IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005219

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr P
Date of birth:	[redacted] 1994
Date of death:	21 September 2020
Cause of death:	*Mixed drug toxicity (MDMA, ketamine, methylphenidate, and novel psychoactive substances)*
Place of death:	[redacted], Werribee, Victoria

INTRODUCTION

1. Mr P,[1] born [redacted] 1994, was 26 years of age at the time of his death. He is survived by his parents [redacted] and [redacted] and older sisters [redacted] and [redacted].

2. Mr P lived with three friends in a rental property in Werribee. He grew up in a very close, supportive and loving family and was very passionate about sport and fitness.[2]

3. On 21 September 2020, Mr P was sadly found deceased in his bedroom at his home.

THE CORONIAL INVESTIGATION

4. Mr P'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.

5. 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.

6. 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.

7. Victoria Police assigned Senior Constable Justin Hollander to be the Coroner's Investigator for the investigation of Mr P's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and compiling a coronial brief of evidence. The brief comprises statements from Mr P's friends, investigating officers, the forensic pathologist who treated Mr P, as well as other relevant materials.

8. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**) was also asked to consider whether there are any prevention opportunities arising from Mr P's death.[3]

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[1] Referred to in this finding as "Mr P", unless more formality is required.

[2] According to the police summary in the coronial brief.

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of

9. This finding draws on the totality of the coronial investigation into the death of Mr P 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.[4]

Background

10. Mr P was born in Melbourne and grew up surrounded by a close and loving family in Werribee. After finishing school, he worked as an apprentice mechanic, for Ambulance Victoria and then at a newspaper printing factory.[5] He was an avid sports fan, playing soccer and football through his childhood and adulthood, and took his fitness and health very seriously. He remained close with his family as an adult and would have weekly dinners with them.[6]

11. There is no evidence to suggest that Mr P had any medical issues or conditions that would have contributed to his death.

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

Circumstances in which the death occurred

12. On Saturday 19 September 2020, Mr P was at home watching television and drinking beers with his close friends and housemates [redacted], [redacted] and [redacted]. At about 2.30pm, he left and returned at around 7.30pm with three other people. A small party began in the garage of their house.

13. During the evening, some party guests were reported to have consumed drugs such as MDMA and ketamine. [redacted] did not see Mr P take any drugs, but Mr P told him he had taken MDMA and ketamine. [redacted] also didn't see Mr P take any drugs but said that it was *clear* [Mr P] *was* [substance] *affected* from his behaviour. He observed that Mr P's *pupils were dilated* and he was *very happy*. [redacted] and [redacted] also later reported that Mr P had taken two more capsules of MDMA during the night. Mr P stayed in the

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prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[4] 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.

[5] According to the police summary in the coronial brief.

[6] According to the police summary in the coronial brief.

garage for some time where he was observed to be swaying and *unable to keep his head up*. He went to bed shortly after.

14. On Sunday 20 September 2020 at about 7.25am, Mr P called his mother and they spoke over a video call for some time. After that, he proceeded to feel very sick and [redacted] observed him to be bent over the toilet intermittently for the rest of the day. His housemates checked on him regularly until he went to bed at about 7.00pm.

15. On Monday 21 September 2020, Mr P's housemates decided to check on him as they had not heard from him all night. At about 11.00am, they entered his bedroom and observed him face down on his mattress. He appeared to be *cold and stiff*.

16. Emergency services were called in response. At about 11.30am, paramedics arrived at the scene and were joined shortly after by police members. Due to Mr P's presentation, no resuscitation was commenced and he was sadly declared deceased.

17. Police commenced an investigation and collected photographic evidence which formed part of the coronial brief. Police observed a wallet and a small bag white a white substance in it which they suspected was ketamine. Following their investigation, police observed no evidence of suspicious circumstances.

Identity of the deceased

18. On 23 September 2020, Mr P, born [redacted] 1994, was visually identified by his father, [redacted].

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

Medical cause of death

20. Forensic Pathologist Dr Mohamed Izzath from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 24 September 2020 and provided a written report of his findings dated 13 January 2021.

21. The autopsy revealed results *consistent with the recent and potentially fatal use of multiple drugs including MDMA (ecstasy) and novel psychoactive substances.* Dr Izzath noted that *the use of these drugs can cause death through centrally mediated depression of cardiorespiratory functions and cardiac rhythm disturbance.*

22. Dr Izzath also noted that *there was no post-mortem evidence of any natural disease or injuries which may have caused or contributed to death.*

23. Toxicological analysis of post-mortem samples identified the presence of MDMA (~0.3mg/L) and MDA (0.04mg/L),[7] ketamine (~0.1mg/L),[8] synthetic cathiones ethylone, eutylone, N-ethylpentylone and N-ethylhexedrone,[9] methylphenidate[10] and paracetamol.[11]

24. Dr Izzath provided an opinion that the medical cause of death was *Mixed drug toxicity (MDMA, ketamine, methylphenidate, and novel psychoactive substances).*

25. I accept Dr Izzath's opinion.

CPU REVIEW AND FURTHER INVESTIGATIONS

26. As already noted, I requested the CPU's advice in relation to whether there were any prevention opportunities in this matter.

Deaths involving synthetic cathinones

27. The CPU undertook a review of the substances that may have been taken by Mr P in the time proximate to his death by reference to the autopsy and toxicology reports.

28. The evidence shows that Mr P died in a setting of mixed drug toxicity, where four of the contributing drugs were synthetic cathinones. Ethylone, eutylone, N-ethylpentylone and N-ethylhexedrone all belong to a sub-class of novel psychoactive substances (**NPS**) called synthetic cathinones. Synthetic cathinones are central nervous system stimulants; they have effects similar to cocaine, MDMA and amphetamines, and are known to be sold on unregulated drug markets in Victoria as MDMA and mixed with cocaine. Like other NPS, the synthetic cathinones are always evolving with new drugs being developed and introduced to unregulated

[7] Methylenedioxymethamphetamine (MDMA) is a designer amphetamine also known as ecstasy, XTC. MDMA is, in part, metabolized in the body to another designer amphetamine known as Methylenedioxyamphetamine (MDA). Following consumption of MDMA**,** typical post-mortem, blood concentrations range up to 0.3mg/L.

[8] Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent. A single oral 50 mg dose results in peak plasma concentration averaging 0.08 mg/L at 30 min.

[9] Ethylone, Eutylone, N-ethylpentylone and N-ethylhexedrone are synthetic cathinones. Synthetic cathinones are a group of Novel Psychoactive Substances (NPS) that act as stimulants and mimic the actions of methamphetamine and MDMA.

[10] Methylphenidate is a phenethylamine derivative indicated for attention deficit hyperactive disorder and narcolepsy (Baselt, 2017; eMIMS, 2018).

[11] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

markets. The CPU noted that the effects of individual synthetic cathinones when taken are poorly understood, however they are known to cause acute toxic effects and death.

29. The CPU identified 10 overdose deaths in Victoria between 2009 and 2020 which involved synthetic cathinones as contributing drugs. The deaths could be divided generally into two groups both chronologically and by contributing drugs:

- There were six deaths between 2013 and 2016 which involved cathinone[12] and/or methcathinone.
- There were no deaths involving synthetic cathinones between 2017 and 2019.
- There were four deaths in 2020 (including the death of Mr P) which involved one or more of ethylone, eutylone, n-ethylpentylone and n-ethylhexedrone.

Prevention

30. There is no evidence to suggest that Mr P intended to consume synthetic cathinones, instead, it is likely he believed he was using MDMA and/or ketamine obtained from unregulated drug markets. Whilst not possible to conclude which of the substances he took contained synthetic cathinones, the CPU considered that the MDMA tablets were the most likely source given: Mr P appears to have taken at least three MDMA tablets; synthetic cathinones are already known to be sold as MDMA in Victoria; and in another synthetic cathinone-involved death[13] which occurred shortly after Mr P's death, witnesses observed the deceased to consume what they believed to be MDMA.

31. The CPU commented that as Victorians are likely to continue to use drugs sourced from unregulated markets, and that any further law enforcement measures are unlikely to impact on this, the primary prevention opportunity emerging from this case is to enable people who obtain substances in unregulated markets to find out what they contain before using them.

Harm minimisation and synthetic cathinones

32. The circumstances in which Mr P died are, tragically, becoming more common. As already highlighted, between August and October 2020 there were three other Victorian overdose deaths involving similar synthetic cathinones to those implicated in Mr P's death. More

[12] Cathinone is a stimulant drug that occurs naturally in the khat plant; it has been used for thousands of years through chewing, smoking or steeping khat leaves. Cathinone can be synthesised in a laboratory, as can a number of derivative substances known collectively as the synthetic cathinones. The synthetic cathinones all have the same general stimulant effect as cathinone, but can differ in potency and toxicity and length of action.

[13] COR 2020 005907

broadly, NPS, the drug class to which synthetic cathinones belong, contributed in 33 Victorian overdose deaths in 2020, up from 17 deaths in 2019 and eight deaths in 2018.[14]

33. The rise of overdose deaths is one manifestation of the broader emerging harms associated with NPS use in Victoria. NPS include a huge range of drugs that are designed to mimic 'traditional' illegal drugs such as heroin, methamphetamine, MDMA, cocaine, cannabis and LSD. They also include non-approved forms of therapeutic psychoactive drugs such as benzodiazepines. They are known to produce adverse and toxic effects that can result in death. New NPS are constantly being developed and produced for unregulated drug markets; they are invariably cheaper and easier to manufacture than 'traditional' illegal drugs, and less risky to possess and distribute because legal and regulatory bodies are often unable to identify them.

34. People have always faced the risk that drugs obtained from unregulated markets are not what they expected: more potent, or adulterated, or even completely different to what was represented by the supplier. Where this occurs, the potential for harm including overdose and death is increased. The appearance of NPS in unregulated markets has substantially increased this risk, because NPS are often substituted for other drugs and represented as being other drugs. The rapid evolution of NPS means that suppliers may not even know what they are offering in the market; and the highly variable effects between NPS with respect to onset of action, potency, interactions with other drugs, and so on, mean that developing informed safe use practices is extremely difficult.

35. These risks were examined during Coroner Paresa Spanos' inquest into the deaths of five young men who died after consuming a particularly dangerous combination of two NPS from the phenethylamine class: 25C-NBOMe and 4-fluoroamphetamine. In each case, the deceased person did not know they were consuming NPS and instead believed they were consuming MDMA (or on one case psilocybin).

36. Assisted by expert evidence as well as submissions from multiple organisations involved in drug harm reduction, Coroner Spanos delivered findings on 31 March 2021[15] which included two recommendations aimed at addressing the risks inherent in a person using a substance when they cannot know with certainty what drug or drugs it contains.

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[14] The rise of NPS benzodiazepine-involved overdose deaths was detailed in the Finding into the death of Mr S., Coroners Court of Victoria, COR 2020 3434.

[15] Finding into Death of Anson with Inquest, Coroners Court of Victoria, COR 2016 3441.

37. Coroner Spanos' first recommendation was that the Victorian Department of Health implement a drug checking service (also known colloquially as a *pill testing* service) in Victoria. Such a service would enable a person who obtains a substance from unregulated markets to submit a sample, where it is analysed to establish what it contains; this information can then be used to inform harm reduction responses. Appropriate responses might include letting the person know what the substance contains and associated risks; counselling the person more generally about safe drug use; and using the insights from drug checking to inform local targeted responses to emerging drug harms.

38. Coroner Spanos' second recommendation was that the Victorian Department of Health establish an early warning network to alert the public and disseminate information rapidly on substances of concern that have been identified circulating in unregulated drug markets. This could integrate information from a range of sources including drug checking services, and provide education in addition to alerts.

39. In a response dated 6 July 2021, Department of Health Secretary Prof Euan Wallace acknowledged but did not accept the recommendations. Prof Wallace indicated there was "no active plan for implementation of a drug checking service" in Victoria, and outlined work in drug surveillance and monitoring as an alternative to an early warning network.

40. While Coroner Spanos' recommendations were made in the context of an investigation into deaths involving NPS phenethylamines, they are entirely applicable to reducing harms associated with synthetic cathinone use (as was found in this case) or indeed other synthetics such as benzodiazepines, which were similarly explored during the investigation into the death of a young man who likely thought he was taking Xanax (alprazolam) but instead consumed a NPS benzodiazepine. [16]

41. As highlighted in these cases a drug checking service would enable people to learn what NPS and other drugs are contained within a substance, so they can make better-informed decisions about drug use as well as services being afforded opportunities to deliver other harm reduction interventions.

FINDINGS AND CONCLUSION

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

[16] Finding into the death of Mr S., Coroners Court of Victoria, COR 2020 3434.

a) the identity of the deceased was Mr P, born [redacted] 1994;

b) the death occurred on 21 September 2020 at [redacted], Werribee, Victoria from *Mixed drug toxicity (MDMA, ketamine, methylphenidate, and novel psychoactive substances)*; and

c) the death occurred in the circumstances described above.

43. Having considered all of the circumstances, I am satisfied that Mr P's death was the unintended consequence of the drugs he intentionally consumed.

RECOMMENDATIONS

44. There is no reason to believe that recent fatal harms associated with synthetic cathinones use (or other categories of NPS) in Victoria are transitory. I am satisfied that a drug checking service and drug early warning system are necessary elements of any strategy to reduce these harms.

45. I therefore recommend pursuant to section 72(2) of the Act:

a) 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 non-fatal harms) associated with the use of drugs obtained from unregulated drug markets.

b) That the Department of Health, as the appropriate arm of the Victorian Government, implements a drug early warning network in the State of Victoria as a matter of urgency, to reduce the number of preventable deaths (and non-fatal harms) associated with the use of drugs obtained from unregulated drug markets.

46. I convey my sincere condolences to Mr P's family and friends for their loss and acknowledge the tragic circumstances in which his death occurred.

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

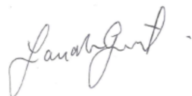
48. I direct that a copy of this finding be provided to the following:

[redacted], Senior Next of Kin

The Department of Health

Senior Constable Justin Hollander, Coroner's Investigator

Signature:



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Coroner Sarah Gebert

Date: 20 May 2022

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.