IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014/4163

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of DANIELLA FRANCESCA SESSAREGO
without holding an inquest:
find that the identity of the deceased was DANIELLA FRANCESCA SESSAREGO
born on 28 September 1989
and the death occurred on 15 August 2014
at the Western Hospital, Gordon Street, Footscray, Victoria 3011

from:

1 (a) PENTOBARBITONE TOXICITY

*Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Sessarego was the 24-year old only daughter and eldest of Sandra Alexander and David Sessarego's three children. Ms Sessarego and her parents migrated to Australia from India in 1991 and lived together in St Albans until her parents separated in 1997. Ms Sessarego was a popular and academically-inclined child who completed secondary school at 17 years of age, commenced a combined degree in law and arts at the University of Melbourne and worked part-time in legal firms.

2. Ms Sessarego's relationship with her mother was punctuated by periods of conflict. As a result, between the ages of 17 and 20 years, Ms Sessarego had little contact with her mother and lived with her father.

3. In about 2008, Ms Sessarago was diagnosed with depression and prescribed antidepressants. Later, when under psychiatric care, she was diagnosed with borderline personality disorder

[BPD]. In July 2010 and December 2012, Ms Sessarago intentionally self-harmed by taking overdoses of medications and cutting herself in the context of alcohol use.

4. After a period of psychiatric inpatient treatment at Orygen Youth Health [Orygen], her treatment continued in the community coordinated by a case manager from Orygen's HYPE clinic which specialises in BPD treatment. Ms Sessarego was considered to be at chronic risk of self-harm and possibly suicide due to BPD and her history of major depressive episodes.

5. After each episode of self harm, Ms Sessarago returned to live with her mother for a period. She also trialled living independently but found it difficult to cope, especially financially, and so returned to live with her mother in 2013. After completing a Bachelor of Arts, Ms Sessarego discontinued her law degree and commenced a bridging course at TAFE that would enable her to study veterinary science. She volunteered at animal welfare organisations, cared for a number of pets at home, became a vegan and later worked at Caroline Springs Veterinary Hospital on Saturdays.

6. In August 2014, Ms Sessarago lost her job as a receptionist due to her TAFE schedule clashing with her shifts and broke up with her boyfriend, reportedly because she felt she was 'dragging him down'. When she unexpectedly visited him on 12 August 2014, she told her father, that she was feeling overwhelmed.

7. Also on 12 August 2014, Ms Sessarego attended an appointment with Ms Crothers with whom she was engaged in cognitive analytic therapy [CAT]. She presented as depressed and feeling hopeless, with increased suicidal ideation but no specific plan or intent. She noted ongoing stressors – working hard to gain entry into another university course and conflict with her mother – and her recent job loss and relationship break-up, acknowledging that her drive to succeed got in the way of feeling happy. Ms Sessarego and Ms Crothers discussed how to manage her heightened distress and developed a plan for an admission to The Melbourne Clinic [TMC] and a medication review by her general practitioner [GP] or psychiatrist. Ms Crothers provided information about crisis assistance services and arranged to maintain regular contact with Ms Sessarego by text message and liaise with her GP, Dr Al Raheb.

8. On 13 August 2014, Ms Sessarego telephoned TMC but was unable to obtain an appointment with her usual psychiatrist. She discussed this with Ms Crothers who made enquiries on her behalf about referral by another psychiatrist. Later that day, Ms Crothers received a text message from Ms Sessarego indicating that any medical practitioner could refer her to TMC and that she had made an appointment with her GP. That evening around 5.15pm, Ms Crothers

discussed Ms Sessarego's presentation and the plan for TMC admission with Dr Al Raheb. Sometime after this, Ms Sessarego attended an appointment with Dr Al Raheb who observed her to be stable and provided a referral to TMC.

9. At about 8.30am on 14 August 2014, Ms Sessarego left home with a packed lunch, telling her mother that she was going to TAFE. She returned home around 1pm complaining of diarrhoea and informing Ms Alexander that she was going to rest in her room. At about 1.40pm, Ms Sessarago sent her father a text message, the content of which concerned him, and so he tried to telephone her. When he was unable to reach her, Mr Sessarego endeavoured to contact Ms Alexander directly, and then through their eldest son, to ask that she check on their daughter.

10. Shortly before 2.15pm, Ms Alexander entered her daughter's bedroom. Ms Sessarego was lying on her side and did not respond when her mother called out to her several times and shook her by the shoulder. Ms Alexander saw that her daughter's lips were blue and that she was not breathing. Near the bedside table, she observed a half-empty bottle labelled 'Lethabarb' (a euthanasia drug for the treatment of animals containing pentobarbitone sodium). She called out to her partner, who telephoned the emergency services, and performed cardiopulmonary resuscitation until paramedics arrived.

11. On arrival, paramedics found Ms Sessarego in cardiac arrest with no pulse or respirations. Cardio-pulmonary resuscitation was continued throughout transportation to Western Hospital and, though spontaneous circulation was restored, Ms Sessarago required manual ventilation and remained unconscious and unresponsive.

12. At Western Hospital, Ms Sessarego was diagnosed with severe post-cardiac arrest syndrome and hypoxic/ischaemic brain injury. She remained on life support but her condition continued to deteriorate. Following a discussion between the treatment team and her family, treatment was withdrawn and Ms Sessarego died at 5.50am on 15 August 2014.

13. A coronial investigation into Ms Sessarego's death was commenced and the brief of evidence on which this finding is based was prepared by Detective Senior Constable Antoinette Vertsonis of Melton Crime Investigation Unit. During the course of the investigation, police seized the Lethabarb container and family photographs found by Ms Alexander near her daughter's bed onto which Ms Sessarego had written, 'Forgive Me I love you all I will always be with you'.

14. Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination of Ms Sessarego's body, including the analysis of post-mortem CT scanning of the whole body (PMCT), and reviewed the circumstances of her

death as reported by police to the coroner. Dr Lynch advised that he found evidence of bibasal pulmonary consolidation and cerebral oedema on PMCT.

15. Dr Lynch noted that toxicological analysis detected pentobarbitone at a concentration of ~49mg/L in an antemortem/admission sample taken at Western Hospital and ~38mg/L in a post-mortem sample taken at VIFM. Analysis of both antemortem and post-mortem samples also detected the antidepressant sertraline and the benzodiazepines diazepam and midazolam and the anaesthetic lignocaine at levels consistent with their therapeutic administration. The toxicologist's report advised that the results were consitent with excessive and potentially fatal use of pentobarbitone.

16. Dr Lynch advised that it would be reasonable to attribute Ms Sessarego's death to pentobarbitone toxicity, without the need for autopsy.

17. At my request, the Coroners Prevention Unit[1] [CPU] conducted a review of available materials and provided advice about the appropriateness of the management of Ms Sessarego's mental health and the storage and accessibility of pentobarbitone in veterinary practices. The CPU advised:

    a. Ms Sessarego had a four year history of mental illness, including a psychiatric admission, and had been diagnosed with major depressive disorder and BPD. At the time of her death, she had been discharged from Orygen and was engaged in CAT with Ms Crothers.

    b. Information provided by her parents indicates that Ms Sessarego's presentation fluctuated regularly and deterioration of her mental health was cyclic. Antemortem toxicology confirms that she was taking medications as prescribed.

    c. CAT was an appropriate treatment for BPD. Ms Crothers made regular contact with Ms Sessarego to check she was well and worked with her and Dr Al Raheb to arrange an admission to TMC when she was experiencing increased suicidal thoughts and had refused an admission to Orygen.

    d. Ms Sessarego did not appear to be in imminent crisis and, up until the evening of 13 August 2014, she was texting Ms Crothers about ongoing arrangements for TMC and that she was 'hanging on'.

[1] The Coroners Prevention Unit was established in 2008 to assist coronial investigations and the formulation of coronial recommendations and comments aimed at "prevention".

e. It appears likely that Ms Sessarego accessed pentobarbitone at the veterinary hospital at which she worked on Saturdays. The head veterinarian, Dr Radihephi, advised that pentobarbitone is stored in a drug cabinet, accessible to all staff throughout business hours, and that it is locked at the end of each day. He confirmed that pentobarbitone is a drug ordinarily used at the hospital to euthanize ill pets and, in this setting, it is used in overdose to minimise distress.

f. Although pentobarbitone is approved as a veterinary drug for euthanasia, and may be possessed and used by vets for this purpose, it not authorised for human use and it is illegal to import the drug into Australia without a licence. For these reasons, most people (excluding veterinarians) who wish to suicide using pentobarbitone need to go to some effort and obtain it unlawfully, including from overseas.

g. Between 2000 and 2014, the frequency of pentobarbitone suicide increased.[2] The increase was particularly pronounced after 2011, reaching 15 deaths in 2014[3] and nine deaths in the first four months of 2015.[4] Even after a coronial investigation the source of pentobarbitone used in suicide often remains undetermined. Many such deaths involved pentobarbitone sourced overseas. Seven deaths involved use by veterinarians who had used pentobarbitone accessible though their work to complete suicides.

h. Veterinarians are not currently required to maintain a register of their use of pentobarbitone, nor to store the drug in a separate drug safe, though these requirements are necessary in relation to drugs of dependence. Accordingly, the safe storage of pentobarbitone and monitoring of its use at veterinary clinics can potentially enhance public safety.

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[2] The CPU analysed the Victorian overdose deaths register to identify all suicides investigated by Victorian coroners between 2000 and 2014 where pentobarbitone overdose was a causal or contributory factor. Each suicide was analysed to determine whether the circumstances of death were consistent with being a "rational suicide". Although "rational suicide" is a contested term (due to debates about what comprises 'rationality') and the definition of "rational suicide" used by the CPU is "suicide seen by others as an understandable reaction to life circumstances; associated with unendurable suffering (usually of a physical nature); in accord with a reasonable appraisal of future outcomes in terms of a cost-benefit analysis; have some connection with a reduced life expectancy; and uncontaminated by psychological dysfunction", after Hewitt, J, "Schizophrenia, mental capacity, and rational suicide," *Theoretical Medicine and Bioethics*, vol 31, 2010, p.72 and Pilpel A, Amsel, L, "What is Wrong with Rational Suicide", *Philosophia*, vol 39, 2011, p.112.

[3] Ten of the fifteen pentobarbitone deaths that occurred in 2014 involved circumstances inconsistent with rational suicide

[4] Six of the nine pentobarbitone deaths that occurred between January and April 2015 involved circumstances inconsistent with rational suicide.

CONCLUSIONS

18. Based on all of the above, I find that Ms Sessarego died on 15 August 2014 at the Western Hospital, Footscray, after having ingested pentobarbitone with the intention of taking her own life.

19. I further find it likely that Ms Sessarego obtained the pentobarbitone from the veterinary clinic where she was previously employed at a time I an unable to determine with the requisite degree of certainty.

20. The evidence does not support a finding that there was any want of clinical management or care on the part of Ms Crothers, Dr Al Raheb, or the medical and nursing staff of Western Hospital, that caused or contributed to her death.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations to the death:

1. That the Veterinary Practitioners Registration Board of Victoria consider extending the application of its guideline for enhanced record keeping and labelling/dispensing of Schedule 8 drugs to pentobarbitone. In particular, that the Board recommends to its members that:

    a. All pentobarbitone transactions are recorded in a record book maintained separately from the patient's medical record;

    b. Details of each pentobarbitone transaction, inclusive of the date and quantity of supply, the name of the veterinary practitioner involved in the transaction and his/her usual signature, are recorded;

    c. The true balance of pentobarbitone is recorded following each transaction;

    d. Pentobarbitone records are maintained in a manner that cannot be altered, obliterated, deleted or removed without detection.

2. That the Veterinary Practitioners Registration Board of Victoria recommends to its members that pentobarbitone is stored in a drug safe accessible only by a veterinary practitioner, or by a staff member under the direction of a veterinary practitioner, that is date and patient-specific and includes a direction to account for or dispose of any unused portion of the drug.

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

Ms Sessarego's family

Ms Crothers, B2 460 Victoria Street, Brunswick

Dr Al Raheb, St Luke's Medical Centre

Dr Hoi, Western Health Emergency Department

Veterinary Practitioners Registration Board of Victoria

Signature:

Paresa Antoniadis Spanos, Coroner
Date: **19 October 2015**

Cc: Manager, Coroners Prevention Unit