IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002632

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Ryan Andrew Robinson
Date of birth:	26 November 1991
Date of death:	17 May 2023
Cause of death:	1a: Mixed drug toxicity (heroin, bromazolam, metonitazine, protonitazene, methamphetamine, oxycodone, dextromethorphan, clonazepam, nitrazepam)
Place of death:	Cheltenham, Victoria, 3192
Keywords:	Mixed drug toxicity; Novel psychoactive substances; NPS; Nitazenes; Victorian Pill Testing Service; Victoria's Drug Checking Service; Pill testing; drug harm reduction.

INTRODUCTION

1. On 17 May 2023, Ryan Andrew Robinson (**Ryan**) was 31 years old when he died from mixed drug toxicity at his home in Cheltenham, Victoria. At the time of his death, Ryan lived with his partner, Caitlin Kennedy (**Caitlin**).

2. Ryan had an extensive medical history which included chronic fatigue syndrome, attention deficit hyperactivity disorder (**ADHD**), post traumatic stress disorder (**PTSD**) stemming from childhood sexual assault, fibromyalgia, chronic pain, depression, anxiety, and mood and fatigue problems associated with fibromyalgia.

3. Ryan also had a longstanding history of drug use commencing in his teenage years, including heroin and prescription drug misuse. Throughout his life, Ryan went through recurrent cycles of heroin use to methadone substitution and had several periods of inpatient rehabilitation.

4. Ryan's parents provided him with extensive support, including financial assistance and support to access treatment and rehabilitation. However, despite their best efforts, Ryan continued to struggle with drug use until the time of death.

THE CORONIAL INVESTIGATION

5. 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.

6. 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.

7. 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.

8. Victoria Police assigned an officer, Senior Constable Hayden Miller, to be the Coronial Investigator for the investigation of Ryan's death. The Coronial 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. Subsequently, a new Coronial Investigator, Senior Constable Mitchell Bayly, was appointed for the remainder of the coronial investigation.

9. My colleague Coroner Catherine Fitzgerald initially held carriage of the investigation into Ryan's death until it came under my purview in July 2023 for the purposes of conducting additional investigations and making findings.

10. Following review of the Coronial Brief, I determined to seek further evidence to assess the adequacy of care provided to Ryan in the period leading to his death, including statements from treating practitioners General Practitioner Dr Peter Drake of Jasper Family Medical Clinic, General Practitioner Dr Jason Rajakulendran of Bluff Road Medical, and Psychologist Monica Wright of Bay Road Counselling and Psychology. I also sought a copy of Ryan's Medicare and Pharmaceutical Benefits Scheme (**PBS**) records.

11. Following review of the post mortem toxicological testing which revealed the presence of novel psychoactive substances (**NPS**), I determined that it was appropriate to conduct further investigations to ascertain whether it was possible to identify the sources of these substances.

12. This finding draws on the totality of the coronial investigation into the death of Ryan Andrew Robinson. 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.[1]

BACKGROUND CIRCUMSTANCES

13. During the final years of his life, from January 2020 until his death, Ryan was under the care of Dr Peter Drake (**Dr Drake**) of Jasper Family Medical Clinic. Upon taking over Ryan's care, Dr Drake's plan was to first stabilise Ryan on methadone and oxycodone, before safely reducing his oxycodone dose over a period of two years until its total cessation in early 2022. Dr Drake did not prescribe oxycodone after this date.

[1] 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.

14. Throughout his period of care, Dr Drake also provided Ryan with referrals to specialists including addiction specialists Dr Benny Monheit and Dr Adam Pastor, psychiatrist Professor David Horgan and psychologist Monica Wright.

15. At the time of his death, Ryan's prescribed medications from Dr Drake were limited to dexamphetamine for ongoing treatment of his ADHD and methadone for ongoing treatment of his opioid use disorder. From 2022 onwards, Ryan was also receiving medicinal cannabis therapy to assist with his chronic pain, which had reportedly had good effect.

16. Ryan was prescribed with a limited supply of oxycodone (9 tablets), as well as antibiotics amoxicillin and metronidazole, by his dentist following a dental procedure. These medications were supplied to him on 1 May 2023.

17. Ryan's psychologist Monica Wright reported that during her final consultation with Ryan on 12 April 2023, she observed several positive changes in Ryan's life, along with things he was looking forward to. Ryan presented as alert and spoke positively about all the improvements in his life. This included getting a 3-month-old kitten called 'Shadow', moving into a new apartment with his partner in Cheltenham that his mother had purchased for him, and that he had engaged a new integrative General Practitioner for issues of chronic inflammation and chronic fatigue.

18. Ryan spoke about having a positive appointment with his disability service provider around resuming work and that he was looking into exploring digital marketing, and also planning to re-apply for the Disability Support Pension (**DSP**). He had also recently been given a new car from his mother, which meant he had more independence and did not have to rely on his mother to drive him around, which he felt very pleased about.

19. Ryan last saw Dr Drake on 11 May 2023 by way of telehealth. He presented with dry socket, which was resolving, though he noted that he was frustrated with the outcome of the dental procedure. Dr Drake otherwise considered Ryan's presentation to be normal, and prescribed his usual dose of methadone.

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

Circumstances in which the death occurred[2]

20. On either the night of 16 May 2023, or the early morning of 17 May 2023, Ryan and Caitlin were watching television in their room when Caitlin fell asleep on Ryan's chest.

21. At approximately 4am on 17 May 2023, Caitlin woke and got up to clean the house, before subsequently falling asleep on a couch located in the living room.

22. At approximately 11am, Caitlin went to the bedroom and found Ryan lying next to the bed on the floor. She observed that Ryan was cold, unresponsive, and had purple lips. Caitlin called Triple Zero (**000**) and attempted cardiopulmonary resuscitation (**CPR**) at the direction of the operator. She also told police that she also moved Ryan in order to put a jumper on him.

23. Emergency services attended shortly afterwards and Ryan was declared deceased at the scene at 11.34am on 17 May 2023.

24. Police commenced an investigation. Following a scene examination, police observed extensive drug paraphernalia throughout the apartment, which included:

    a) In the lounge area, a number of used syringes, wipes and silver foil pieces;

    b) In the front bedroom, upwards of 150 used syringes and a small number of tissues on the bed with specks of what appeared to be blood.

25. Police also located prescription medications including:

    a) 7 packets of physeptone;

    b) A plastic bag containing open and sealed boxes, 5 bottles of dexamphetamine, and loose tablets; and

    c) An additional 2 bottles of dexamphetamine.

[2] There is limited evidence available with regard to the circumstances immediately preceding Ryan's death. This is because Ryan's partner, Caitlin Kennedy, was the only person present during the relevant events but has not responded to police requests for a statement. The following account is based on information provided by Caitlin to uniform police members at the time they attended the scene, immediately following Ryan's death.

Identity of the deceased

26. On 17 May 2023, Ryan Andrew Robinson, born 26 November 1991, was visually identified by his partner, Caitlin Kennedy.

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

Medical cause of death

28. On 19 May 2023, Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed relevant information, including the Victoria Police report of death (**Form 83**), the post mortem computed tomography (**CT**) scan, medical records from Jasper Medical Centre and correspondence from the Victorian Department of Health.[3] Dr Fronczek provided a written report of her findings dated 13 July 2023.

29. The external examination revealed findings in keeping with the known history. In particular, Dr Fronczek noted multiple fresh puncture marks and scar tissue in keeping with chronic injection sites.

30. Toxicological analysis of post mortem blood samples identified the presence of numerous prescription and illicit drugs, including:

    a) 6-monoacetylmorphine (6-MAM), the principal metabolite of heroin;

    b) Codeine, which Dr Fronczek noted is often found as an impurity in heroin.

    c) Oxycodone, an opiate;

    d) Dextromethorphan, a synthetic analogue of codeine;

    e) 7-Aminoclonazepam, a metabolite of clonazepam, a benzodiazepine;

    f) 7-Aminonitrazepam, a metabolite of nitrazepam, a benzodiazepine;

    g) Three novel psychoactive substances (**NPS**):

        i. Bromazolam, a novel benzodiazepine;

[3] This correspondence confirmed that at the time of death, Dr Drake held a permit to treat Ryan with Schedule 8 poisons for treatment of chronic pain.

ii. Protonitazene, a novel synthetic opioid;

iii. Metonitazene, a novel synthetic opioid.

h) Amphetamine, a metabolite of methamphetamine.

i) THC, the primary psychoactive compound (or ingredient) in cannabis.

31. Dr Fronczek noted that all of the substances listed above at paragraphs (a) to (g) are central nervous system (**CNS**) and respiratory depressants. She commented that concurrent use enhances these effects and increases the risk of a fatal outcome.

32. Dr Fronczek further noted that amphetamine is a CNS stimulant, and that the combination of depressants and stimulants is more dangerous than when either class of drugs is used alone, as stimulants potentiate the tendency of depressants to cause respiratory depression.

33. Toxicological analysis of urine samples also identified the following:

a) Methylamphetamine;

b) Benzoylecgonine, a metabolite of cocaine, a stimulant;

c) Methadone and a metabolite, indicated for opioid dependence;

d) Alprazolam, a benzodiazepine;

e) Diphenhydramine, an antihistamine; and

f) Quinine, used for the treatment of muscle cramps.

34. Taking into account all available information, Dr Fronczek provided an opinion that the medical cause of death was:

> *1(a) Mixed Drug Toxicity (Heroin, Bromazolam, Metonitazine, Protonitazene, Methamphetamine, Oxycodone, Dextromethorphan, Clonazepam, Nitrazepam)*

35. I accept Dr Fronczek's opinion.

PRESCRIBING PRACTICES AND FAMILY CONCERNS

36. Taking into account the cause of death, as well as concerns articulated by family members about prescribing practices of Ryan's clinicians,[4] I determined to seek further information to consider the appropriateness of care provided to Ryan in the period leading to his death, with a focus on appropriate prescribing practices in light of his ongoing dependency issues. I subsequently obtained a copy of Ryan's Medicare and Pharmaceutical Benefits Scheme (**PBS**) records, as well as a statement and records from Dr Peter Drake, his treating GP, since retired.

37. As previously noted, upon commencing treatment in 2020, Dr Drake implemented a long-term and meticulous plan to treat Ryan's opioid use disorder by commencing him on methadone, referring him to specialists, including addiction specialists Dr Benny Monheit and Dr Adam Pastor, psychiatrist Professor David Horgan and psychologist Monica Wright, and slowly reducing his reliance on oxycodone until its total cessation in approximately March 2022. This is supported by PBS records which indicate that Ryan was not prescribed any opioids by Dr Drake, except methadone, during the final 12 months of his life.

38. In circumstances in which Ryan's fatal overdose involved a number of illicit drugs (heroin, methamphetamine), pharmaceutical drugs which had not been prescribed (methorphan, clonazepam, nitrazepam) and NPS (bromazolam, metonitazene, protonitazene), and that he did not report his illicit substance use to Dr Drake alongside his prescribed medications, I consider that the opportunities for prevention and intervention were limited.[5]

39. After carefully reviewing Dr Drake's statement, medical records and referrals made, and noting his observation Ryan was challenging to treat in light of his complex background, which was shared by his broader treating team, I am satisfied that Ryan received appropriate care and management in the period leading up to his death.

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[4] I note that the main concern of Ryan's father appeared to focus on one of Ryan's former prescribers and treating clinicians, who has since been disqualified from re-registering until March 2029, following a finding of professional misconduct related to prescribing of Schedule 8 medications, involving 14 patients over five years. However, noting that my jurisdiction is limited to investigating events which are sufficiently proximate and causally related to the death, and that Ryan had not received care from this practitioner for over three years prior to death, I did not consider there to be sufficient basis for further investigation in this regard. However, I have noted Dr Drake's evidence in this connection in which he, upon assuming care of Ryan in 2020, '*declined to prescribe some of the medications prescribed by [the former clinician] and my plan was to first stabilise him on Methadone and oxycodone, before then attempting to reduce the oxycodone in accordance with the recommendations of Dr Monheit'.*

[5] Upon review of Ryan's PBS records, I note that Ryan had been prescribed on 1 May 2023 with oxycodone (9 tablets), as well as antibiotics amoxicillin and metronidazole, by his dentist following a medical procedure. In circumstances where the prescribed supply of oxycodone was limited to 9 tablets, and intended to respond to a discrete occurrence of dental pain, and where the postmortem toxicology was replete with a range of other non-prescribed substances, I have not determined it necessary to investigate this single act of prescribing further.

INVESTIGATIONS REGARDING NOVEL PSYCHOACTIVE SUBSTANCES (NPS)

40. Ryan's fatal overdose involved a combination of 'classic' illicit drugs (heroin, methamphetamine), pharmaceutical drugs (oxycodone, methorphan, clonazepam, nitrazepam) and new or novel illicit drugs (bromazolam, metonitazene, protonitazene).

41. From a prevention perspective, this last group of drugs - which are referred to broadly as new or novel psychoactive substances (**NPS**) - were of particular interest in my investigation. NPS are a highly diverse family of drugs that have become established in unregulated drug markets around the world over the past 20 years.[6]

42. NPS first appeared as contributing drugs in Victorian overdose deaths in 2013, and in recent years the number of overdose deaths in which they were involved has grown steadily, from 17 deaths in 2019 to 48 deaths in 2024. The number of NPS-involved overdose deaths appears to have plateaued in recent years, after steadily increasing between 2017 and 2022.

43. Despite this apparent plateau, NPS remain a closely-monitored concern for at least two reasons. First, because they include particularly risky drugs such as nitazenes, which are a group of (mostly) very potent opioids that can be up to 1000 times stronger than morphine. Second, because NPS evolve so rapidly: in the decade between 2015 and 2024, 59 different individual NPS were identified as contributors to overdose deaths in Victoria, but most NPS only contributed to one or two deaths before not being seen again.

44. We are still only at an early stage of understanding how NPS enter and circulate through unregulated drug markets in Victoria and Australia. This information will be critical so that effective interventions can be designed to reduce the risk of harm to people who use drugs.

45. One important way that understanding of these drugs can be improved is through documenting whatever we can establish about substances containing NPS: where and how they were obtained, what they were believed to be (often substances containing NPS are sold as other drugs, for example novel benzodiazepines being sold as alprazolam), what form they came in

[6] While NPS are 'new' or 'novel' in the sense that they usually have only entered unregulated drug markets over recent years (or months or even in some cases weeks), they for the most part produce similar effects to (and indeed are often specifically designed to mimic) 'classic' illicit drugs and pharmaceutical drugs. For example, bromazolam is a drug of the benzodiazepine class, similar to diazepam and nitrazepam and other pharmaceutical benzodiazepines, though it has not undergone formal clinical trials for use in humans. Metonitazene and protonitazene are novel opioids belonging to the nitazene family of drugs; they have similar effects to illicit opioids such as heroin and pharmaceutical opioids such as oxycodone and methorphan, though they are far more potent (both are estimated to be at least 100 times more potent than heroin).

(be it a pill, tablet, powder, capsule or otherwise), how they were used, and what effects were observed after the person took the substance.

46. Unfortunately, in Ryan's circumstances, there was no direct evidence available to answer many of these questions, because the only witness who was with him on the night in question did not provide a statement and statements from others who knew Ryan did not include any detailed information about his substance use beyond prescribed medication.

47. Noting that Victoria Police members who attended the scene of Ryan's death seized several substances (pills and tablets), I considered that these exhibits presented an opportunity to find out what form the bromazolam, metonitazene and protonitazene might have come in. I therefore directed Victoria Police to transfer the seized substances to the Victorian Institute of Forensic Medicine (**VIFM**) for toxicological testing, to establish whether any of them contained bromazolam, metonitazene or protonitazene. However, the testing revealed that none of the exhibits seized contained any NPS, instead variously containing amphetamine, methamphetamine and methadone.

48. It is possible, then, that Ryan may have injected the bromazolam, metonitazene and/or protonitazene, as a number of used syringes were noted at the scene of the fatal incident. Unfortunately, as no syringes were seized as exhibits, they could not be tested to verify this.

49. From a prevention perspective, it is disappointing that my investigation has been unable to confirm the source, appearance, method of use, or any other relevant details about the bromazolam, metonitazene and protonitazene that contributed to Ryan's fatal overdose.

50. Nonetheless, I consider that the circumstances of Ryan's death raise a broader call for caution when obtaining substances from unregulated drug markets, noting that it is often not possible for drug users to know what any substance might contain.

51. In this context, I consider that the Victorian Pill Testing Service,[7] which is currently being trialled and commenced its fixed site phase today, is a crucial drug harm reduction initiative.

52. The Victorian Pill Testing Service provides a free, confidential and anonymous drug checking service, which aims to detect life-threatening substances and reduce potential harms by giving people the information they need to make safer and informed decisions. It follows numerous coronial recommendations made in Victoria regarding the need for implementation of a drug-

[7] Previously known as Victoria's Drug Checking Service.

checking service in this state as a critical harm reduction measure, including in the face of dangerous, potent and potentially fatal substances such as nitazenes being 'passed off' as other drugs such as heroin, ketamine, oxycodone or similar.

53. Building on the recommendations made by my fellow Coroners, on 13 March 2024, I delivered the finding into the death of Mr SL (which involved the unknowing ingestion of a nitazene),[8] in which I recommended the trial of 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. My colleague Coroner Simon McGregor made similar recommendations in his finding into the death of Mr KM, which he delivered on the same day.[9]

54. In response to this body of coronial findings and recommendations, as well as sustained advocacy from drug harm reduction organisations, addiction medicine and public health experts among others, the Victorian Department of Health subsequently announced a drug checking trial was to be established in Victoria, with the *Drugs, Poisons and Controlled Substances Amendment (Pill Testing) Act 2024* (Vic) providing the legal framework.

55. The first stage of the trial has recently been completed, which involved a mobile service attending five music festivals and events across Victoria between 1 January 2025 and 25 April 2025. The next stage of the trial, a fixed-site service in Fitzroy called the Victorian Pill Testing Service, commenced today. The service is described on the Department's website as follows:

> *At the pill testing service, people are asked to provide a small sample of their drugs. This is usually a tiny scraping of a pill or a bit of powder that a chemist will analyse. The drug checking technology at services can test the make-up of most pills, capsules, powders, crystals, or liquids and identify substances such as dangerous synthetic opioids, like fentanyl and nitazenes. A harm reduction worker provides the test results and offers tailored advice. This includes information about potential risks and how the drug may interact with prescription medications and existing health conditions. For many, this will be the first time they've had a chance to talk openly with a health professional about drug use in a private, judgement-free space.*[10]

[8] Finding into the death without Inquest of Mr SL, 13 March 2024, COR 2022 006970, available here.
[9] Finding into death without Inquest of Mr KM, 13 March 2024, COR 2023 002206, available here.
[10] https://www.health.vic.gov.au/alcohol-and-drugs/pill-testing - accessed 15 August 2025.

56. As outlined on the website, there is data to support the effectiveness of pill testing as a method of reducing harms from illicit drugs. For example, a 2023 evaluation of the Australian Capital Territory drug checking service, CanTEST, revealed only 53% of substances tested matched the expected drug. For those where an additional drug, a different drug or an inconclusive result was found, one-third reported that they *'definitely will not'* use the drug.

57. I note that the initial experience of delivering the mobile drug checking trial across Victorian music events also appears to be very positive from a drug harm reduction perspective. In particular, for 65% of service users, it was the first time they had ever spoken to a health professional about drug and alcohol safety. More than 30% said they would take a smaller amount after having a conversation with the harm reduction worker. Two statewide drug advisories were also issued to the public following the detection of highly potent and unexpected substances with unpredictable effects.

58. In this context, I am optimistic that the Victorian Pill Testing Service will support Victorians to make more informed and safer choices about using drugs from the unregulated drug market – whether in pill form or otherwise - which may in turn to lead to a reduction in the number of preventable deaths.

59. I consider this to be of critical importance in circumstances in which, as noted in recent days by State Coroner Judge John Cain, a new report from the Coroners Court demonstrates that the state of Victoria recorded its highest number of fatal overdoses in a decade in 2024. The report, Victorian Overdose Deaths 2015–2024, is the first release of 2024 full year overdose data and reveals 584 Victorians died from overdose last year, compared to 547 in 2023 and 552 in 2022.

60. In my view, this highly concerning data amplifies the need for harm reduction measures such as the Victorian Pill Testing Service, which, in light of the ominous rise of nitazenes and other novel substances, has the power, promise and potential to save the lives of members of our community.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ryan Andrew Robinson, born 26 November 1991;

b) the death occurred on 17 May 2023 at 18/9 Latrobe Street, Cheltenham, Victoria, 3192, from 1(a) *mixed drug toxicity (heroin, bromazolam, metonitazine, protonitazene, methamphetamine, oxycodone, dextromethorphan, clonazepam, nitrazepam)*; and

c) the death occurred in the circumstances described above.

62. Having considered all of the circumstances, I am satisfied that Ryan's death was the unintended consequence of the deliberate ingestion of numerous drugs, including both illicit and prescription medications, and notably, a number of novel psychoactive substances (**NPS**), in the context of a longstanding history of drug dependence. Although Ryan suffered from mental ill health, and had recently suffered from dental-related pain, there is no evidence to suggest that his death was intentional, noting in particular that Ryan presented as '*doing well*' in recent consultations and that there was no known history of suicidality.

63. I note further that the impacts of using NPS in combination with other drugs would likely have been unable to be accurately gauged by Ryan, which increased the risk of a fatal outcome.

64. While I have been unable to confirm any details with regard to the source of the NPS which contributed to Ryan's fatal overdose, I consider that the circumstances of Ryan's death reinforce a broader need for caution by the general public when obtaining substances from unregulated drug markets. I am optimistic that Victoria's Pill Testing Service will constitute a valuable contribution to a harm reduction approach in this regard.

65. Finally, after careful consideration, I am satisfied that Ryan received appropriate care and management in the period leading to his death. Sadly, despite the best efforts of treating clinicians and the ongoing support of his parents, Ryan was ultimately unable to overcome his longstanding struggles with substance use. In these circumstances, I have not identified any opportunities for better clinical care to have been provided.

ACKNOWLEDEMENTS

66. I convey my sincere condolences to Ryan's family for their immeasurable loss and note the lasting impact that his death has had on the family.

67. Ryan's mother said of him, that in addition to arranging and supporting him at multiple medical appointments over many years: '*I did everything I could to keep him on the straight and narrow*'.

68. Ryan's father said of him: '*I loved him deeply and have been deeply hurt and distressed by his death. I had always hoped (probably forlornly) that if he could only get off the drugs then the 'real Ryan' – the sweet boy of his childhood – perhaps still buried deeply within, might somehow return so that he could live a happy and productive life'*.

ORDERS AND DIRECTIONS

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:

Caitlin Kennedy, Senior Next of Kin

Geoffrey Robinson, Father

Colleen Jeffreys, Mother

Dr Peter Drake, c/- Wotton Kearney

Victorian Department of Health

Harm Reduction Victoria

Senior Constable Mitchell Bayly, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 21 August 2025

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.