IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006970

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr SL[1]
Date of birth:	25 August 1984
Date of death:	5 December 2022
Cause of death:	1(a) Mixed drug toxicity including metonitazene
Place of death:	Wangaratta, Victoria, 3677
Keywords:	NITAZENES; MIXED DRUG TOXICITY; BENZIMIDAZOLE OPIOIDS; NEW PSYCHOACTIVE SUBSTANCES; NOVEL PSYCHOACTIVE SUBSTANCES; NPS; DRUG TESTING; DRUG CHECKING; PILL TESTING

[1] This finding has been de-identified to replace the name of the deceased with a pseudonym of a randomly generated two-letter sequence for the purposes of publication.

INTRODUCTION

1. Mr SL (**SL**) was 38 years old when he was found deceased on 5 December 2022. At the time of his death, SL lived alone in Wangaratta, Victoria. SL was described by his father, Mr KG (**KG**), as having been a good child, and as having been very close with his brother, who was '*his best mate*'.

2. SL had a long history of struggles with his physical and mental health. He was diagnosed with anxiety, depression, and Attention Deficit Hyperactivity Disorder (**ADHD**). SL also suffered from a congenital bowel problem caused by a megacolon, and which resulted in chronic bowel issues that required in-patient and specialist treatment.

3. SL reportedly first started using drugs after he was diagnosed with ADHD at the age of 13. KG stated that SL ceased being prescribed methylphenidate (Ritalin) at the age of 16, which he considered caused him to become '*non-functioning*'. He was then prescribed dexamphetamine instead of methylphenidate at this time as it was considered to work better for him.

4. SL's brother passed away from a drug overdose in 2009. KG stated that SL was already on a wayward path at this time but '*really went downhill*' following his brother's death.

5. SL was supported by his General Practitioner (**GP**), as well as community mental health staff and drug and alcohol counsellors. He was most recently managed by a psychiatrist, who liaised closely with his GP regarding appropriate prescribing practices for SL. He was prescribed a number of medications for his mental and physical health, including alprazolam, dexamphetamine, and olanzapine. SL was also known to use illicit drugs including heroin and methamphetamine, and had previously been prescribed suboxone for opiate addiction.

6. SL had a non-fatal overdose after taking methamphetamine on 17 November 2022. He received CPR and was taken to hospital by ambulance. SL denied any self-harm or suicidal ideation. He was reviewed by the alcohol and other drug service at Northeast Health Wangaratta and was to be followed up in the community after discharge.

THE CORONIAL INVESTIGATION

7. SL'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.

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

9. 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.

10. Deputy State Coroner Jacqui Hawkins (as she then was) initially held carriage of the investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of SL's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. Following receipt of the coronial brief and medical examiners report, assistance was sought from the Coroners Prevention Unit (**CPU**)[2] to provide information regarding deaths involving nitazenes in Victoria, and which is referred to further below.

12. I took carriage of this matter in October 2023 for the purposes of obtaining further statements, seeking further advice from the CPU, finalising the investigation, and making findings.

13. This finding draws on the totality of the coronial investigation into the death of SL including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

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.[3]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 4 December 2022 at about 10:00am, SL's neighbour observed him speaking to an unknown male at the front of his house. She then saw this man leave and walk down the street. This was the last time SL was seen alive.

15. The neighbour awoke during the night of 4 December 2022 to let her dog out. She observed a male standing in SL's backyard holding a flyscreen.[4] The neighbour texted SL's mother who replied to say SL was at home.

16. SL's father, KG, collected his medication from Ramsay Pharmacy the morning of 5 December 2022. KG then drove to SL's residence to drop the medication to him. He arrived at about 9:15am.

17. SL did not answer the door, and KG gained entry to the house by removing the flyscreen from a window. KG located SL lying at the end of his bed. SL was cold, curled up in a ball, and clearly deceased.

18. KG contacted emergency services via '000', who attended and confirmed SL was deceased.

19. Victoria Police attended and processed the scene. SL was found to have a small wound on his right arm which appeared to be an injection site. A used syringe was located on the carpet near SL, and he had a cable tied in a loose knot around his arm. Other drug-related paraphernalia was found in the room including a vial containing two small bags of white and brown powder. This was presumed to be methamphetamine (the white powder) and heroin (the brown powder). Empty prescription packets of alprazolam and dexamphetamine in SL's name were also found in the room.

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[3] 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.

[4] Victoria Police investigations did not identify any fingerprints on the window frame. Further, there were cobwebs around the window suggesting it had not been opened for some time.

20. Victoria Police members did not identify any suspicious circumstances.

IDENTITY OF THE DECEASED

21. On 5 December 2022, SL, born 25 August 1984, was visually identified by his father, KG, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

23. On 9 December 2022, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Dr Bedford reviewed the scene photographs, post-mortem computed tomography (**CT**) scan, and Victoria Police Report of Death Form 83 and provided a written report of his findings.

24. The post-mortem examination showed evidence of decomposition changes but no injury or internal pathology likely to lead to death.

25. Post-mortem toxicology indicated the presence of several drugs including methylamphetamine, alprazolam, olanzapine, and metonitazene. These drugs have effects on the brain. In particular metonitazene is a novel synthetic opioid which has not yet been fully studied but appears to have elevated toxic effects on the body and in particular the brain. The combination of drugs can lead to respiratory depression and death.

26. I accept Dr Bedford's opinion.

27. The VIFM subsequently conducted tests of the white and brown powder found in SL's room. The white powder was found to be methamphetamine, and the brown powder was found to be metonitazene.

CPU REVIEW

28. Following review of the coronial brief, the CPU was requested to provide some additional information surrounding nitazenes. Advice was requested on the origins of nitazenes and the prevalence of nitazenes in deaths investigated by Victorian coroners. The CPU was also invited to identify whether there were any prevention opportunities arising from SL's death.

29. The CPU considered that the circumstantial evidence from the scene of the fatal incident indicates that immediately prior to his death, SL injected what he believed to be heroin into his body. An expended syringe was found on the carpet close to SL's shin, and a thin white cable was tied in a knot around his arm. Additionally, other drug paraphernalia common to people who use heroin and a vial containing a fine brown powder thought to be heroin were found at the scene. After finding SL's body in his bedroom, KG also confirmed to investigating members of Victoria Police that SL was known to use heroin.

30. However, subsequent toxicological testing of a blood sample taken from SL and conducted by the VIFM revealed no trace of heroin or any of its metabolites (such as 6-monoacetylmorphine or codeine) in SL's system. Instead, the test detected the presence of amphetamine, alprazolam, and olanzapine (all of which were prescribed to SL and all of which were detected in levels consistent with therapeutic use), as well as one other drug – metonitazine. The fine brown powder located at the scene was also tested by VIFM and was established to be metonitazene.

31. Metonitazine is a member of the nitazene drug family. Nitazenes, also known as benzimidazole opioids, are a group of opioid compounds developed in the 1950s as analgesics. They are highly potent drugs which can exhibit potency up to several hundred times that of morphine. Nitazenes have never been approved for use in clinical medicine due to their profound risk of respiratory depression and death. As such, they have not historically been well known outside of academic research laboratories.

32. Reports of nitazene detections in unregulated drug markets across Europe, the USA, and Canada started to emerge in around 2019. The main nitazenes documented internationally in unregulated drug markets included metonitazine, as well as etodesnitazene, etonitazene, isotonitazine, and others. Dozens more nitazenes besides those detected in unregulated drug markets exist. As metonitazine is just one of many nitazenes, I have approached SL's death as a nitazene-involved death, rather than specifically a metonitazene-involved death, when considering it from a public health and death prevention perspective.

33. The CPU has advised that, including the death of SL, there had been at least 16 Victorian overdose deaths involving nitazenes to date, all of which occurred since the start of 2021. In most of these deaths, the available evidence indicated that the deceased probably used nitazenes while believing they were using other substances such as heroin, oxycodone, and

MDMA. The risk of unintentionally obtaining substances containing nitazenes from unregulated drug markets in Australia is documented in an emerging body of health warnings and literature across the country.

34. I further note that the issue of nitazenes being 'passed off' as other drugs such as heroin, ketamine, oxycodone or similar, is merely a new form of a long-standing and ongoing problem: that when individuals obtain drugs from unregulated drug markets, they do not always receive what they believe they have obtained. The substance can be markedly different to what they expected in terms of composition or dose strength. In turn, this poses an increased risk of adverse events causing the individual harm, such as an overdose.

35. Victorian coroners have highlighted the risks of consuming substances obtained from unregulated drug markets in several recent matters.

36. In her investigation into the deaths of five young people between July 2016 and January 2017, Coroner Paresa Spanos noted that they had consumed a particularly dangerous combination of two novel psychoactive substances, whilst believing that they were consuming MDMA or psilocybin.[5]

37. In her investigation into the death of a young male in 2020, Coroner Sarah Gebert identified that the deceased believed that he was using alprazolam tablets but had instead consumed tablets containing the novel benzodiazepines etizolam and flubromazolam.[6]

38. Coroner Sarah Gebert also investigated the death of a young male in 2020 who took a substance he believed to contain MDMA, but which instead contained synthetic cathinones.[7]

39. Most recently, State Coroner Judge John Cain investigated the death of a 26-year-old man in March 2022, who attended a music festival and took cocaine as well as an extremely potent MDMA pill known as a "Blue Punisher".[8]

40. In these cases, the deceased either used substances the contents of which were different to

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[5] *Finding into Death of Ansont*, Coroners Court of Victoria, COR 2016 003441, delivered 31 March 2021.

[6] *Finding into Death of Mr S,* Coroners Court of Victoria, COR 2020 003434, delivered 29 April 2022.

[7] *Finding into Death of Mr P*, Coroners Court of Victoria, COR 2020 005219, delivered 20 May 2022. Synthetic cathinones are a type of novel psychoactive substance.

[8] *Finding into Death of P without Inquest*, Coroners Court of Victoria, COR 2020 001464, delivered 25 August 2023.

what they expected, or – in the most recent case – contained very high doses of what they intended to take. I believe the circumstances of SL's death are similar, in that the available evidence invites a reasonable conclusion that he intended to use heroin on 5 December 2022 (a drug for which he had an established history of use) rather than metonitazene.

41. In each of the above-mentioned investigations, the coroner concluded the risk of further deaths in similar circumstances could be reduced if a drug checking service was introduced in Victoria.

42. A drug checking service[9] enables a person who obtains a substance from an unregulated drug market to submit a sample, where it is analysed to establish what it contains. This information can then be used to deliver harm reduction interventions such as education to the individual who submitted the substance. Additionally, when particularly risky substances are detected during testing, more general warnings can be disseminated publicly through a drug early warning system (usually a website, application, or other online resource) so the broader community of people who use drugs are aware of the potential dangers.

43. In support of this conclusion, in each of the abovementioned cases, the coroner recommended that the Victorian Department of Health implement a drug checking service. The most recent recommendation, made by State Coroner Judge John Cain, was as follows:

> *That the Department of Health, as the appropriate arm of the Victorian Government, implements a drug checking service in the State of Victoria as a matter of urgency, to reduce the number of preventable deaths (and nonfatal harms) associated with the use of drugs obtained from unregulated drug markets.*[10]

44. In making this recommendation, the State Coroner was reiterating a coronial recommendation which has previously been made by other coroners. I am aware that the Victorian Department of Health did not accept this same recommendation when previously made by Coroner Sarah Gebert.[11] On that occasion, the Department of Health Secretary, Professor Euan Wallace (**Professor Wallace**), responded that "*there are no current plans to*

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[9] Also known colloquially as a 'pill testing' service, although such a service tests any submitted substance, not just substances in pill form.
[10] *Finding into Death of P without Inquest*, Coroners Court of Victoria, COR 2020 001464, delivered 25 August 2023.
[11] *Finding into Death of Mr P*, Coroners Court of Victoria, COR 2020 005219, delivered 20 May 2022.

implement a drug checking service of the kind you have recommended in your findings."[12]

45. A written response to the State Coroner's recommendation was provided on 17 October 2023, from Jacinda de Witts, Acting Secretary at the Victorian Department of Health (**Ms de Witts**). Again, the Department did not accept the recommendation, stating:

> *The department acknowledges that drug checking services, where implemented, can provide another source of information to support decision-making but there are no current plans to implement a drug checking service of the kind the Coroners Court has recommended in these and previous findings. The department will continue to consider evidence for additional harm reduction approaches that will prevent further deaths and support improved health and social outcomes for people who use drugs and will brief Victorian Government accordingly.*

46. I note that Ms de Witts' response, like the earlier response provided by Professor Wallace, contrasts with developments in some other jurisdictions in Australia which have introduced or are in the process of introducing drug checking services. For example, in the Australian Capital Territory (**ACT**), a coalition of drug harm reduction services, with the support of the ACT Government, currently operate the CanTEST fixed-site drug checking service.[13] In February 2023, the Queensland Government announced that they were developing protocols to implement a combination of mobile and fixed-site drug checking.[14]

47. It is impossible to know for certain whether SL would have submitted a sample of the substance he injected on or prior to 5 December 2022 to a Victorian drug checking service, had one existed at the time. However, he would have at least had the option to do so and could also have been given vital harm reduction information from such a service – in this case, by informing him that he was not in possession of heroin (as he appeared to have believed), but rather an extremely potent drug called metonitazene that poses a serious risk if consumed. Whilst such information may not have prompted SL to act differently, the lack

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[12] Wallace E, Untitled response to recommendations in death of Mr P, Victorian Department of Health, 27 July 2022, <https://www.coronerscourt.vic.gov.au/sites/default/files/202209/2020%205219%20Response%20to % 20recommendations%20from%20Department%20of%20Health_Mr%20P.pdf>, accessed 12 October 2023.
[13] Canberra Alliance for Harm Minimisation and Advocacy, "CanTEST Health & Drug Checking", 2023, <https://www.cahma.org.au/services/cantest/>, accessed 12 October 2023.
[14] Queensland Minister for Health and Ambulance Services, the Hon Yvette D'Ath, "Pill testing gets the green light", 25 February 2023, <https://statements.qld.gov.au/statements/97250>, accessed 12 October 2023.

of a drug checking service at the time meant that changing his drug consumption behaviour did not exist as a possible outcome.

48. For this reason - and also after considering the clear evidence that nitazenes are being detected across Australia in unregulated drug markets, as well as the at least 15 other nitazene-involved overdose deaths that have occurred in Victoria over the past few years - I have determined to support my fellow coroners' recommendations that the Victorian Department of Health implement drug checking services to reduce the risk of similar deaths occurring in future.

49. However, noting that the Victorian Department of Health has not supported the four previous recommendations made by Victorian coroners, I have determined not to call directly for implementation of drug checking.

50. Instead, noting the Department's previously-articulated concerns about the harm reduction potential of drug checking services in Victoria, I am instead recommending **an initial trial** of a drug checking service to be considered. I note that the ACT implementation involved initial government-approved trials of drug checking in 2018 and 2019 at music festivals in Canberra, the outcomes of which informed the establishment of the CanTEST fixed-site drug checking service for an initial six-month pilot period between July 2022 to January 2023. The CanTEST pilot has now been extended twice, with lessons learned being used to inform future service design. A similar pilot in Victoria would assist in building the evidence base for drug-checking services in this state, and build on learnings from other jurisdictions.

RECOMMENDATION

1. Pursuant to section 72(2) of the Act, I make the following recommendation to the Secretary, Department of Health:

> *As the appropriate arm of the Victorian Government, I recommend the Department of Health trial a drug checking service in the State of Victoria to gather evidence, experience and insights into how drug checking might reduce risks (including preventable deaths) associated with the use of drugs obtained from unregulated drug markets.*

COMMENTS

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

1. While I do not presume to advise the Department of Health as to how any drug checking trial ought to be implemented, I have some clear expectations as to what drug checking services need to deliver for effective drug harm reduction, and would ask the Department of Health to consider these in designing any trial.

2. I note that SL's death occurred far from metropolitan Melbourne in Wangaratta, and that at least four other recent nitazene-involved overdose deaths also occurred in a regional setting. This reinforces that drug checking services need to be available to all Victorians, and that it ought to be considered whether different types of service delivery are needed to meet the needs of people who reside in metropolitan Melbourne versus in regional areas. I would encourage the Department of Health to design any drug checking trial in such a way as to produce insights into how drug checking can be delivered effectively to all Victorians to reduce drug-related harms across the entire state.

3. Further, I note that the Canberra drug checking service originated in trials that ran at music festivals. Drug checking at music festivals has recently gained a great deal of media attention in Victoria, after nine attendees at the Hardmission festival on 7 January 2024 were hospitalised for adverse drug events, and following the publication in January 2024 of an academic paper on overdose deaths at Australian music festivals.[15]

4. While the Department of Health may determine that a music festival context is appropriate for any drug checking trial, I make clear that, in any ensuing rollout of drug checking services across Victoria, such services ought to be available to all Victorians, not just to people who attend certain designated events (be they music festivals or otherwise). I would urge the Department of Health to design any trial so that it provides insight into how best to deliver drug checking as a general harm reduction service rather than an event-specific service.

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[15] Santamarina R et al, "Drug-related deaths at Australian music festivals", *International Journal of Drug Policy*, January 2024, doi: 10.1016/j.drugpo.2023.104274).

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was SL, born 25 August 1984;

   b) the death occurred on 5 December 2022 in Wangaratta, Victoria, 3677, from mixed drug toxicity including metonitazene; and

   c) the death occurred in the circumstances described above.

2. Having considered all of the evidence, I find that SL's death was the unintentional consequence of the deliberate ingestion of drugs. I consider that SL was not aware the substance he was injecting was metonitazene and that the evidence points to him believing he was injecting heroin. It is noteworthy that the other prescribed substances detected upon post-mortem toxicological testing were shown in levels consistent with therapeutic use.

3. I convey my sincere condolences to SL's family and loved ones for their loss. In particular, I note the poignant observation of SL's father in his recent statement to the Court that '*drug addiction is a health issue not a criminal issue*', and his opinion that the genesis of his son's issues with illicit drugs included his struggle with ADHD and associated issues with appropriately medicating this. KG provided ongoing support to his son into adulthood and had a deep insight into the issues he was facing. The loss of his child the circumstances detailed above is tragic, and no doubt very keenly felt by SL's father and by all of his loved ones.

4. For this reason, while it cannot be said that SL's death was preventable, it is my view that, given the tragic outcome, the potential for systemic improvement should be identified, considered, and pursued. The trial of a drug checking service represents a concrete opportunity to help to save the lives of people in the Victorian community and constitutes a mechanism for those who use drugs to be better informed of the unknown and potentially dangerous substances in those drugs.

ORDERS

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

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

KG, Senior Next of Kin

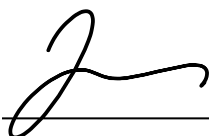
Professor Euan Wallace, Secretary, Department of Health

Dr Pradeepa Dasanayake, Consultant Psychiatrist

Dr Alex Traill, General Practitioner

Detective Senior Constable James Howarth, Coroner's Investigator

Signature:



Ingrid Giles

Coroner

Date: 13 March 2024

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.