekends.

13. After a brief stint in Sydney for a 'fresh start' she moved back to Melbourne. She lived with friends in Brunswick, then moved into an apartment in South Yarra. Around this time, she suffered from anxiety and was prescribed Zoloft.

14. Her parents became concerned about her lifestyle and moved from Sydney to Melbourne to provide her with support and a stable base. In 2017 Ms Schneider moved in with her parents to their house in Moonee Ponds and her brother, Ryan, moved over from Tasmania to live with them.

15. Her parents were aware she was partying hard on the weekends, '*using a lot of cocaine and alcohol.*'[2] Her mother described her as '*extremely private*', which, as parents, they respected, and that Ms Schneider felt she had lost her independence by moving back home. Her mother stated: '*... I used to tell her that I just wanted to know that she was safe if she*

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[2] Coronial Brief, page 25.

didn't come home. I didn't need to know where she was or what she was doing, I knew she was out dancing but I just wanted to know she was safe.'[3]

16. Towards the end of 2017 and early 2018, Ms Schneider spent some time in Bali, modelling and then on holidays. When she returned to Melbourne, her mother stated she started a relationship with Anthony Hampel.

17. Ms Schneider enrolled in an online Applied Medical Sciences course at university, which her father described as '*getting her life back on track.*'[4] She was about to start a new job in a dental practice.

18. In early June 2018, Ms Schneider attended Royal Melbourne Hospital and was treated with stitches for a deep cut to her arm. She was interviewed by police and her father said this was described by police as a suicide attempt.[5]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

19. On Friday night, 22 June 2018, Ms Schneider told her parents she was going to a barbeque at Mr Hampel's house, where she said she would be staying the night.

20. In reality she went to work as a dancer at a nightclub in the city. She commenced work at 6.45pm and left work in a taxi at 1.08am on 23 June 2018. She then went to party at an acquaintance's apartment in Toorak and left there at around 8.00am, by taxi or Uber, and returned home to Moonee Ponds. A witness at the party described the scene: '*We were all pretty drunk ... Towards the morning Baillee seemed really depressed and down but I am not aware of anything in particular that happened during the night at the party.*'[6]

21. At around 10am that morning, Ms Schneider's mother found her crying in her bedroom and she stated she had just broken up with Anthony, '*and that it was a mutual decision because their worlds were just too different.*'[7] They discussed the breakup, and Ms Schneider's anxiety.

[3] Coronial Brief, page 25.
[4] Coronial Brief, page 11.
[5] Coronial Brief, page 12.
[6] Statement by Samantha Norrie, unsigned and undated. This statement arose from a telephone conversation between LSC Rijks with Ms Norrie on 11 April 2019. It remains unsigned. Ms Schneider's attendance at the party is corroborated by the statement from Anthony Malcolm signed and dated 11 April 2019.
[7] Coronial Brief, page 29.

22. Ms Schneider's parents left her on the couch watching Netflix whilst they went to do the weekly shopping. Ms Schneider's brother, Ryan, was watching a movie in his bungalow at the back of the house. At one point during the morning, Ryan saw her in the back garden talking on the telephone and she appeared to be upset but she gestured to him that she was 'OK.'

23. When Mr and Mrs Schneider returned home from shopping with the groceries, they found Ms Schneider lying on the floor in the corner of the kitchen with her head leaning against the lower kitchen cabinet. Her father noticed blood coming from her nose. He then saw a cord around her neck, which he unsuccessfully tried to loosen and pull off. He grabbed a kitchen knife and cut it off. Noting she was not breathing and did not have a pulse, Mr Schneider commenced mouth to mouth resuscitation and cardiopulmonary resuscitation (CPR). Her mother called Emergency Services and on loudspeaker the operator talked her father through CPR whilst the ambulance was on its way.

24. Paramedics arrived and continued CPR, however Ms Schneider was unable to be revived.

25. Mr and Mrs Schneider noted the presence of a bottle of wine in the kitchen when they returned home that had been moved from the pantry and was half to three quarters empty. They were of the view Ms Schneider had taken it from the pantry and been drinking prior to her death.

CAUSE OF DEATH

26. On 27 June 2018, Dr Mathew Lynch, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report, dated 1 August 2018. In that report Dr Lynch concluded that a reasonable cause of death was '*Compression of the neck.*'

27. Toxicological analysis identified the presence of Ethanol, Cocaine, (Cocaine metabolites Benzoylecgonine, Ecgonine methyl ester and Cocaethylene), the anxiolytic Alprazolam and the anti-depressant Sertraline.

28. The toxicology report noted the Blood Alcohol Concentration of 0.17 g/mL, which is over three times the legal limit for fully licenced car drivers of 0.05%. The toxicology report noted:

6. A BAC in excess of 0.15% can cause considerable depression of the Central Nervous System affecting cognition and capable of producing adverse behavioural changes.

7. Other drugs capable of depressing the CNS will increase the effects of alcohol when consumed. These include benzodiazepines, opiates and amphetamines.[8]

29. Dr Lynch commented:

'The cause of death in Baillee Schneider, is compression of the neck. The circumstances suggest that she may have suspended herself from a pantry door from which her body subsequently became dislodged but were not entirely clear. The possibility of "self-strangulation" in this instance is not excluded. The circumstances were not considered suspicious.'[9]

30. I accept Dr Lynch's opinion as to cause of death.

FURTHER INVESTIGATION

31. As part of the initial investigation, the Moreland Crime Investigation Unit attended the scene following Ms Schneider's death.

32. Following his inspection of the scene, Detective Sergeant Andrew Todorov reached the conclusion that there were no suspicious circumstances surrounding the death. Both Detective Sergeant Todorov and LSC Rijks were of the view the most likely mechanism used by Ms Schneider for suspension was the pantry cupboard door.

33. As indicated above, Ms Schneider's parents communicated their concerns regarding the circumstances surrounding their daughter's death in correspondence to the court dated 20 July 2019, 27 August 2019 and 4 November 2019.

34. Their principal concern, particularly detailed in their correspondence dated 20 July 2019, was the mechanism of death with the curtain tie ligature and whether there was any third-party involvement.

35. The unusual aspects of Ms Schneider's death were the use of a curtain tie as a ligature and that there appeared to be no obvious suspension point as Ms Schneider was on the floor and the curtain tie was not attached to a door or object when she was discovered.

---

[8] Coronial Brief, page 84.

[9] Medical Examiner's Report, dated 1 August 2018.

36. The review of the Coronial Brief by Homicide squad Detective Acting Senior Sergeant Rowe considered a number of aspects of the investigation.

37. Firstly, the ligature was examined. Detective Acting Senior Sergeant Rowe reported analysis of the ligature by forensic officers at the Chemical Trace Unit at the Victoria Police Forensic Services Centre matched substances on the inside of the loop at the top end with samples from the top of the pantry door in the Schneider residence. Further he advised there are tutorials online regarding how to tie this particular knot, which has the ability to slide and tighten.

38. Secondly, a scene examination by Detective Acting Senior Sergeant Rowe included a pana-scan, which gave a scale depiction of the kitchen area, for him to consider other possible scenarios. Detective Acting Senior Sergeant Rowe was satisfied the pantry cupboard was the hanging point by virtue of the chemical trace evidence. Although it was impossible to say to what extent, he was of the view it was possible the ligature tightened sufficiently without Ms Schneider being suspended for a significant period of time. He believed Ms Schneider placed her black jacket (visible in the scene photographs) between and slightly underneath the pantry doors to inhibit the ability of the doors to move.

39. Detective Acting Senior Sergeant Rowe was of the view it was unlikely an intruder had entered the premises and detailed the impediments that an intruder would have to overcome to be able to retrieve the curtain tie from Ms Schneider's bedroom and then tie it into a ligature.

40. Detective Acting Senior Sergeant Rowe also considered the possibility of third-party involvement. Mr Hampel stated to LSC Rijks that on 23 June 2018 he attended an exhibition in the Melbourne CBD before going to lunch in Richmond. Detective Acting Senior Sergeant Rowe advised this was entirely consistent with the records and there is no evidence of Mr Hampel attending at Ms Schneider's home address on 23 June 2018.

41. Analysis of Ms Schneider's mobile phone confirmed evidence of a disagreement/ break up with Mr Hampel throughout the morning of 23 June 2018. Detective Acting Senior Sergeant Rowe noted it was evident from the material in the phone records that the two had a personal relationship, which included frequent communication and at least two trips away together. I note that Mr Hampel made two statements as part of the coronial investigation and an email

to LSC Rijks,[10] which detail his relationship with Ms Schneider and his whereabouts on 22 and 23 June 2018.

42. I accept Detective Acting Senior Sergeant Rowe's advice that he has not identified any suspicious circumstances with respect to Ms Schneider's death.

Intent

43. I am satisfied that Ms Schneider, whilst affected by alcohol, prescription medication and cocaine, and upset by relationship difficulties, made an impulsive decision to end her own life.

FINDINGS AND CONCLUSION

44. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Baillee Petra Schneider, born 19 February 1993, died on 23 June 2018 at 71 Darling Street, Moonee Ponds, Victoria, from compression of the neck in the circumstances described above.

COMMENTS

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

1. The Victorian Suicide Register (VSR) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present. The VSR was designed, built and piloted by staff in the Coroners Prevention Unit (CPU), [11] between 2011 and 2012, and became integrated into the Court's work in 2013.

2. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

[10] Statements dated 28 August 2018, 15 April 2019 and a statement by LSC Rijks dated 12 August 2019.

[11] The Coroners Prevention Unit is a specialist unit within the Coroners Court of Victoria, which undertakes case reviews, literature reviews and data analysis to support the Coroner in their prevention role.

3. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

4. There is an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder. [12] VSR data shows that alcohol is consistently detected during post-mortem examination in between 25% and 35% of Victorian suicides each year. Substance misuse generally predisposes an individual to suicide by disinhibiting or providing "courage" to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. However, it should be noted that the nature of the association between alcohol consumption and self-harm/suicide is not entirely clear. Consumption of alcohol might influence self-harm/suicide due to the depressant influence of the substance itself; likewise, acute alcohol intoxication might contribute to disinhibited or impulsive behaviours.

I convey my sincere condolences to Ms Schneider's family for their tragic loss.

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

Mrs Sabine and Mr Cameron Schneider, senior next of kin.

Leading Senior Constable Katyana Rijks, Victoria Police, Coroner's Investigator.

Detective Acting Senior Sergeant Paul Rowe, Homicide squad

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 23 April 2020

[12] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, 2013, p.493.