IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 005071

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 SJD without holding an inquest:

find that the identity of the deceased was SJD
born in 1959

and that the death occurred on 2 October 2014

at an address in Clyde, Victoria 3978

from:

1 (a) MIXED PENTOBARBITONE AND ALCOHOL TOXICITY

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

1. SJD was a 54 year old man who was self-employed as a freelance veterinary surgeon. SJD was separated from his wife of 25 years and lived alone in a unit in Clyde. He had a history of long term alcohol abuse and a problem with gambling. He is survived by his wife and two adult children.

2. SJD graduated in veterinary science from The University of Melbourne around 1982. He worked in various veterinary capacities including greyhound racing, animal shelters and the Australian Quarantine and Inspection Service (AQIS). As SJD was a contract veterinarian, he had his own Australian Business Number (ABN) and drug company account. As a matter of general practice he would have veterinary equipment and veterinary drug supplies on hand.

3. SJD had a long history of alcohol abuse. Initially, he would only drink in the evenings and family life was happy for the most part. Over the years, his alcohol intake increased as a means of dealing with the stressors associated with his job. Work stresses tended to precipitate bouts of heavy drinking and gambling, frequently leading to incidents of verbal aggression and occasional violence toward his family.

4. SJD's alcohol consumptiou did not appear to interfere with his work until around 2009 when he was charged with a number of drink-driving offences. After the first offence, he was very remorseful, stopped drinking and completed an alcohol education course. A second offence in 2009 led to the loss of his position at AQIS. This had an enormous impact on him. His drinking escalated, he gambled large sums of money, became very depressed and his behaviour became unmanageable. His wife asked him to move out of the family home and into a unit at the rear of the family home.

5. In September 2013, SJD's wife and the two adult children moved out of the family home. SJD remained in the unit at the rear. The house was then rented to BD and he and SJD got along well and would occasionally share a drink together.

6. On Saturday 27 September 2014, AFL Grand Final day, SJD telephoned his wife at home and asked her to "come over and bring the dog". SJD's wife came without the dog and he was slightly annoyed but quite calm. She had a cup of tea and he had some beer or wine. After about an hour she left. SJD rang again asking his wife to come over. She returned this time with the dog and some food. She made him toasted sandwiches whilst SJD continued to drink throughout the evening. When she asked him how he was going he gave a non-committal reply. When pressed, he responded that he was not really coping and was probably suicidal. SJD's wife offered to take him to the doctor but she desisted when he became angry and aggressive. She decided to leave and the two walked to the car and hugged before she left. SJD's wife told police that her husband had never verbalised suicidal ideation before that day and, at the time, she did not believe he would act upon it.

7. On 1 October 2014, police intercepted SJD in Carrum Downs for driving while disqualified. He told the police he needed to drive for work. SJD then telephoned BD who caught a taxi to the location and drove SJD's car back to Clyde. The two men arrived home at about 5.00pm and went to the unit to share a beer. According to BD, SJD was a little annoyed that he would not be able to drive to work the next day but did not appear otherwise distressed. BD offered to drive him to work and they agreed to leave at 9.30am. BD returned to the main house at about 6.30pm.

8. On 2 October 2014, BD went to SJD's unit to see if he was ready to leave for work. He saw SJD lying in bed, on his side, apparently sleeping. BD called to him but got no response.

9. At about 12.00pm BD went to SJD's unit but did not go into his room. He called to him and once again received no response. He left the house, returning at about 7.00pm when he went straight to SJD's room and noticed no lights were on. BD called out to him again. When there was no response and he realised SJD was in the same position as he had been in the morning, he went to the neighbour's house to raise the alarm. The neighbour, FM returned with BD. When FM shook SJD and realised he was deceased he called 000.

10. Police attended the scene and commenced a coronial investigation into SJD's death. One of the attending members, First Constable Caroline Taylor, prepared a brief of evidence upon which this finding is based.

11. FC Taylor inspected the premises and found 3 x 450ml bottles labelled 'Lethabarb euthanasia injection' located on the kitchen bench. Next to this on a chopping board were SJD's keys and three capped syringes, two of which contained blood. A used 5ml plastic syringe was also found on the draining board next to the sink. A packet of 'Tramadol' was on the dining table. SJD's bag also contained a plastic box containing blood taking equipment, blood specimen vials, and used syringes and needles possibly associated with his veterinary practice.

12. Dr Joanna Glengarry, Forensic Pathologist with the Victorian Institute of Forensic Medicine, reviewed the circumstances of death as reported by police to the Coroner and performed an autopsy on SJD's body. External examination showed subcutaneous bleeding in the left antecubital fossa (inner elbow), but no definitive evidence of a needle mark. Dr Glengarry noted that a needle puncture site may not always be evident on examination of the skin and there was no evidence of violence or injury contributing to death.

13. Anatomical findings at autopsy included pulmonary oedema, cardiomegaly, coronary artery and aortic atheroma, eczema, probable sarcoidosis (cardiac, pulmonary, carinal lymph node) and a papillary thyroid micro-carcinoma (a small cancer within the thyroid gland). Dr Glengarry advised that the probable sarcoidosis and papillary thyroid micro-carcinoma were incidental findings that she did not believe caused or contributed to death.

14. Post Mortem toxicological analysis detected ethanol (alcohol) at a concentration of 0.17g/100ml and pentobarbitone at ~30 mg/L. Dr Glengarry advised that the level of pentobarbitone is consistent with levels associated with fatalities and further that depression of the central nervous system by barbiturates such as pentobarbitone can be worsened by alcohol.

15. The toxicologist's report included the following comment about the results – *"The pentobarbitone detected is consistent with excessive and potentially fatal use. Depression of the central nervous system by barbiturates can be worsened by alcohol and may cause death in the absence of other contributing factors."*

16. Dr Glengarry concluded by attributing SJD's death to drug and alcohol toxicity. As Dr Glengarry has since left this jurisdiction, I asked Dr Linda Iles, Head of Pathology at VIFM to express an opinion of the formulation of the cause of death and she advised that it would be appropriate to change the cause of death to *mixed pentobarbitone and alcohol toxicity.*

17. I find that SJD intentionally took his own life by drinking a significant quantity of alcohol and injecting himself with pentobarbitone. I further find that he gave little indication to his wife and BD that he was at immediate risk.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:

1. In Australia, pentobarbitone is approved as a veterinary drug for euthanasia and may be possessed and used by veterinary surgeons for this purpose. It is not a drug that is authorised for human use and it is illegal to import the drug into Australia without a licence. It is reasonable to infer that SJD used pentobarbitone from within his own veterinary supply to take his own life.

2. At my request, the Coroners Prevention Unit[1] [CPU] has on previous occasions after such similar deaths,[2] conducted a review of available materials and provided advice amongst other things, about the prevalence of pentobarbitone suicide and the appropriateness of the management, storage and accessibility of pentobarbitone in veterinary practices.

3. At the time, CPU advised, inter alia, that between 2000 and 2014, the frequency of pentobarbitone suicide increased.[3] The increase was particularly pronounced after 2011, reaching 15 deaths in 2014[4] and nine deaths in the first four months of 2015.[5] Although even after a coronial investigation the source of the pentobarbitone used in suicide often remains undetermined, a

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

[2] Daniella Francesca Sessarego COR 2014 4163; "WJ" COR 2014 0169.

[3] 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.

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

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

number involved pentobarbitone sourced overseas and seven deaths involved veterinarians who had used pentobarbitone accessible through their occupation.

4. Veterinarians are not currently required to maintain a register of their use of pentobarbitone nor store the drug in a separate drug safe, though these requirements are in place for drugs of dependence. It is unlikely that regulation of the storage or accessibility to pentobarbitone will deter veterinarians bent on self-harm or suicide.

5. That said, the ready access to pentobarbitone by veterinarians and others employed in veterinary practices, coupled with their appreciation of its properties, make this a very particular occupational hazard.

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

SJD's family

First Constable Caroline Taylor (#38853) c/o O.I.C. Narre Warren Police

Veterinary Practitioners Registration Board of Victoria

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 24 June 2016