IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004832

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	PA[1]
Date of birth:	1994
Date of death:	12 September 2021
Cause of death:	1(a) Pentobarbitone toxicity
Place of death:	Castlemaine, Victoria, 3450
Keywords:	Pentobarbitone; Veterinary Nurse; Suicide; Multiple suicide stressors;

[1] This finding has been de-identified in accordance with the family's wishes.

INTRODUCTION

1. On 12 September 2021, PA was 26 years old when she was found deceased at home in circumstances suggestive of suicide. At the time, PA lived alone in a unit in Castlemaine, Victoria.

2. PA was born in South Australia and had one older sister. Almost immediately after PA's birth the family moved to Hong Kong for around a year before returning to Australia where they resided in Sydney for another year. The family then moved to Bacchus Marsh, Victoria where they settled.

3. Since she was a child, PA was known to have a "*very sensitive soul*"[2] and a strong sense of compassion. At times at school, this made her susceptible to bullying. PA was passionate about animals and had adopted a vegan lifestyle. She was happiest in nature and with animals and enjoyed reading, music, and the piano. Her mother noted issues such as deforestation and poor treatment of animals had a profound effect on PA, and she frequently signed petitions for related causes about which she was passionate.

4. After finishing high school, PA completed a Bachelor of Photography. She struggled to find consistent work as a photographer following the completion of her studies. She briefly moved to Newcastle and completed a qualification in bookkeeping before returning to Melbourne. In around 2019 she met James and commenced an intimate relationship with him.

5. After a series of jobs, in November 2020 PA began work as a veterinary nurse at the Castlemaine Veterinary Clinic (**CVC**).

6. In the statement she provided for the coronial brief, practice owner and veterinarian Ms Yvette Berkeley noted that when PA started working at CVC she was bright and bubbly although extremely sensitive. PA was good at her job, good with people, and the clients loved her.[3]

7. However, as PA continued to work at CVC, she became increasingly disillusioned with her job complaining to her mother and close friends about her working conditions and aspects of the clinic's practice. Her co-worker, Jessica, observed that PA became more and more unhappy with work and that her happiness disappeared the longer she worked at CVC.

[2] Coronial Brief [CB], Statement of PA's mother dated 12 September 2021.
[3] CB, Statement of Yvette Berkeley dated 14 September 2021.

8. In her statement, Jessica said she believed PA was "*to some extent bullied by the practice owners*" at CVC.[4] Jessica believed that PA was unfairly targeted and received unwarranted criticism over her job performance. Another colleague of PA, Courtney, stated that all the veterinary nurses at CVC "*cop it*" from management, however, she did not believe that PA was treated differently from the other nurses. There is no evidence PA raised a formal complaint of workplace bullying with her employer or any other entity at any time.

9. On one occasion, PA approached Jessica and asked if she could take some diazepam from the veterinary clinic for her own personal use.[5] Jessica denied PA permission to access the substance for personal use and raised the issue with the practice manager of CVC. In particular, Jessica raised concerns about the fact that there was a key accessible to all staff that was known to allow access to the pharmacy cupboard.[6]

Mental Health

10. PA had a history of mental health issues dating back to age 15, including depression, anxiety and panic attacks at various times. She had previously self-harmed to her wrists and legs but was not known to self-harm for several years prior to her death.

11. PA was predominately treated by General Practitioner (**GP**) Dr Sogand Sahari of the Werribee Women's Health Hub/ Hoppers Lane General Practice from 2019. During a consultation with Dr Sahari on 7 August 2019, PA confided she had previously experienced suicidal thoughts and intent without a plan. She denied any present suicidal thoughts or intent but did present with symptoms consistent with anxiety and depression. Subsequently, Dr Sahari commenced PA on the anti-depressant, venlafaxine 37.5mg and provided a Mental Health Care Plan (**MHCP**) with referral to a psychologist.

12. Medical records suggest PA completed six sessions of counselling but did not find the sessions helpful. On 18 June 2020 PA's anti-depressant medication was changed to agomelatine 25 mg. The dose was increased to 50mg daily a short time later. There was an unexplained interruption to antidepressant therapy sometime between the end of 2020 and the start of 2021, but treatment was recommenced in February 2021.

[4] CB, Statement of Jessica dated 1 December 2021.
[5] It is unclear from Jessica's statement when this event occurred. The statement from James refers to a similar event involving PA taking diazepam from CVC around three months prior to their separation. It is unclear whether Jessica and James refer to the same event.
[6] According to Jessica the communal key was hidden to a location only known by a few people, however, after a few weeks the key was returned to the location known by all staff as people grew frustrated at the new practice.

13. On 7 June 2021, PA consulted Dr Sahari for depression and other medical concerns. It was documented that PA's anxiety had improved, but her depression had not. A decision was made to revert to the antidepressant venlafaxine. Dr Sahari administered a Depression Anxiety Stress Scale (**DASS**) and provided a MHCP with referral to a psychologist.

14. On 7 July 2021, PA consulted GP Dr Shaifullah Yoosuflebbe of MyClinic Bacchus Marsh. She presented with stomach issues and sought a medical certificate for work. According to medical records she also presented with depression, stress at work, and difficulty sleeping. Dr Yoosuflebbe provided PA with a prescription for melatonin help her sleep.

15. PA returned to Dr Sahari on 20 July 2021 and sought a referral to another psychologist. Accordingly, Dr Sahari provided a referral to MBS Psychology (**MBS**) in Bendigo. PA complained of episodes of dizziness and Dr Sahari changed her antidepressant back to agomelatine. The evidence is unclear whether this change was in response to the reported episodes of dizziness. Dr Sahari noted PA's report of suicidal thoughts and occasional intent when driving but no plan. With PA's consent, Dr Sahari also made a referral to CAREinMIND, a local suicide prevention program. A family history of suicidal ideation was also discussed.

16. On 28 July 2021, PA had a final telehealth consultation with Dr Sahari. PA advised she had received a call from CAREinMIND but did not take the call and had not yet called them back. Dr Sahari advised PA that if she failed to call them back within seven days the referral would be closed. In the time between her last consultation with Dr Sahari and her death, PA had arranged three appointments with psychologist Anne Finlayson Smith of MBS, with the first appointment scheduled for 24 August 2021.

17. As at her last consultation, on 28 July 2021, PA was still experiencing suicidal thoughts with no plan or intent. Dr Sahari assessed her as being at low risk. On 4 and 9 August 2021, Dr Sahari made two failed telehealth calls to PA, messages were left with no response from PA.

18. PA emailed MBS late on 18 August 2021 and cancelled the three sessions she had previously made with Chloe. She cited that Medicare had rejected her MHCP and therefore she was unable to afford the sessions. The following morning, a staff member from MBS replied to PA's email and advised there did not appear to be any issues with her MHCP and that it

"*should be ready to use*."[7] The evidence suggests PA did not have any further contact with MBS.

19. In the weeks leading up to her death, PA experienced several traumatic events. The family dog, Sapph, was euthanised in late July 2021. Sapph had been in the family since PA was 10 years old and PA shared a strong bond with her dog. Around two weeks after Sapph passed away, PA witnessed a joey (baby kangaroo) that she was assisting be struck and killed on the road. After the incident, PA drove to her mother's house distraught. PA's mother stated she had never seen her daughter in so much distress.

20. PA continued to struggle at work. Her co-worker Jessica noted that PA appeared to be a "*shadow of who she was"* when she first started with CVC. Around a month before her death, PA disclosed to Courtney that she had ceased taking her anti-depressant medication as it cost her around $200 per month which she could not afford. PA was actively looking for new work. In the weeks leading up to her death, she was informed by email that she unsuccessful with one of her job applications.

21. In late August 2021 PA and her partner ended their relationship. PA was upset by the break-up but was well comforted by her friend, Chloe, who supported PA following the separation. PA last saw Chloe for dinner on 9 September 2021 when her friend talked positively about future plans.

22. PA had been trying to find alternative employment and applied for a 12-month position at the Bendigo Gallery. On 8 September 2021, she received an email advising that she had been unsuccessful in that application.

THE CORONIAL INVESTIGATION

23. PA's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

24. 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

[7] CB, email from enquiries@mbspsychology.com.au dated 19 August 2021.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

25. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

26. Victoria Police assigned Detective Senior Constable Daniel Vear to be the Coroner's Investigator for the investigation of PA's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

27. This finding draws on the totality of the coronial investigation into the death of PA including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[8]

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

Identity of the deceased

28. On 12 September 2021, PA, born 1994 was visually identified by her landlord, Craig, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

30. Forensic Pathologist Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection of PA's body in the mortuary on 14 September 2021 and provided a written report of his findings dated 21 October 2021.

[8] 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.

31. The post-mortem examination was consistent with the clinical history. Multiple superficial marks consistent with self-harm were observed on both arms and legs.

32. Routine toxicological analysis of post-mortem samples detected pentobarbitone in blood samples. The contents of a syringe located at the scene containing a green coloured liquid was tested which confirmed the presence of pentobarbitone.

33. Pentobarbitone is a sedative drug which is used for humane euthanasia of animals. Pentobarbitone is not registered for use in humans and there are no proprietary medicines containing pentobarbitone in Australia. It is a barbiturate drug with potent central nervous system depressant effects. Toxic effects include drowsiness and respiratory depression which can progress quickly to coma and death.

34. Toxicological analysis showed ethanol (alcohol) at a concentration of 0.04g/100mL in blood samples but not in vitreous humour[9] samples. Nordiazepam, the metabolite of diazepam[10], was also detected.

35. Dr Beer provided an opinion that the medical cause of death was *1(a) pentobarbitone toxicity*.

36. I accept Dr Beer's opinion.

Circumstances in which the death occurred

37. At around 10.00am on 11 September 2021, PA met with her friend and co-worker Courtney. The friends attended the 'Garden of St Erth,' a nursery and café in Blackwood. They had discussed attending this particular café for several months.

38. There was nothing that appeared overtly out of the ordinary with PA while she was at the café. Courtney stated she was chatty as always, pretty upbeat, and very bubbly and observant. The friends talked about life generally and PA spoke a lot about her ex-boyfriend. PA also spoke about how she was unhappy in her current job, that she was looking for jobs online, and was considering a move to Tasmania.

[9] Vitreous humour is the clear gel that fills the space between the lens and the retina of the eyeball. Generally, toxicological analysis of vitreous humour provides a better indicator of perimortem levels than post-mortem blood.

[10] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

39. The friends left the café and returned to Courtney' house arriving at around 3.00pm. Shortly after, PA left in her car. Courtney did not hold any concerns for her friend and believed that she had seemed normal throughout their day together.

40. PA returned home and as she arrived, she had a brief conversation in the driveway she shared with her landlord, Craig. PA reported that "*her job was getting a bit much*" and that she hoped the COVID-19 lockdown would return due to a recent local positive case. Craig stated she seemed unusually short with him as though she just wanted to go straight into her unit. This was unusual for PA who would frequently stop and have long conversations with Craig. Although Craig believed PA's behaviour was out of the ordinary, he stated she was friendly as always.

41. Later that evening, PA and her friend Chloe exchanged a series of text messages. PA was upset about the recent separation from her boyfriend and Chloe provided support.

42. In the early hours of 12 September 2021, PA left her home and attended her workplace. At 1.44am, closed circuit television (**CCTV**) captured PA arriving at CVC and entering the clinic using her set of keys. She entered the treatment room at CVC where she gathered various needles, syringes and bags. PA then retrieved a key from the endoscope machine and unlocked the medication cabinet where she obtained a bottle of Lethabarb (pentobarbitone) used for animal euthanasia procedures. CCTV footage then showed her taking an intravenous fluid pump before leaving the clinic at 1.50am.

43. At 8.09am on 12 September 2021 PA received a text message from her former partner asking her to meet. Later that morning at around 8.30am, PA published a post on her Instagram page suggestive that her mental wellbeing had substantially deteriorated. At 9.35am, Victoria Police received a request for a welfare check for PA from someone who had seen her post on Instagram. Police received a second welfare check request a short time later.

44. At 9.54am, Victoria Police members arrived at PA's home and obtained a key to enter from Craig. They entered and located PA unconscious in bed with an intravenous (**IV**) line inserted into her left arm. A syringe with green fluid was inserted into the IV line.

45. Ambulance Victoria paramedics responded a short time later. They did not detect any signs of life and formally verified that PA was deceased at the scene.

46. Attending police members conducted a search of the scene and discovered a note written by PA expressing a clear intent to end her own life. A bottle of Lethabarb was located on the kitchen bench.

47. Having investigated the circumstances surrounding PA's death and provided the brief of evidence, Detective Senior Constable Daniel Vear concluded that PA intentionally took her own life.

FURTHER INVESTIGATIONS- CPU REVIEW

48. As part of my investigation, I obtained advice from the Coroners Prevention Unit (CPU) about the medical care PA received from GPs Dr Sogand Sahari and Dr Shaifullah Yoosuflebbe shortly before her death. I also sought advice from CPU about PA's ability to access pentobarbitone through her employment as a veterinary nurse.

49. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

50. Following a preliminary review of the matter, the CPU recommended that further statements be obtained from Dr Sahari, Dr Yoosuflebbe and a statement from the owner of the Castlemaine Vet Clinic. On the advice of the CPU, I requested and obtained further statements from the above and referred the matter to the CPU for their appraisal of PA's care.

51. As part of their review, the CPU were assisted by medical records from MyClinic Bacchus Marsh, Hoppers Lane General Practice, and Werribee Women's Hub. They were also assisted by the statements from GPs Dr Sahari and Dr Yoosuflebbe, additional statement from veterinarian Dr Yvette Berkeley, the coronial brief and the court file.

Care provided by Dr Sogand Sahari

52. In her statement provided to the court, Dr Sahari confirmed she considered herself PA's primary GP. Throughout 2021, PA consulted Dr Sahari on seven occasions. Due to the pandemic, most of these consultations were conducted via telehealth.

53. Dr Sahari treated PA for her mental health by prescribing anti-depressants, alternating between agomelatine and venlafaxine. Following her death, the court obtained from Services

Australia a copy of PA's Medicare and Pharmaceutical Benefits Scheme (**PBS**) claims history for the 12 months preceding her death. PBS record show PA did not have any claims under the PBS for either agomelatine or venlafaxine in the twelve months leading up to her death. PA also confided in a friend she was unable to afford her anti-depressants. The absence of agomelatine, the anti-depressant most recently prescribed, on post-mortem toxicology analysis suggests a sustained period of non-compliance.

54. Dr Sahari was unaware that PA was not compliant with her medication and the CPU found there was nothing to suggest that Dr Sahari ought to have been aware that PA was not compliant with her anti-depressants.

55. Dr Sahari provided PA with a MHCP on two occasions, the first in August 2019 and the second on 7 June 2021. As part of the MHCPs, Dr Sahari provided three separate referrals to different psychologists. Unfortunately, PA did not see a psychologist as referred by Dr Sahari. An appointment with a psychologist was scheduled for late August 2021, however, PA cancelled the appointment citing an issue with Medicare rejecting her MHCP. There is no evidence to suggest there were any issues with the MHCP provided by Dr Sahari and the CPU was unable to identify why PA believed Medicare had rejected her MHCP.

56. The CPU advised the treatment provided by Dr Sahari was reasonable and appropriate. Dr Sahari was aware of and continued to monitor PA's mental health and associated risks including suicidality. The CPU did not identify any prevention opportunities with respect to Dr Sahari's care.

Care provided by Dr Shaifullah Yoosuflebbe

57. Dr Yoosuflebbe treated PA on three separate occasions, once in 2016 and 2020, with their final consultation on 7 July 2021. During the final consultation PA presented with stomach issues and sought a medical certificate. According to medical records she also presented with depression, stress at work, and difficulty sleeping. Dr Yoosuflebbe prescribed melatonin to help PA sleep.

58. The CPU sought a statement which Dr Yoosuflebbe and it remains unclear what discussions were held, or advice provided by Dr Yoosuflebbe about PA's mental health on 7 July 2021. However, the CPU identified that Dr Yoosuflebbe was not PA's primary GP and his final consultation with her was two months before her passing after which she had subsequent attendances on Dr Sahari who was her primary treating GP. In those circumstances, the CPU

were of the view that further investigation of the attendance on 7 July 2021 is unlikely to reveal a prevention opportunity.

59. I accept the advice of the CPU and do not propose to investigate this matter further.

Access to pentobarbitone

60. In the ordinary course of her employment at CVC, PA had access to the locked pharmacy cupboards in which pentobarbitone was stored. Veterinarian and practice owner of CVC Dr Yvette Berkeley advised that all nurses, including PA, had access to the keys to the pharmacy cupboards as part of their normal duties. At the time, the key to the pharmacy cupboard was kept in a draw in the common staff area of the clinic.

61. During ordinary business hours, veterinary nurses at CVC were permitted by management to access the pharmacy cupboard under veterinary supervision. As the key was not moved overnight, there was no additional measure preventing access to the pharmacy cupboard outside of work hours when not supervised by a veterinarian.

62. In her statement provided to the court, Dr Berkeley conceded that PA would have known exactly where the pentobarbitone was stored, how to access it, how to use it, and what its effects would be if used.

63. Since 1 October 2020, the Therapeutic Goods Administration (**TGA**) requires that injectable pentobarbitone be stored in a locked container to prevent unauthorized access. A person with 'authorized access' under the TGA's storage regulation includes a veterinary practitioner.[11] As a level 4 TAFE qualified veterinary nurse, PA did not have 'authorized access' to pentobarbitone.

64. Nevertheless, PA was able to access pentobarbitone, both within in the ordinary course of her duties, outside the scope of her work duties, and as is clear from the CCTV footage, entirely without hindrance outside of clinic hours. It is clear that CVC's storage of pentobarbitone and the practice of permitting veterinary nurses access to the drug at the material time were in clear breach of the TGA's regulations in force since 20 October 2020.

[11] Authorised access as stipulated in the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) includes a veterinary practitioner, s13(1)(a). A veterinary practitioner being a person who has been awarded a tertiary degree in veterinary science or medicine as per the *Veterinary Practice Act 1997* (Vic), s5(1)(a).

65. Dr Berkeley advise that, following PA's death, CVC immediately changed their protocols in relation to the storage and handling of restricted drugs, including pentobarbitone. These changes included:

i. Pentobarbitone being permanently removed from the locked pharmacy cupboard and relocated to a new drug safe.

ii. Veterinary nurses are no longer permitted to access or handle pentobarbitone.

iii. Veterinarians are no longer permitted to ask nurses to access or handle pentobarbitone.

iv. Pentobarbitone orders received must be signed off by a veterinarian and immediately locked in the safe.

v. Each veterinarian has their own key to the new drug safe containing pentobarbitone which they take home with them. There is no spare key left unattended at any time in the clinic.

66. Dr Berkely also stated CVC management have allocated additional time in leadership meetings to identify at-risk individuals or colleagues potentially in crisis, and more formal and informal time for pastoral care.

67. The CPU concluded by advising that the measures put in place by CVC following PA's death bring them into line with the current regulations regarding the safe handling and storage of pentobarbitone and that CVC's added focus to the mental health and wellbeing of its employees was a positive change.

FINDINGS AND CONCLUSIONS

68. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explication.[12]

69. Moreover, adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where

[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was PA;

    b) the death occurred on 12 September 2021 in Castlemaine, Victoria, 3450;

    c) the cause of PA's death was pentobarbitone toxicity;

    d) the death occurred in the circumstances described above; and

    e) the available evidence, including in particular the lethality of means chosen and her handwritten suicide note, supports a finding that PA intentionally took her own life by accessing and, and in due course, self-administering a sufficient quantity of pentobarbitone intravenously to cause her death.

71. PA was able to access the pentobarbitone in the early hours of 12 September 2021 as CVC were not compliant with the storage and handling requirements of pentobarbitone and other substances at the time.

72. I commend CVC for the changes they implemented immediately after PA's death. However, the effectiveness of the measures implemented by CVC following PA's death are reliant on staff awareness and compliance, and the ability of staff to respond and rectify any deviations from expectations.

73. Despite presenting to Dr Sahari on multiple occasions, and Dr Yoosuflebbe on one occasion for mental ill health, PA did not present as overtly suicidal. She was in contact with friends the day before her death and did not appear to them to be at risk of self-harm.

74. The available evidence does not support a finding that there was any want of clinical management or care on the part of Dr Sahari or Dr Yoosuflebbe that may have caused or contributed to PA's death.

75. Post-mortem toxicology and PBS records support a finding that PA was not compliant with her anti-depressant medication and likely had not been for some time. It is not clear why PA complained she could not afford to purchase the antidepressants prescribed to her or whether this was simply an excuse she gave for not taking them. Nor is it apparent that there was any

problem with the MHCP and referral provided by Dr Sahari. What is clear is that PA was not engaged with any mental health treatment in the period immediately preceding her death.

76. Determining the precise reasons or factors leading a person to end their life, to the applicable standard of proof, is not always possible. Experience in this jurisdiction suggests there are often multiple, sometimes inter-related and dynamic suicide stressors (so-called) and certainly this was the case with PA.

77. PA's mother has made a comprehensive and heart-felt submission to the court about the stressors experienced by PA while working at CVC, in particular from March 2021 until her death. AP's mother strongly held belief was that "workplace bullying" was a significant stressor for PA and the available evidence does support a finding that this was so.

78. As a coroner, I need cogent evidence to make a positive coronial finding about all material facts including which suicide stressors PA experienced. While the available evidence supports a finding that PA had a very negative workplace experience at CVC, it also supports the existence of other suicide stressors.

79. PA's love of animals which drew her to working in a veterinary clinic also appears to have caused her distress due to her daily exposure to sick and sometimes dying animals. PA's own beloved border collie "Sapph" was euthanised on 27 July 2021 which was humanely done but nevertheless distressing. On 15 August 2021, PA approached a joey by the side of the road which she saw glance off one car only to see it jump into the path of another car and be hit directly by that car which failed to stop. PA's mother described her daughter as arriving home extremely traumatised after carrying the joey's broken body off the road. On 29 August 2021, PA's relationship with James broke down. On 8 September 2021, she received an email advising that she had been unsuccessful in securing alternative employment.

80. Having reviewed all the available evidence, including PA's handwritten suicide note and AP's mother's submission, I am unable to determine a primary suicide stressor in PA's case. Rather, my determination is that it was the cumulative effect of the various stressors mentioned above that combined to lead PA to end her life.

81. I convey my sincere condolences to PA's family and friends for their loss.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with PA's death:

1. The Coroners Court of Victoria maintains an overdose death register, which contains information on all deaths investigated by Victorian coroners where it was concluded the acute toxic effects of a drug or drugs played a contributory role.

2. Between 1 January 2000 and 31 December 2021, there were 115 suspected or coroner-determined suicides for which pentobarbitone was coded as a contributing drug in Victoria. In 15 of these deaths, the pentobarbitone was accessed through the deceased's workplace. All 15 of these deceased worked in the veterinary industry, either as veterinarians or veterinary nurses. There was an additional death where pentobarbitone was noted to have been taken from a veterinarian's car.

3. For a total of 52 out of the 115 deaths, the source of the pentobarbitone could not be established. This is unsurprising as there is no legal use for pentobarbitone in humans, and therefore no legal means to obtain it. Moreover, there are known instances of the drug being sourced overseas.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations including recommendations relating to public health and safety or the administration of justice:

1. That **Castlemaine Veterinary Clinic** ensure that escalation processes are in place regarding deviations from expected practice around the use, storage and monitoring of pentobarbitone.

2. That **Castlemaine Veterinary Clinic** ensure that all staff are educated around escalation processes if they identify deviations from expected practice around the use, storage and monitoring of pentobarbitone.

To promote industry wide compliance with pentobarbitone storage and handling regulations, I make the following recommendations:

3. That the **Veterinary Practitioners Registration Board of Victoria** encourage its members to identify deviations from legislation and guidelines around the safe use, storage and monitoring of pentobarbitone and escalate these appropriately.

4. That the **Veterinary Practitioners Registration Board of Victoria** encourage its members who operate veterinary practices communicate to their staff the expectations for use, storage and monitoring of pentobarbitone when deviations from policies and expected practice are identified. Such communication should be safety and prevention focused.

PUBLICATION OF FINDING

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

PA's family

Castlemaine Veterinary Clinic

Dr Sogand Sahari

Dr Shaifullah Yoosuflebbe

Therapeutic Goods Administration

Veterinary Practitioners Registration Board of Victoria

WorkSafe

Department of Health, Medicines and Poisons Regulation.

Detective Senior Constable Daniel Vear, Victoria Police, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 10 May 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.