IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006085

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Ryan Govind Chisholm
Date of birth:	04 December 1999
Date of death:	08 November 2020
Cause of death:	1(a) Mixed drug toxicity (ethanol, cocaine, etizolam, diazepam, nordiazepam and oxycodone)
Place of death:	91 McDougall Drive, Footscray, Victoria, 3011
Keywords:	Overdose; drug toxicity; novel psychoactive substances; benzodiazepines; etizolam

INTRODUCTION

1. On 08 November 2020, Ryan Govind Chisholm was 20 years old when he was located deceased due to drug toxicity. At the time of his death, Ryan lived in Pascoe Vale with his parents, Richard and Kala.

2. Ryan is remembered as a social, strong minded young man who was devoted to his family, in particularly his mother Kala.

Background

3. According to Richard, Ryan had a normal childhood. He loved sports and the outdoors and was extremely social. Towards the end of primary school, Ryan stopped regularly attending and would get into trouble when he did attend. He moved to a new school in year 9 which he enjoyed, and his attendance improved. Ryan completed year 11 before leaving school to commence a TAFE course in logistics. At the time of his death, he was employed at a logistics company. [1]

4. Ryan began using cannabis in year 7, before moving to other drugs such as benzodiazepines and cocaine. He was seen by his General Practitioner Dr Alfy Habib on many occasions regarding his substance abuse.[2]

5. In 2016, Ryan was referred to a psychologist for mixed anxiety and depression. He saw the psychologist on a number of occasions. Richard stated that although Ryan did not disclose much to his parents, he hinted that he suffered from anxiety.[3] According to his friend Connor, Ryan was suffering from depression at the time of his death, though Connor was unsure whether this had been officially diagnosed.[4]

6. According to Richard, there were periods throughout Ryan's high school life where he would 'go off the rails' and not come home for a number of days. This continued into adulthood, with the COVID-19 lockdowns being particularly difficult for Ryan and his mental health as he was an extremely social person.[5]

[1] Coronial Brief (**CB**), Statement of Richard Chisholm, dated 9 November 2021.
[2] CB, Statement of Dr Alfy Habib, dated 20 August 2021.
[3] CB, Statement of Richard Chisholm, dated 9 November 2021.
[4] CB, Statement of Connor Russell, dated 13 October 2021.
[5] CB, Statement of Richard Chisholm dated 9 November 2021.

THE CORONIAL INVESTIGATION

7. Ryan'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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ryan's death. The Coroner's Investigator conducted inquiries on my 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. This finding draws on the totality of the coronial investigation into the death of Ryan Govind Chisholm 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.[6]

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

Circumstances in which the death occurred

12. On 7 November 2020, Ryan and his friend Connor went out for dinner in the city, accompanied by two girls. The pair drank a considerable amount, with Ryan purchasing a tray

[6] 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.

of 50 shots. Ryan also consumed cocaine, and though Connor did not see him do so, he 'knew he would have taken' prescription medications.[7]

13. At around 3am on 8 December 2020, the group left the city via ride-share vehicle and arrived at Connor's house. Upon arriving at the house, Ryan reportedly took Xanax[8] and oxycodone before he lay on Connor's bed and fell asleep.[9] Connor turned him on his side in case he choked on his own vomit.[10]

14. At around 2pm, Connor woke up and walked to the shops before returning home to make his breakfast. He then checked on Ryan and noticed he was stiff, cold and had a clenched jaw. Connor immediately called a friend who attended and attempted to wake Ryan up, before calling emergency services.[11]

15. Emergency services including police and Ambulance Victoria paramedics arrived shortly thereafter, though sadly Ryan was declared deceased.[12]

Identity of the deceased

16. On 8 November 2020, Ryan Govind Chisholm, born 04 December 1999, was visually identified by his friend, Ryan Lamb, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Ryan Chisholm on 11 November 2020. Dr Parsons reviewed the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of her findings dated 8 February 2021.

19. The post-mortem examination did not reveal evidence of any natural disease that would have caused or contributed to the death.

[7] CB, Statement of Connor Russell, dated 13 October 2021.
[8] Alprazolam, sold under the brand name Xanax, is a benzodiazepine medication used in the treatment of anxiety and panic disorder.
[9] Court File (**CF**), Victoria Police Report of Death (Form 83).
[10] Ibid.
[11] Ibid.
[12] CF, Ambulance Victoria Verification of Death Form.

20. Toxicological analysis of post mortem blood samples identified the presence of the following:[13]

    a) Ethanol ~ 0.12 g/100mL

    b) Cocaine[14] ~ 0.06 mg/L and its metabolites benzoylecgonine, ecgonine methyl ester and cocaethylene

    c) Etizolam[15] ~ 0.03 mg/L

    d) Oxycodone[16] ~ 0.2 mg/L

    e) Diazepam[17] ~ 0.08 mg/L and its metabolite nordiazepam

21. Additionally, analysis of post mortem urine samples identified the presence of diazepam metabolites temazepam and oxazepam, and quinine. According to Ryan's GP, Dr Habib, Ryan was prescribed diazepam on two occasions in 2020.[18]

22. Dr Parsons noted that the combination of drugs found at toxicological analysis may cause death in the absence of other factors.

23. Dr Parsons provided an opinion that the medical cause of death was 1 (a) MIXED DRUG TOXICITY (ETHANOL, COCAINE, ETIZOLAM, DIAZEPAM, NORDIAZEPAM AND OXYCODONE).

FURTHER INVESTIGATION

24. Having reviewed the coronial brief, medical examiner's report and toxicology report, I asked the Coroners Prevention Unit (**CPU**) to provide me with information regarding etizolam and its involvement in overdose deaths, noting the drug is not listed on the Australian Register of Therapeutic Goods.[19]

[13] CF, Toxicology Report of Mark Chu, Senior Forensic Toxicologist, dated 1 February 2021.
[14] Cocaine is an illicit drug commonly abused by nasal insufflation for its stimulant properties.
[15] Etizolam is a benzodiazepine with amnesic, anxiolytic, anticonvulsant, hypnotic, sedative and skeletal muscle relaxant effects. It is not listed on the Australian Register of Therapeutic Goods.
[16] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[17] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[18] CB, Statement of Dr Alfy Habib, dated 20 August 2021.
[19] 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 prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner.

25. The CPU advised that etizolam is a benzodiazepine approved for therapeutic use in certain countries (including Japan and India), but not Australia. In the Australian and international drug literature it is generally classified as a novel psychoactive substance (**NPS**). Other terms for NPS benzodiazepines include 'street' and 'illicit' benzodiazepines. Etizolam is known to be sold in Australian unregulated drug markets as alprazolam and can also be found openly for sale on the internet.

26. Etizolam is the most prevalent NPS benzodiazepine implicated in drug related deaths in Victoria, with etizolam contributing to 36 overdose deaths from 2015 to 2020. Further, the annual frequency of overdose deaths involving etizolam has increased substantially in recent years, from one death in 2018, to 10 deaths in 2019, to 24 deaths in 2020, the year Ryan died.[20]

27. The CPU noted that based on the available evidence, it is impossible to know where Ryan obtained the etizolam, but it is possible that Ryan obtained Xanax (alprazolam) tablets that instead contained etizolam, or alternatively, that the etizolam was a contaminant in the cocaine he consumed.

COMMENTS

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

1. My investigation into Ryan's death highlights the potentially tragic consequences of the use and abuse of illicit drugs, particularly those purchased from unregulated markets where the actual content of the drugs can never be known.

2. Drugs obtained from unregulated markets may not be what the user 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.

The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[20] Coroners Prevention Unit Issues Brief on NPS Benzodiazepines, 29 October 2021

3. As outlined at paragraph 26, the number of Victorian overdose deaths involving NPS benzodiazepines has risen quite suddenly in recent years. This increase is mirrored in several other countries, and the Coroners Court of Victoria is concerned that it may be indicative of an emerging trend, rather than a transitory feature of drug-related harms in the state. Therefore, I have distributed this Finding for information to the Victorian Department of Health, with the aim that it assists the Department in understanding and responding to the risks presented by NPS benzodiazepines in Victoria.

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 Ryan Govind Chisholm, born 04 December 1999;

   b) the death occurred on 08 November 2020 at 91 McDougall Drive, Footscray, Victoria, 3011;

   c) I accept and adopt the medical cause of death as ascribed by Dr Sarah Parsons and find that Ryan Govind Chisholm died from mixed drug toxicity;

2. AND, having considered all of the circumstances, I am satisfied that Ryan Govind Chisholm's death was the unintended consequence of his use and abuse of illicit and prescription drugs.

I convey my sincere condolences to Ryan's family for their loss.

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

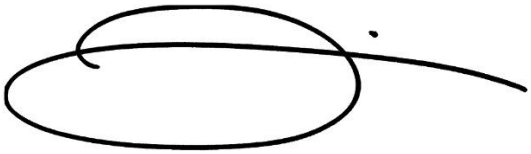
I direct that a copy of this finding be provided to the following:

Richard & Kala Chisholm, Senior Next of Kin

Senior Constable Andrew Harrex, Coroner's Investigator

Department of Health

Signature:



AUDREY JAMIESON

CORONER

Date: 27 September 2023

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.