IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 005612

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Michael Richard Ruell Bell
Date of birth:	2 May 1987
Date of death:	9 October 2023
Cause of death:	1(a) Injuries sustained in a motor vehicle collision (driver)
Place of death:	Intersection of Tooradin Station Road and Manks Road, Tooradin, Victoria
Key words:	Motor vehicle collision, cannabis, medicinal cannabis

INTRODUCTION

1. On 9 October 2023, Michael Richard Ruell Bell was 36 years old when he sustained fatal injuries in a motor vehicle collision. At the time, Mr Bell lived in Cranbourne East.

2. Mr Bell was employed as a skilled labourer and was the holder of a full Victoria driver's licence.

3. His family described Mr Bell has a fit young man who went to the gym regularly. He did not have any major health issues, but his family noted he had used medicinal cannabis for anxiety and back pain.

4. Mr Bell attended Langwarrin Medical Clinic between 2017 and 10 May 2023. According to Dr Christopher Baker, at his last consultation, Mr Bell advised he had previously used cannabis to treat chronic back pain but had now ceased and was experiencing insomnia and anxiety as a result of the cannabis withdrawal. Dr Baker diagnosed anxiety and insomnia related to cannabis withdrawal and prescribed mirtazapine (an anti-depressant) in the lowest dose of 15mg for improved sleep and control of anxiety and depression.

THE CORONIAL INVESTIGATION

5. Mr Bell'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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Bell's death. The Coronial 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.

9. This finding draws on the totality of the coronial investigation into Mr Bell's death, 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.[1]

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

Identity of the deceased

10. On 12 October 2023, Michael Richard Ruell Bell, born 2 May 1987, was visually identified by his mother, Shianna Bell, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 10 October 2023 and provided a written report of her findings dated 14 October 2024.

13. The post-mortem examination revealed multiple significant injuries.

14. Routine toxicological analysis of post-mortem samples detected cannabis[2] – delta-9-tetrahydrocannabinol (**THC**)[3] at 47 ng/mL, 11-OH-delta-9-tetrahydrocannabinol (**11-OH-THC**) at 4 ng/mL, and 11-nor-delta-9-carboxytetrahydrocannabinol (**THC-COOH**) at 36 ng/mL.[4]

15. Dr Francis provided an opinion that the medical cause of death was *"1(a) Injuries sustained in a motor vehicle collision (driver)"*.

16. I accept Dr Francis' opinion.

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[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.
[2] Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.
[3] THC is the active form of cannabis (marijuana).
[4] 11-OH-THC and THC-COOH are metabolites of THC.

Circumstances in which the death occurred

17. At about 5.00pm on the afternoon of 9 October 2023, Mr Bell drove his Mazda 2 Hatch (**the Mazda**) north along Tooradin Station Road in Tooradin. Tooradin Station Road was a two-way, undivided, aligned predominantly in a north-south direction. The posted speed limit was 80 kilometres per hour (**kmph**).

18. At about the same time, a Mitsubishi Triton Utility (**the Mitsubishi**) travelled east on Manks Road. In this area, Manks Road was a two-way bitumen road, and the opposing travel lines were separated by broken white lines.

19. According to the Coronial Investigator, Senior Constable Jason Schefman (**SC Schefman**), at the material time, the roads were dry, visibility was good, traffic was light, and the weather was fine.

20. Tooradin Station Road and Manks Road intersect in the form of a cross intersection governed by stop signs applicable to vehicles travelling on Tooradin Station Road, meaning that traffic driving through the intersection on Manks Road had right of way. On the approach to the intersection, Tooradin Station Road had 'Reduce Speed' and 'Stop sign' advisory signs approximately 158 meters prior to the intersection. Just prior to the intersection, a painted solid white line divided the opposing travel lanes and audio tactile rumble strips ran for about 100 metres.

21. Mr Bell was witnessed driving in the middle of the Tooradin Station Road as he drove toward the intersection or Tooradin Station Road and Manks Road. At the intersection, Mr Bell failed to stop and give way at the stop sign and travelled into the intersection and into the path of the Mitsubishi. The driver of the Mitsubishi stated he did not have time to take evasive action. The two vehicles collided, causing the Mazda to veer off the road into an adjacent paddock.

22. Other road users stopped to assist, extracting Mr Bell from his vehicle and administering cardiopulmonary resuscitation until emergency personnel arrived. Ambulance Victoria paramedics arrived a short time later and formally verified Mr Bell deceased at 5.24pm.

23. Victoria Police estimated that at impact the Mazda was travelling at about 78 kmph and the Mitsubishi was travelling between 86 and 94 kmph.

24. Victoria Police inspected the Mazda and found it was in good condition with no faults, failures, or conditions that would have caused or contributed to the collision.

25. SC Schefman advised that his investigations indicated that Mr Bell's mobile phone was switched off at the time of the collision and therefore not a factor in the collision. He concluded that the factors that contributed to the collision were the speed the vehicles were travelling at prior to impact; Mr Bell's failure to stop and yield to the Mitsubishi, and Mr Bell's impairment by cannabis use.

FAMILY CONCERNS

26. Mr Bell's father, Richard Bell, stated that his son had used medicinal cannabis for about two years, which he believed had been prescribed to assist with anxiety and back pain.

FURTHER INVESTIGATION

Evidence of Mr Bell being prescribed medicinal cannabis

27. SafeScript[5] records for the period from June 2020 to December 2022 show Mr Bell had been prescribed and dispensed a number of cannabis products such as oil, bud, dried herb, powder, and flower. These products were prescribed by:

    (a) Dr Andrew Taylor of Frankston HealthCare Medical Clinic, for prescriptions issued from June 2020 to 30 September 2021; and

    (b) Dr Fiona Zafiris of MediCann Clinics, for prescriptions issued on 19 August 2022 only.

28. There is no SafeScript record of Mr Bell being dispensed a medicinal cannabis product after 3 December 2022. In addition, no medicinal cannabis products appear in Mr Bell's Pharmaceutical Benefits Scheme records.

Dr Fiona Zafiris

29. Records from MediCann Clinics indicate Dr Zafiris prescribed the following cannabis products to Mr Bell on 19 August 2022:

    (a) Maali Sky (Royal Moby) THC flower, THC 20% CBD <1%, dose 0.1g as required (route: vaporisation), for daytime use;

[5] SafeScript monitors certain prescription medicines such as strong opioid painkillers, benzodiazepines, stimulants, and other high-risk medicines such as medicinal cannabis products (when included in Schedule 8 of the Poisons Standard).

(b) Cannatrek T25 Topaz (Kush Cookie) THC flower, THC 25% CBD <1%, dose 0.1g as required (route: vaporisation), for nighttime use to induce sleep. According to SafeScript records, this product was dispensed on 16 November, 24 November, and 3 December 2022;

(c) Tasmanian Botanics C100 oil, THC 5mg/ml CBD 100mg/ml, dose 0.1ml as required (route: sublingual);

(d) ANTG Rocky THC oil, THC 30mg/ml THC 30mg/ml, dose 0.1ml to 1ml nightly (route: oral) for nighttime use;

(e) Adaya 26 THC oil, THC 26mg/ml CBD <1mg/1ml, dose 0.1ml as required (route: sublingual); and

(f) Tetrahydrocannabinol powder 55%, dose 1 nightly (route: Inhalation/Respiratory).

30. Dr Zafiris' notes from the consultation indicate Mr Bell's history included back pain and forearm injury with nerve symptoms. Mr Bell stated that he had previous experience with medicinal cannabis via his general practitioner and was using 2 to 3 grams per day via vaporiser and smoking joint/glass. Notes of the consultation also include Dr Zafaris' advice to start *"low and slow"* and possible side effects of THC and CBD and, *"Discussed not legally able to drive, if want to comply with state laws will need to self test to determine if clear to drive, or avoid THC containing products 48 hours prior to driving"*.

31. In her statement, Dr Zafiris confirmed that Mr Bell presented for a consultation for his chronic back pain, a long-standing issue from his 19 years in a physical concreting job, which was being managed by his general practitioner. He informed Dr Zafiris had been using medicinal cannabis prescribed by a previous general practitioner and was using 2 to 3 grams of dried flower daily via a vaporiser/glassware. She conducted a risk assessment, noting that Mr Bell denied any mental health disorders and denied the use of other prescription medications. She did not identify any contraindications.

32. Dr Zafiris added that Mr Bell had a high tolerance to cannabis due to prolonged use. He had an established diagnosis of chronic back pain and expressed a preference for natural remedies over pharmaceuticals. Mr Bell had not found benefit from the standard treatments and medical cannabis was providing reasonable pain management.

33. Therapeutic Goods Administration (**TGA**) approval for higher limits was obtained to ensure Mr Bell was not prescribed or utilising above his current usage amount.

34. Dr Zafiris noted that the plan was to continue medicinal cannabis for Mr Bell's chronic back pain with the intention to consider ways to reduce his high consumption to avoid any complications from long term high THC use. Her intention was to gradually titrate Mr Bell's use down from 2 to 3 grams per day to approximately 1 gram per day, supplemented with oils over the subsequent 3 to 6 months.

35. She also stated the following:

> *Advice was provided regarding driving, specifically that it is not legal or safe to drive with THC in his system and that he should avoid THC products for 48 hours before driving. Given his high use of THC, driving would have been best avoided depending on his specific circumstances. I suspect he would have been driving whilst using THC but advised him against this due to safety concerns and the law.*

36. Dr Zafiris confirmed Mr Bell did not schedule any follow-up appointments to continue the titration process.

Dr Andrew Taylor

37. Dr Taylor was not able to provide a statement or records as Frankston HealthCare Medical Clinic closed in late 2023 and he did not have access to those records.

38. I note the last prescription for a cannabis product from Dr Taylor was in September 2021, which was not proximate to Mr Bell's death.

Evidence of Mr Bell using illicit cannabis

39. Records from Beach Street Family Medicine include a note of a consultation occurring on 8 May 2023 during which Mr Bell indicated he had been a long-term user of marijuana.

40. Records from Langwarrin Medical Clinic include notes of a consultation on 10 May 2023 during which Mr Bell disclosed he *"was on cannabis for chronic back pain"* and he was experiencing cannabis withdrawal. The records and Dr Baker's statement do not indicate whether Mr Bell was referring to medicinal cannabis, and I note that this consultation occurred approximately five months after Mr Bell's last dispense of a medicinal cannabis product (according to SafeScript records). In his statement, Dr Baker noted that he was not aware that

Mr Bell was being prescribed medicinal cannabis and he understood that following their consultation, *"Mr Bell's cannabis use would not continue, at least in the quantity he was then using, therefore I did not consider it necessary to make any further enquiries in respect of his cannabis use"*.

41. Records from the same clinic also capture historical consultations on 26 March 2005 and 9 September 2013 during which Mr Bell disclosed smoking marijuana. Notes of the latter consultation indicate Mr Bell wanted to stop using marijuana and he was provided contact details for Peninsula Drug and Alcohol Program (**PenDAP**).

Whether Mr Bell was affected by medicinal cannabis whilst driving

42. Noting the toxicological analysis which detected cannabis in Mr Bell's post-mortem samples and Richard Bell's statement that his son was using medicinal cannabis, I conducted further enquiries as to whether medicinal cannabis could have contributed to Mr Bell's death.

Effects of cannabis on driving

43. I received a report from Dr Jason Schreiber, forensic physician at VIFM, dated 22 March 2024, which provided the following expert evidence and information about cannabis.

44. Dr Schreiber explained that cannabis is the generic name given to the drug obtained from the plant *Cannabis sativa*. It is usually consumed by smoking a product of the plant and this results in rapid ingestion of the active component of cannabis, delta-9-tetrahydrocannabinol (**THC**).

45. THC intoxication is known to cause impairment in cognitive and psychomotor functions, producing risk-taking behaviours that may impair driving skills. THC intoxication may cause euphoria, dysphoria, sedation, and altered perception.

46. Dr Schreiber referred to a recent study which looked at the culpability of drivers under the influence of THC. It found that drivers with a THC concentration greater or equal to 5 ng/mL were 3.2 times more likely to be responsible for a crash when all other factors are taken into consideration. The odds for culpable driving increased to 10 times for THC concentration greater or equal to 10 ng/mL. His report goes on to detail the way that cannabis can affect a person's ability to drive safely.

47. Dr Schreiber noted that Mr Bell had THC and its active metabolite, 11-OH-THC, in his post-mortem blood samples. Whilst he noted the interpretation of the blood levels in a deceased may differ from a living person due to drug redistribution and blood pooling in the body after

death, he advised that the detected blood concentrations of THC and 11-OH-THC were in ranges that indicated recent cannabis use, and that were likely to significantly impact on Mr Bell's driving prior to death.

48. He concluded that the presence of THC and 11-OH-THC in relation known detrimental effects on the psychomotor skills and driving had created an appreciable risk such that Mr Bell's driving would have posed a significant risk to the public.

Medicinal versus illicit cannabis

49. In light of Dr Schreiber's report, I asked Associate Professor (**A/Prof**) Dimitri Gerostamoulos, Head, Forensic Sciences and Chief Toxicologist at VIFM, whether it could be identified whether Mr Bell was using medicinal or illicit cannabis from his post-mortem blood samples.

50. A/Prof Gerostamoulos responded that he was unable to ascertain from the post-mortem toxicology whether Mr Bell was taking medicinal cannabis or using illicit cannabis. He explained that it is not possible to discern between the two preparations based on VIFM's toxicology. He added that the components of medicinal cannabis (THC and cannabidiol (**CBD**)) is also found in illicit cannabis – unless Mr Bell was prescribed a CBD *only* preparation.[6] This would mean that Mr Bell's toxicology results would be consistent with illicit cannabis as illicit cannabis also contains CBD in addition to THC.

51. A/Prof Gerostamoulos also noted that post-mortem interpretation of cannabis is challenging as the drug is released after death from fatty stores in the body. He noted that whilst Dr Schreiber had arguably come to a reasonable conclusion regarding possible driving impairment, it is not always necessarily the case when assessing post-mortem concentrations of THC.

52. A report from Professor Olaf Drummer, Forensic Toxicology Consultant Specialist at VIFM, dated 24 July 2025 provided further information as to why medicinal cannabis could not be distinguished from illicit cannabis in post-mortem samples. Professor Drummer noted that products obtained for use as medically prescribed cannabis can effectively be very similar to those cannabis products obtained illegally, although cannabis from legally obtained sources usually has a defined dose.

[6] According to Professor Olaf Drummer, cannabidiol (**CBD**) does not have the psychoactive effects of THC but can be useful in the treatment of certain clinical conditions.

53. Professor Drummer explained that THC is the main active component of both medical and illicit cannabis, however other chemicals can be present depending on the source. These include, most commonly CBD which does not have the psychoactive effects of THC but can be useful in the treatment of certain clinical conditions, that are often the reason for prescribing 'medical marijuana'.

54. Medicinal cannabis contains variable amounts THC and CBD and can also be pure THC or pure CBD. Illicit cannabis will also contain variable amounts of THC and often also contains CBD.

55. In a 2022 Australian survey, 27 percent of medical cannabis was sourced illegally either as the user's main source or as an additional source.

56. Professor Drummer explained that the toxicology laboratory at the VIFM routinely tests for THC in blood and provides an approximate concentration and occasionally has monitored levels of CBD. However, measuring CBD has not proven useful to distinguish medicinal from illicit use, given the variable presence of CBD in illicit supplies.

57. In a deceased person in whom toxicology testing is conducted on blood there is no current way to distinguish use of prescribed medical marijuana from illicit use of cannabis.

58. Professor Drummer noted that repeated use of cannabis from any source will lead to a build-up of THC (and CBD) concentrations that become much higher than from single doses or a short period of use. These substances also accumulate in tissues of the body, particularly muscle and fat and will lead to a prolonged excretion lasting weeks on cessation of cannabis use. This accumulation of cannabinoids complicates the interpretation of their concentrations in cases. Repeated long-term use also leads to the development of tolerance and addiction.

59. Similar to Dr Schreiber, he noted:

> *Sufficient amounts of THC from any source will render a person as under the influence of cannabis and will experience impaired cognition (reasoning and thought), poor vigilance, impaired reaction times, and impaired decision making, however the degree to which these occur vary substantially between subjects and of course is very dependent on the dose(s) and to what degree any tolerance to the effects of cannabis has been developed with regular use.*

Published government resources about medicinal cannabis and driving

60. The Victorian Department of Health provides the following advice to patients in relation to driving and medicinal cannabis use:[7]

> *It is also important to note that THC in cannabis is known to have impairing effects. As such, patients should not drive or operate machinery while being treated with medicinal cannabis products containing THC.*
>
> *In addition, driving with any detectable amount of THC in oral fluid is a criminal offence in Victoria even if a person has been prescribed a legal medicinal cannabis product.*

61. Transport Victoria has published a factsheet titled *Medicinal cannabis and driving*,[8] which provides consumers advice if they have been prescribed medicinal cannabis for a medical condition and wish to drive. The factsheet outlines the applicable law – that it is an offence in Victoria for a person to drive with any detectable amount of THC in their system, including from prescribed medicinal cannabis – and that consumers may be subject to roadside testing.

62. Patients taking CBD-only medicines can lawfully drive as long as they are not impaired. It is therefore important for patients to check the whether the medicinal cannabis product contains THC.

63. Transport Victoria also advises prescribers to discuss driving with their patients and has published a number of resources to assist prescribers.[9]

64. In 2021, the Department of Justice and Community Safety published *Assisting medicinal cannabis patients to drive safely*,[10] a report of the Medicinal Cannabis and Safe Driving Working Group which looked at existing evidence regarding road safety risks, potential

[7] Department of Health, Information for patients and carers, page updated 17 December 2024, https://www.health.vic.gov.au/drugs-and-poisons/information-for-patients-and-carers. Emphasis added.
[8] Transport Victoria, Medicinal cannabis and driving, October 2025, https://transport.vic.gov.au/road-and-active-transport/road-rules-and-safety/alcohol-drugs-and-driving/medicinal-cannabis-and-driving.
[9] Transport Victoria, Medicinal cannabis and driving resources for health professionals, https://transport.vic.gov.au/road-and-active-transport/registration-and-licensing/licences/medical-conditions-and-reviews/medicinal-cannabis-and-driving-resources-for-health-professionals.
[10] Department of Justice and Community Safety, February 2021, Assisting medicinal cannabis patients to drive safely, https://www.justice.vic.gov.au/medicinal-cannabis.

options to allow driving, and the current legal framework. The Working Group made similar comments to Dr Schreiber regarding the road safety risks and use of THC as follows:[11]

> *Evidence on THC and road safety risk shows that there is global consensus that THC impairs key driving skills for up to a few hours after consumption. This is supported by a host of psychometric, behavioural and on-road studies. These studies show that THC causes risky driving behaviours such as lane weaving, inappropriate speed changes and following distances, reduced reaction time, reduced capacity to divide attention, and reduced vigilance. The Working Group also heard evidence of large scale odds ratio studies which have shown increased crash risk in relation to recreational THC use.*

65. To assist prescribers to convey accurate and patient-tailored advice, the Working Group developed a decision tree support tool to work through a clear and logical pathway to determine a patient's fitness to drive.[12]

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Michael Richard Ruell Bell, born 2 May 1987;

    (b) the death occurred on 9 October 2023 at the intersection of Tooradin Station Road and Manks Road, Tooradin, Victoria;

    (c) the cause of Mr Bell's death was injuries sustained in a motor vehicle collision (driver); and

    (d) the death occurred in the circumstances described above.

67. Mr Bell's post-mortem samples – THC detected at 47 ng/mL – indicate he had used cannabis proximate to his death and therefore was likely impaired while he was driving.

[11] Department of Justice and Community Safety, February 2021, Assisting medicinal cannabis patients to drive safely, p 9.
[12] Department of Justice and Community Safety, February 2021, Assisting medicinal cannabis patients to drive safely, p 15. Emphasis added.

68. Mr Bell's family were aware that he had used medicinal cannabis in the past. Records indicate that Mr Bell had been prescribed and dispensed medicinal cannabis products from 2020 to 2022 for back pain, but not for anxiety as his family believed.

69. Dr Zafiris was the last clinician to prescribe a medicinal cannabis product to Mr Bell, and it was her evidence that she advised him not to drive with THC in his system, and to avoid THC products for 48 hours before driving.

70. In addition to medicinal cannabis, records also indicate that Mr Bell had been a long-term user of illicit cannabis and that, as recently as March 2023, he had reported experiencing the symptoms of cannabis withdrawal.

71. Expert evidence from A/Prof Gerostamoulos was that it could not be determined from Mr Bell's post-mortem samples whether he was taking medicinal cannabis or using illicit cannabis. I acknowledge A/Prof Gerostamoulos' caution about the need for care when interpreting post-mortem levels due to the phenomenon of post-mortem redistribution.

72. Expert evidence from Dr Schrieber and Professor Drummer was that THC is known to cause impairment in cognitive and psychomotor functions, producing risk-taking behaviours that may impair driving skills. Specifically, for drivers with a THC concentration greater or equal to 5 ng/mL they were 3.2 times more likely to be responsible for a crash. Culpable driving increased to 10 times for THC concentration greater or equal to 10 ng/mL. Studies have shown THC use causes risky driving behaviour.

73. The last time Mr Bell was dispensed a medicinal cannabis product was on 3 December 2022, which is about 10 months before his death. While it is *possible*, it seems highly *unlikely* that Mr Bell was still using this product at the time of his death.

74. In any case, whether Mr Bell was using prescribed medicinal cannabis products or illicit cannabis proximate to his death is beside the point as the current Victorian legal framework makes it an offence for a person to drive with *any* detectable amount of THC in their system.

75. Mr Bell's post-mortem samples indicating a THC level of 47 ng/mL in postmortem blood support a finding that he was significantly impaired at the time of the collision.

76. The available evidence supports a finding that Mr Bell's use of cannabis and level of impairment from cannabis caused or contributed to the collision in which he sustained the injuries that led to his death.

77. From a coronial perspective, this was a significant case as it was the first where there was a (known) possibility that medicinal cannabis may have been implicated in the fatal incident.

78. However, a thorough investigation does not support a finding that the THC impairing Mr Bell's driving was derived from consumption of medicinal as distinct from illicit cannabis. In any event, Mr Bell's death is a powerful reminder that consumption of cannabis irrespective of its source can impair driving and lead to fatalities and thus supports the need for ongoing investment in messaging and initiatives to ensure that people prescribed medicinal cannabis do not drive.

79. This case is also a reminder of the importance of witness testimony in coronial investigations. Given post-mortem toxicology analysis is unable to differentiate between medicinal cannabis and illicit cannabis use, the Court relies on witnesses – family and friends – to raise the possibility that medicinal cannabis may be implicated so that its contribution to the death can be investigated.

80. I convey my sincere condolences to Mr Bell's family for their loss and thank them for contributing to the investigation.

COMMENTS

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

The legislative framework

81. Medicinal cannabis was legalised in Victoria in 2016. A doctor or nurse practitioner can prescribe medicinal cannabis if they believe it is clinically appropriate to do so. Recognising that cannabis is a drug of dependence and carries a high risk of misuse, medicinal cannabis is generally listed as a Schedule 8 drug under Australia's 'Poisons Standard', which means it is subject to a range of prescribing, dispensing, and access controls to manage this risk. In addition, some cannabis preparations containing low levels of psychoactive compounds are listed under Schedule 4 of the Poisons Standard, which means they are still prescription medications but are subject to slightly less stringent controls.

82. The Victorian Department of Health requires that clinicians intending to prescribe a Schedule 8 drug to a patient in certain circumstances must apply for a permit to do so. The purpose of the permit system is to ensure as far as possible that only one clinician is prescribing a high-risk drug of dependence to a patient at a time, so the patient is not accessing the drug in excess

of therapeutic need. When medicinal cannabis was first introduced, clinicians seeking to prescribe cannabis to a patient were required to apply for a permit to do so. However, in February 2022 this requirement was relaxed, and at present a clinician is only required to apply for a permit if they believe the patient is a drug dependent person.[13]

83. Another key medicines safety initiative implemented by the Victorian Department of Health is the SafeScript system, which monitors in real time the prescribing and dispensing of certain target drugs including Schedule 8 (but not Schedule 4) medicinal cannabis products. Following the SafeScript rollout, since April 2020 every time in Victoria a clinician intends to prescribe a Schedule 8 medicinal cannabis product, or a pharmacist intends to dispense a Schedule 8 medicinal cannabis product, they are required to check SafeScript first to understand what other target drugs are being prescribed and dispensed to the patient, to inform their clinical decision-making and ensure the patient is not accessing these medicines in excess of therapeutic need.

Registered and non-registered medicinal cannabis products

84. According to the Victorian Department of Health, there are only two medicinal cannabis products entered on the Australian Register of Therapeutic Goods (**ARTG**):

    (a) Nabiximols (Sativex®), a Schedule 8 controlled drug approved for the treatment of spasticity due to multiple sclerosis; and

    (b) Epidyolex (Cannabidiol), a Schedule 4 prescription only medicine approved as an adjunctive therapy of seizures associated with Lennox-Gastaut or Dravet syndrome for patients 2 years of age and older.

85. For products not registered on the ARTG, an approval is required from the Commonwealth Therapeutic Goods Administration (**TGA**) for prescription. Approval is obtained through the TGA's Special Access Scheme or by becoming an Authorised Prescriber.

86. A medical practitioner can apply to prescribe an unapproved medicinal cannabis product to a single patient through the Special Access Scheme Category B (**SAS B**). If a medical practitioner intends to prescribe the same category of medicinal cannabis product to a group

[13] Department of Health, Medicinal cannabis, page updated 21 November 2025, https://www.health.vic.gov.au/drugs-and-poisons/medicinal-cannabis.

of patients with the same condition, then they may apply to the TGA to become an Authorised Prescriber of that product type.[14]

87. These approvals/ authorities are granted to the medical practitioner prescribing the product, rather than to the person taking it.

Pharmaceutical Benefits Scheme

88. Currently, no medicinal cannabis products are subsidised by the Commonwealth Government under the Pharmaceutical Benefits Scheme (**PBS**). This means prescribed medicinal cannabis will not be captured in a patient's PBS records.

Schedule 4 and 8 drugs

89. The *Poisons Standard* classifies medicines and poisons into Schedules for inclusion in the relevant legislation of the States and Territories.

90. Schedule 4 and 8 drugs are subject to strict legislative controls due to their high potential for misuse, abuse, and dependence. Medicinal cannabis products are currently listed as either Schedule 4 or Schedule 8 substances in the Poisons Standard, depending on their cannabinoid content.

91. Medicinal cannabis products containing over 2 per cent THC are Schedule 8 drugs of dependence. Prescribers are therefore required to apply for and hold a Victorian Schedule 8 treatment permit when prescribing a Schedule 8 medicinal cannabis product to a drug-dependent person. For non-drug dependent patients, no Victorian treatment permit is required.

92. Pure CBD preparations, containing 2 percent or less of any other cannabinoids (including THC) are classified as Schedule 4 prescription only medicines. The CBD content of Schedule 4 medicinal cannabis products must be 98 per cent of the total cannabinoid content.

SafeScript implications

93. SafeScript is a real-time prescription monitoring software system used in Victoria to track the prescribing and dispensing of high-risk medicines for patients. From April 2020, it has been

[14] Department of Health, Medicinal cannabis information for health professionals, page updated 9 Febraury 2026, https://www.health.vic.gov.au/drugs-and-poisons/medicinal-cannabis-information-for-health-professionals.

mandatory for prescribers and pharmacists to check SafeScript prior to writing or dispensing a prescription for a medicine monitored through the system.[15]

94. Medications currently monitored by SafeScript include all Schedule 8 medicines and some high-risk Schedule 4 medicines such as benzodiazepines, zolpidem and zopiclone, quetiapine, and codeine.[16]

95. As noted above while medicinal cannabis products with cannabinoid content over 2 per cent THC are Schedule 8 drugs and are therefore be monitored via SafeScript. However, medicinal cannabis products where the cannabinoid content is at least 98 percent cannabidiol and less than 2 percent THC are Schedule 4 drugs and are currently not listed amongst the other Schedule 4 drugs currently monitored by SafeScript.

96. From time to time, the Victoria Department of Health considers the inclusion of new drugs to be monitored by SafeScript, including Schedule 4 medicines. According to the Department, the review of medicines monitored by SafeScript is determined by the department in consultation with the Expert Advisory Committee on Potential Misuse of Drugs of Dependence and based on specific criteria.[17] A submission is then made to the Governor-in-Council and approval by the Minister for Health. The Minister will need to be assured that a thorough consultation process has been undertaken, and any recommended changes are based on best evidence and expert advice. A Regulatory Impact Statement and wider public consultation may also be necessary.[18]

PUBLICATION

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.

[15] Department of Health, SafeScript for prescribers and pharmacists, page updated 11 May 2026, https://www.health.vic.gov.au/safescript/safescript-for-prescribers-and-pharmacists.
[16] Department of Health, Medicines monitored in SafeScript, page updated 11 Febraury 2026, https://www.health.vic.gov.au/drugs-and-poisons/medicines-monitored-in-safescript.
[17] The criteria for consideration include: Evidence of harms; Trends in prescribing, misuse and abuse; 'Substitution effect'; 'Chilling effect'; Regulatory burden and cost-benefit; and Inter-jurisdictional approaches. Further information can be found at https://www.health.vic.gov.au/publications/criteria-for-inclusion-of-additional-medicines-in-safescript.
[18] Department of Health, Criteria for inclusion of additional medicines in SafeScript, page updated 3 December 2024, https://www.health.vic.gov.au/publications/criteria-for-inclusion-of-additional-medicines-in-safescript.

DISTRIBUTION

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

Richard and Shianna Bell, senior next of kin

Dr Christopher Baker (care of Avant)

Victorian Department of Health

Senior Constable Jason Schefman, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 31 July 2026

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.