IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2015/4118

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***
Amended pursuant to *Section 76 of the Coroners Act 2008* on 18 May 2018[1]

I, Rosemary Carlin, Coroner having investigated the death of Dannika Michelle Smith

without holding an inquest:
find that the identity of the deceased was Dannika Michelle Smith
born on 6 February 1989
and the death occurred on or about 15 August 2015
at 101/432 Geelong Road, West Footscray
from:

1. (a) Toxicity to Pentobarbitone

Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) there is a public interest to be served in making findings with respect to the following circumstances:

1. Dannika Michelle Smith (referred to in my finding as 'Dannika'), aged 26 years, resided alone in a unit in West Footscray at the time of her death. She was the daughter of Ann Smith and Tony Smith, and had an older brother, Ben.
2. Dannika suffered from many physical ailments including osteoporosis and fibromyalgia, which caused her pain. During her teenage years, she took a number of drug overdoses and

[1] This document is an amended version of the finding into Ms. Smith's death dated 30 October 2017. Paragraph 21 has been corrected pursuant to Section 76 of the *Coroners Act 2008 (Vic)*, in response to an email from Epworth Hospital.

was treated for mental health issues. Her eventual diagnosis was Borderline Personality Disorder (BPD).[2] In 2015, Dannika was also diagnosed with narcissistic personality disorder traits.[3]

3. Despite her physical and mental challenges, Dannika had worked at the Emergency Services Telecommunications Authority (**ESTA**), held a Certificate III in aged care and commenced a post graduate nursing degree in the year of her death. She had a student placement at Rosary Home ACF, who reported that she was gentle and kind with the residents and worked well with the care team. Dannika also travelled extensively.

4. Between 12.15pm and 1.05pm on 15 August 2015, members of Victoria Police interviewed Dannika in relation to the importation of pentobarbitone which had been confiscated from her on 8 July 2015.

5. About 7.00pm on the same day, Dannika was found deceased by police in her bed after they were requested to perform a welfare check. Ambulance officers attended, but Dannika was declared deceased at the scene.

6. There were several suicide notes found on the kitchen counter and in her computer.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. The Coroners Court of Victoria is an inquisitorial jurisdiction[4]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurs refers to the context or background and surrounding circumstances which are

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[2] BPD is a debilitating disorder characterised by rapid and extreme mood changes including depressive, aggressive and anxious states; intense fears of abandonment and rejection; a pattern of unstable and intense interpersonal relationships; impulsivity; a persistent unstable sense of self; chronic feelings of emptiness and a tendency toward self-harming and suicidal behaviours. The behaviour of people with BPD often disrupts family and work-life, long term planning, and interpersonal relationships. *Beatson J, Rao S, Watson C. 2010 Borderline Personality Disorder. Towards Effective Treatment. Australian Postgraduate Medicine. Melbourne, page 20.*

[3] NPD traits include grandiosity, need for admiration, sense of entitlement, and a lack of empathy.

[4] Section 89(4) of the Act

[5] Section 67(1) of the Act.

proximate and causally relevant to the death, rather than to all of the circumstances which might form part of a narrative culminating in death. [6]

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine whether there is any criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

STANDARD OF PROOF

9. All coronial findings must be made based on proof of relevant facts on the balance of probabilities but with due regard to the principles enunciated in *Briginshaw* v *Briginshaw*.[8] 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 that they caused or contributed to the death.

IDENTITY OF THE DECEASED

10. The Deceased's identity was not in dispute and did not require investigation.

MEDICAL CAUSE OF DEATH

11. A post-mortem examination was conducted by Dr Michael Burke, Pathologist of the Victorian Institute of Forensic Medicine, who determined the cause of death to be 'Toxicity to Pentobarbitone.'

12. A toxicological examination revealed the presence of pentobarbitone (~22mg/L), oxycodone (~0.02mg/L), diazapam (~0.09mg/L), nordiazepam (~1mg/L), temazepam (~0.03mg/L), amitriptyline (~0.04mg/L), nortriptyline (~0.03mg/L), quetiapine (~0.2mg/L) and metoclopramide (~0.03mg/L).

13. The Toxicological Report noted that post mortem blood concentrations of pentobarbitone in, deaths attributed largely to toxicity to pentobarbitone, range from 10 mg/L.

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[6] *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] *Keown v Kahn* (1999) 1 VR 69.

[8] (1938) 60 CLR 336.

CIRCUMSTANCES

14. I was assisted in my investigation by Detective Sergeant Dennis Williams, Wyndham Criminal Investigation Unit, who prepared a coronial brief of evidence which contained witness statements, photographs and other documentation.

Incident on 8 July 2015

15. On 8 July 2015, Dannika sought assistance from the Epworth Hospital. She reported, '[I] *told them that I had Nembutal in my possession and that I wanted admission because I didn't want to kill myself ...Because I changed my mind*'.

16. As a result, Victoria Police were requested to conduct a welfare check, and at about 10.05am, four police officers (Senior Constable Peter Romanis, Senior Constable Paul Micallef, Sergeant Daniel Johnson and First Constable Brendan Williams) attended Dannika's unit with Ambulance Victoria. She disclosed that she had in her possession pentobarbitone for the purpose of suicide. Eventually Dannika also disclosed its location (the fridge) after which it was seized by police.

17. Dannika was taken by ambulance with police escort to the Western Hospital under section 351 of the Mental Health Act.

18. As a result of this attendance, a Person Warning Flag (**PWF**) was created by Senior Constable Romanis and placed on the Victoria Police Law Enforcement Assistance Program (**LEAP**) recording that she had suicide/self harm behaviour. The purpose of the PWF was to alert other police members who may have contact with Dannika in the future to the existence of this risk. Those members could then look behind the PWF for the details of the event giving rise to it.

19. In addition, an Information Report (**the 1st IR**) was created in relation to Dannika's possession of the seized pentobarbitone, pentobarbitone being an illegal import. The criminal investigation in relation to the matter was assigned to Detective Sergeant Russell Sheather, Maribyrnong Criminal Investigation Unit (**CIU**) on 10 August 2015 (see below).

20. On 10 July 2015, Dannika attended the Footscray Police Station and thanked the members who attended on 8 July.

Incident on 12 July 2015

21. On 12 July 2015, the Enhanced Crisis Assessment and Treatment clinician **(ECAT)**, who assessed Dannika on 8 July, requested that police conduct a welfare check as they had not been able to contact Dannika by telephone and she had previously indicated she would suicide on this day. Police members from the Footscray Police Station attended her unit at 2.25 pm and found Dannika to be well, with nothing in her presentation giving rise to any concerns. Their observations were communicated to the hospital.

22. Later that evening Dannika ingested tablets and upon becoming ill called an ambulance. She was subsequently conveyed to the Western Hospital.

23. Dannika remained a mental health inpatient (voluntarily and involuntarily) at Western Hospital, the Epworth Hospital and St Vincent's Hospital until her discharge on 29 July, whereupon her care was managed by the Saltwater Clinic Community Team. Whilst in hospital she was at times physically aggressive, angry, hostile, abusive and threatening to staff. She was sometimes future focused but on a number of occasions threatened to kill herself once discharged. She reported that she would (or had) purchase(d) pentobarbitone online in order to suicide.

The purchase and reporting of pentobarbitone importation

24. Analysis of Dannika's email account reveals that whilst she was in hospital she negotiated the purchase of pentobarbitone from two different Mexican suppliers. In the emails Dannika advised the suppliers that she had transferred the money via Western Union and the suppliers confirmed shipment on 23 and 24 July 2015 respectively. On 13 August 2015 Dannika emailed one of the suppliers and advised that 'the package arrived safe and sound today'.

25. After Dannika's death, her mother located Western Union receipts for the transfer of money. A receipt of 21 July 2015 from Australia Post at Camberwell West confirms a transfer of

money by Dannika. Dannika's mother further indicated that she went with her daughter to that branch of Australia Post when she was on hospital day release.

26. A treating health professional reported to 'customs' that any international package addressed to Dannika was likely to be pentobarbitone which she would use for suicide.

27. The Department of Immigration and Border Protection (**DIBP**) confirmed it received such an anonymous report on 25 July 2015 and then conveyed the information to Victoria Police.

28. On 29 July 2015, an Information Report (**2nd IR**) was created by the Victoria Police Intelligence Collection and Liaison Unit (ICIU), based on information from DIBP, noting among other things that:

   - Dannika had sent sums of money to Mexico and one of the recipients was linked to the importation of pentobarbitone.
   - An anonymous source said that she had ordered a euthanasia drug from overseas and it will be delivered by mail.

Welfare Check on 3 August 2015

30. As a result of the 2nd IR, on 3 August 2015 a check on Dannika's welfare was conducted at about 6.04pm by the Footscray Police (Senior Constable Jonathon Miller and Constable Brendan Slappendel) at her home address. Dannika refused access to police but assured them that she was fine. She wanted to know who had requested the check and later called Sgt Leemara Fairgrieve, Divisional Supervisor at the Altona Police Station to request this information. She was reportedly curt and unhappy that the information was not forthcoming. It was reported that her speech was 'slightly slurred' and she was confused as to the day of the week. She was apparently offered advice if she believed the request for checks was malicious.

31. It appears that the job request to the attending officers advised that Dannika should not be told who requested the welfare check. Police simply advised her that it was '*someone who is concerned about you.*'

32. The fact of this welfare visit/check, was not recorded on LEAP as Victoria Police has no requirement or avenue for recording welfare checks, other than on a patrol duty return.

Welfare check on 4 August 2015

33. On 4 August 2015, Dannika's mother was unable to raise her by telephone so contacted the police to conduct a welfare check. Victoria Police made contact with the Saltwater Clinic Case Manager, Ms Sarah Colone.[9]

34. Police (including Constable Thomas Briggs and S/C Romanis) attended at Dannika's unit at about 12.08pm, at which time they found her suffering from the effects of a drug overdose. She said that she had taken a combination of prescription medication including Tramadol to '*end it all*'. Suicide notes were located as well as a play list for her funeral and instructions for her burial.

35. She was transported to the Western General Hospital and went voluntarily and subsequently released by medical staff on 5 August 2015.

Request for a further Person Warning Flag on LEAP

36. As it had not been recorded on LEAP, Constable Briggs and Senior Constable Romanis were unaware of the welfare check on 3 August 2015. However, after attending on 4 August they sought to update the LEAP database (by completing a L14B 'Antecedent Form') as well as by creating a further PWF.

37. In fact no new PWF was created on LEAP. Investigation by the CI revealed that whilst Constable Briggs made the request, the senior officer to whom it was forwarded for processing and uploading, did not pass it on in the normal course of business. No explanation could be provided other than human error.

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[9] I note that she would have been able to provide some information because the situation could be deemed to be imminent risk as described in the *Health Records Act 2001* (Vic)

Testing of packages stopped on 10 August 2015

38. On 10 August 2015, two small parcels addressed to Dannika were intercepted at the post office as a result of a postal stopper which had been in place since 27 July 2015. They were returned to the Melbourne Gateway Facility on 12 August 2015 for testing by DIBP.

39. Although DIPB clearly had information about Dannika's activities, the examining officer was not aware of the reason for the testing. He conducted presumptive tests on two bottles in one parcel and one bottle in the other parcel using a chemical called First Defender RM. At that time First Defender was not capable of detecting pentobarbitone. The tests on all three bottles indicated the presence of a mixture of substances including Propylene Glycol. Propylene Glycol is a substance commonly used in electronic cigarettes and anti-freeze, and is not prohibited.

40. During the course of my investigation DIBP advised that there was an alternative, less commonly used, test available at the relevant time called HazMat which could detect pentobarbitone. However, not knowing of a reason to conduct further testing, the examining officer did not do so.

41. After testing, the parcels were released. According to usual practice they would have been accompanied by an *'Opened for Inspection'* information pamphlet and/or tape placed upon the closed mail articles stating *'Opened by Australian Post for inspection by Customs'* and I assume that it happened in this case.

42. As stated above, the email exchange between Dannika and one of the Mexican suppliers indicates that she received one parcel on 13 August 2015.

15 August 2015

43. On 15 August 2015, Detective Sergeant Russell Sheather and Detective Senior Constable Stephen Reid arrived at Dannik's unit to interview her in relation to her possession of pentobarbitone on 8 July 2015. Her mother was present. The police attended from 12.15pm

to 1.05pm. At the end of the interview they advised that, despite her admission to importation, the most likely outcome would be that no action would be taken.

44. Dannika was apparently distressed after the interview but was calm and settled by time her mother left at 4.45pm. She called her father at about 5.30pm to say that she would watch a movie and some *anime*, and would switch her phone off for some peace and quiet. When asked how she was, Dannika said: '*Life is shit*'.

45. Dannika's mother returned at about 7.00pm, after Dannika failed to respond to a text message. She sought assistance from police for a welfare check and Dannika was found lying on her bed unresponsive. She was later pronounced deceased after resuscitation attempts by police and ambulance were unsuccessful.

46. One empty glass bottle with 'Happy Pills' on the label was located. Other empty plastic vials (measuring about 13cm) were located in the kitchen bin.

47. Suicide notes were located (some in hardcopy and some on her computer) which were addressed to Dannika's mother, father and brother. Other 'complaint' style letters were also found directed to the university, council and health professionals. I note that all of these documents were created and last modified in June and July 2015.

Quality of care provided to Dannika by the health services

48. During my investigation Dannika's mother made a number of complaints about the care given to her daughter. [10] I referred the matter to the Coroners Court Prevention Unit **(CPU)** for review and analysis by the Mental Health team. The review was confined to services in the month prior to Dannika's death, other services not being sufficiently proximate or relevant to her death and therefore outside the scope of my investigation

[10] Email to the Court dated 17 August 2015 (Ann Smith); Statement of Anne Smith dated 29 September 2015; Email dated 6 January 2016 (Ann Smith) with attachments (Dannika Smith and Borderline Personality Disorder and Professor Channen); Email dated 23 January 2017 (Ann Smith); Email dated 2 February 2017 (Ann Smith); and Email dated 4 January 2017 (Ann Smith).

49. I note that the coronial brief, medical records of Western Health, St Vincent's Health, Mercy Mental Health, Epworth Hospital as well as the family letters of concern were examined by CPU.

50. In summary, following a detailed review, the CPU was not critical of, nor did it identify any issues for further investigation in the care provided by any of the Epworth Hospital, St Vincent's Hospital, Western Health's ED, Ursula Frayne Mental Health Inpatient unit, General Medical Unit Western Health and Mercy Health Saltwater Clinic.

51. I accept and agree with CPU's assessment.

Police contact and dealings with Dannika

52. Dannika's mother said that, '*Overall Danni and [I] felt the police were the most thoughtful, helpful and considerate professionals we came into contact with from that first day 08 July.*' She did however raise three issues of concern. The first was that Dannika was upset that she did not know who had prompted the request for the welfare check on 3 August 2015.

53. The second was that the visit by police on the day of her death was not expected, and whilst she understood why it was done, she said that if Dannika had known of the visit she would have '*been a little more prepared for the implications of her actions and what it might mean for her future.*'

54. The final concern was that, following Dannika's death she reported to police that she thought the package containing the pentobarbitone was in the recycling bin and asked them to search for it. She was disappointed in their advice that they were not '*much interested but if I wanted to, I could look*' and believed they should have followed up.

Police attendance 15 August 2015

55. As noted above, D/S Sheather and DSC Reid interviewed Dannika on 15 August 2015 about her possession of pentobarbitone on 8 July 2015.

56. D/S Sheather said that he was notified of the 1st and 2nd IR on 10 August 2015. He said that he was aware from the 1st IR that Dannika had imported pentobarbitone for the purpose of

suicide and that police had attended on 8 July 2015 for a welfare check. He noted in his statement that whilst an offence had been committed, consideration '*must be given to her state of mind and mental health*'.

57. D/S Sheather said that it was evident from the 2nd IR that Dannika had made multiple attempts to import pentobarbitone and that:

- she was a student nurse and had her Certificate III in aged care;
- it was possible that she could sell the barbiturates to family members of relatives in aged care to facilitate euthanasia; and
- her Facebook account indicated that she was doing work placement at Rosary Home Accredited care facility in Keilor.

59. D/S Sheather undertook the following tasks:

- interrogated the incident of the welfare check on 8 July 2015, including obtaining running sheets, incident summaries and a verbal briefing (Sgt Daniel Johnson);
- interrogated the incident of the welfare check on 3 August 2015, including obtaining running sheets, CAD job and a verbal briefing (S/C Miller);
- sought information from Rosary Home and was advised that Dannika no longer had access to the facility or patients; and
- sought information from the Australian Catholic University.

60. D/S Sheather formed the viewed that to progress the investigation (including assessing the potential risk to the community and to Dannika herself) it was appropriate to interview Dannika in person.

61. Further, after due consideration D/S Sheather decided the most appropriate method of interview was an impromptu attendance. This was because there was some evidence of Dannika's reluctance to cooperate with police which raised the possibility that she would refuse to engage or avoid contact if given advance notice. Also an impromptu attendance

was the best investigative technique to elicit information from a subject as it minimised the opportunity to concoct or rehearse answers or scenarios.

62. The audio of the record of the interview was made available to me as part of my investigation. During the interview D/S Sheather repeatedly asked Dannika if she was happy to proceed; said that her participation was voluntary, that the interview could be stopped at any time and held at another time and/or at the station if that was more convenient. Dannika did ask to take diazepam and D/S Sheather spoke about the implications it may have on her ability to participate in the interview. Dannika and her mother explained to police that it was part of her usual daily dose and would not affect her participation.

63. Nothing in the recording indicates that Dannika was intimidated, distressed, agitated, or unable to participate in the interview or that her mental state was abnormal.

64. During the interview it is clear that Dannika understood she was importing an illegal substance and the consequences for so doing. Dannika showed a high level of insight and understanding of the sourcing and use of pentobarbitone for suicide and shared details of her initial sourcing of the drug that was confiscated on 8 July 2015 saying '*I knew that it was lethal. I knew that it's like the gold standard for euthanasia and I wanted to kill myself*'.

65. D/S Sheather explained the implications for importing and possessing pentobarbitone as a banned substance, and asked Dannika if she had made any more attempts to purchase pentobarbitone. She gave some details of her online activities but neither divulged nor denied possession.

66. About her future plans, Dannika said: '*I'm stuck right now, to be honest, with the mental health issues and the suicide, Assuming I don't kill myself then, yes, the plan would be to do – finish the course work for the PCA and work on the weekends while I studied full time during the week.*' She also said that she was continuing to seek the drug '*Because I hate myself and want to die every single day……..I just want to die I don't really care.*' She

clarified that she would never assist anyone else kill themselves, even if they asked for assistance.

67. Dannika was advised after the interview that authorities would continue to monitor her, any overseas money transactions and international parcel deliveries. D/S Sheather further advised Dannika and her mother that he did not believe Dannika had any intention to use the drug to assist or harm others and he would recommend that no further action be taken.

68. The officers left at 1.05pm. They determined that because Dannika was well supported by family and health professionals, there were no immediate concerns for her welfare as a result of being interviewed.

69. DSC Reid said that he believed that she '*had mental health issues for which she was receiving on-going treatment from a number of sources. However, I did not form an opinion that she posed a risk of serious or imminent harm to either herself or other persons.'*

70. Further, he said that Dannika's mother '*did not speak with us about any concerns that she had regarding her daughter, including any concerns that Dannika may suicide or self-harm.'*

71. I note that police have powers under section 351 of the *Mental Health Act* to arrest a person who appears to have a mental illness, if satisfied that the person needs to be apprehended to prevent serious and imminent harm to themselves or to another person. The officers reported that there was nothing in Dannika's presentation to enliven this power.

72. According to D/S Sheather's statement, despite a search in Interpose and LEAP the officers had no knowledge that Dannika had attempted suicide on 4 August 2015, the day after a police visit, and nor was he advised of this incident by Dannika or her mother. As noted above, the PWF arising from this incident was never uploaded on the LEAP system.

73. D/S Sheather said: '*Had I been aware of the suicide attempt By Dannika Smith on 4/8/2015 following the visit by police on 3/8/2015, I would have investigated those circumstances to*

ensure that I possessed all available information to make an accurate risk assessment of my duties.'

74. I note that he does not suggest that he would not have approached her for an interview on 15 August 2015, had he known that information.

Comments on final police visit

75. I am satisfied that the decision to interview Dannika, on 15 August 2015 was reasonable. The focus of the interview was Dannika's access to pentobarbitone and the safety of elderly patients in the aged care facility in which she had completed her personal carer placement. At the conclusion of the interview Dannika and her mother both reported that they were satisfied with the manner in which the interview was conducted.

76. Whilst the attending police were not aware of Dannika's suicide attempt on 4 August 2015, they were clearly aware that she had made multiple attempts in the past and this was an issue of concern to them.

77. The evidence indicates that Dannika did not appear agitated or distressed in police presence, but became so afterwards when she discussed with her mother that it was unlikely she could source pentobarbitone as *big brother* was watching. Nevertheless Dannika encouraged her mother to meet with friends as previously arranged. I note her mother did not see an increase in her daughter's risk and considered her to be calm and settled enough when she left the apartment shortly prior to Dannika's death.

78. I can only speculate as to whether the police would have approached Dannika for an interview in the same manner, had the information regarding the suicide attempt on 4 August been known. It is clear, however, that their concern that she may have been a danger to others, let alone herself, meant that she should be interviewed regarding her importation activities.

79. The interview was conducted at Dannika's home in the company of her mother and Dannika was left with her mother. They were advised that the likely outcome was that no further

action would be taken. There is nothing to indicate that the police actions on that day were inappropriate.

Request to search the recycle bins

80. The CI indicated that he was unable to identify the police member at the Footscray police station that Dannika's mother spoke to about searching the bins. I note his comment that the member '*would also have no greater immediate resources available other than to have sent a uniform patrol vehicle to search the bins in the same fashion that Mr and Mrs Smith did. It is doubtful that in the circumstances that any specialist police resources...would be prepared to respond to such as request.*'

81. It would have been appropriate for the member to whom Mrs Smith spoke to have passed on the information to the CI, or to have advised Mrs Smith to do so. Nevertheless since he cannot be identified, I do not propose to comment further.

Comments regarding intercepted importations and testing

82. As already noted, two mail parcels in transit from overseas addressed to Dannika were intercepted and tested on 12 August 2015.

83. In relation to Dannika's death the Australian Border Force (**ABF**)[11] advised that, '*For parcels subject to international mail stoppers, the examining officer may be informed either by way of email or verbally as to why the stopper has been put in place. The background information regarding the reason for the mail stopper is not directly accessible to the examining officer. In this instance, the reason for the mail stopper, ie. That there was a concern that Ms Smith may seek to import pentobarbital, a known euthanasia/suicide type drug, was not passed on to the examining officer. When the presumptive test using the First Defender RM technology indicated the presence of propylene glycol, and did not indicate the presence of any illicit substance, the examining officer, ..., discontinued the testing.*' [My emphasis]

[11] The operational agency within DIBP with responsibilities including compliance and enforcement in relation to illicit goods.

84. By way of explanation for the test chosen by the examining officer, the AFB said:

- First Defender RM was *'more commonly used by ABF than Hazmat'*;
- Whilst the examining officer may be informed why a *'stopper'* is put in place, the information cannot be directly accessed by the officer and on this occasion the reason was not passed onto to him (as already noted); and
- There was no information then available to the ABF suggesting a heightened risk of pentobarbital importation and so no broader general warning had been issued to its officers.

85. Given DIPB was aware of the reason for the interception and testing of the parcels on 12 August 2015, the fact that it did not ensure that appropriate testing was conducted constitutes a clear systems failure.

Triggers for suicide in a person with BPD

86. It is clear that Dannika had a long and sustained premeditation of her suicide involving complex planning and activities related to her chosen methods which were of high lethality.

87. On 10 August 2015 in a lengthy assessment session with a clinician from Saltwater Clinic, Sarah Colone, Dannika noted that her No 1 and 'gold standard' suicide plan was to source pentobarbitone because she wanted a painless death. She told Ms Colone that she was currently trying to source it but denied having found a supply, although she would not tell anyone if she did. The No 2 plan was an overdose of prescribed medications combined with a noose, and the No 3 plan was to crash her car into a tree.[12]

88. I note that Dannika had worked towards and was intending to complete her nurse training. She also had established plans to allow her to successfully suicide. CPU advised that future planning and suicidal intentions are not mutually exclusive in a person with a BPD. It is apparently also not unusual for a person with BPD to have a premeditated *back-up* plan for

[12] Mercy Health Medical Records dated 10 August 2015.

suicide, as having future options for suicide (as opposed to current intent) can have a calming effect on people with BPD.

Summary

89. It is clear from the medical evidence that Dannika died from pentobarbitone toxicity. It is also clear that she is likely to have sourced this from overseas, as she did on at least one earlier occasion.

90. I am satisfied that the two parcels stopped, tested and cleared by customs on 12 August 2015 were likely to be the two parcels of purported pentobarbitone Dannika ordered from her Mexican suppliers in July 2015. In this regard it is notable that Dannika confirmed receipt of a parcel to one of her suppliers on 13 August 2015. Further, according to her mother Dannika received two packages in the week before her death which she did not want her mother to see. Mrs Smith asked what they were but Dannika told her they were special gifts for the family. Mrs Smith later examined the empty packages and noted labels which read '*This package has been opened and inspected by customs*'. She said that she concluded from that that the packages in fact contained gifts.[13]

91. I am also satisfied that it is likely that at least one of the parcels examined on 12 August 2015 contained the pentobarbitone which was used by Dannika to end her life. The evidence compels this conclusion even though the parcels were not tested for pentobarbitone. First, Dannika died of pentobarbitone toxicity two days after she acknowledged receipt of one of the parcels. Secondly there is no other apparent source of pentobarbitone. These were the only parcels intercepted after the mail stoppage was implemented on 27 July 2015. Further, if Dannika had had another cache (or a sufficient other cache) there would have been no need for her to order for her to order more in July 2015 and it is likely she would have used that other cache of pentobarbitone as part of her overdose on 4 August.

[13] **In addition, she noted the police comments on 15 August that 'Big Brother' was watching her and '*if she paid money for Nembutal she would be wasting that money as the drugs would never reach her.*'**

92. I have already concluded that testing conducted by DIBP on 12 August 2015 failed to achieve its purpose. This failure facilitated the delivery of pentobarbitone to Dannika which she used to take her life on 15 August 2015.

93. However, other than by stopping her from taking that drug on that day, I am not satisfied that appropriate intervention by DIBP on 12 August 2015 would necessarily have prevented Dannika's death. That is because Dannika was clearly committed to the idea of suicide. It appears to have been an alternative or safety-net to what she perceived as a painful and difficult life, as well as a means to end her self-loathing. The evidence indicates that although pentobarbitone was her first choice, Dannika also had other suicide plans. As noted by her mother, she used anything she could take as part of her suicide attempt on 4 August.

94. In these circumstances, I am unable to say with any certainty that if Dannika had not had access to the pentobarbitone on 15 August, the outcome would have been different.

Findings

95. Having considered all the evidence, I find that Dannika Michelle Smith, born on 6 February 1989, died as a result of 'Toxicity to Pentobarbitone' on 15 August 2015, in the circumstances outlined above.

96. I find that Ms Smith took Pentobarbitone with the intention of taking her own life.

Comments

Pursuant to Section 67(3) of the *Coroners Act 2008* I make the following comments in connection with the death:

97. I am satisfied the current laws in relation to the possession, use and importation of pentobarbitone are adequate and can identify no prevention opportunities in that regard.

98. The ABF advised that subsequent to Dannika's death '*[t]he ABF's Regional Command Victoria/Tasmania appointed an Executive level officer to conduct a review of the mail stopper process. Particularly, how the background information as to why a mail stopper has been put in place can be reliably received by the examining officer.*'

99. I am not aware of the result of this review, however this case demonstrates that it is vital that the examining officer is possessed of sufficient information to perform the appropriate tests. I therefore propose to make a recommendation to that effect.

RECOMMENDATIONS

100. Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

That the Department of Immigration and Border Protection establish processes to ensure that when a mail stopper is issued, officers who examine items seized under the auspices of that mail stopper are aware of why it was issued. This would enable officers to focus their attention on known risks when examining items, and select tests and examination techniques that are appropriate to the risks.

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

Ms Ann Smith, Senior Next of Kin
Department of Immigration and Border Protection
Australian Border Force
Civil Litigation Division, Victoria Police
Detective Sergeant Dennis Williams, Wyndham Criminal Investigation Unit, Coroner's Investigator

Signature:

ROSEMARY CARLIN

Date: 30 October 2017

Amended: 18 May 2018