IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000913

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Raymond John Flaherty
Date of birth:	14 December 1966
Date of death:	16 February 2024
Cause of death:	1a: Mixed drug toxicity (heroin, methadone, benzodiazepines including novel benzodiazepines, amitriptyline, olanzapine) Contributing factor: Methylamphetamine use
Place of death:	Holden Court Fitzroy North Victoria 3068
Keywords:	Mixed drug toxicity; opioid use disorder; benzodiazepine dependence; naloxone; novel psychoactive substance; NPS; counterfeit benzodiazepines; drug checking; harm reduction

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. Raymond John Flaherty,[1] a proud 57-year-old Wurundjeri man who had strong connections with his culture, passed in circumstances consistent with a drug overdose on 16 February 2024. Before his passing,[2] Raymond resided at Holden Court in Fitzroy North, Victoria, where he had lived for approximately 20 years, but often spent periods of time staying with his mother at her residence in St Albans.

2. Raymond had a complex psychosocial history, including a longstanding history of drug use and opioid use disorder, mental ill health, and extensive contact with the criminal justice system throughout his life, including multiple periods of incarceration.

3. Raymond's sister described that Raymond was raised by their mother and father around Carlton Housing Commission in a "*kind and loving environment*". She stated that from a young age, Raymond was known for his "*cheeky personality*" but became *"increasingly troubled*" throughout his teen years and began to have regular contact with the police and justice system. Raymond left school in Year 8 and spent multiple periods of time incarcerated in youth detention facilities throughout his teens.

4. During his teen years, Raymond commenced using illicit drugs, beginning with marijuana and subsequently progressing to heroin and prescription drug misuse by his 20s. Raymond continued to use drugs throughout his life, including intravenous heroin and methylamphetamine. Raymond also had a long history of prescribed and non-prescribed benzodiazepine use, used cannabis on a regular basis, and had periods of amphetamine use.

5. In 2001, Raymond began receiving treatment for opioid dependence through Cohealth Innerspace (**Cohealth**), a community health service, where he was commenced on buprenorphine in 2001 and then methadone in 2003, which he remained on for many years. Raymond reportedly displayed a pattern of abstaining from non-prescribed opioids when on higher doses of methadone and relapsing to other opioid use when he attempted to wean. In 2021, he expressed a desire to cease methadone and was successfully rotated to buprenorphine. However, in mid-2023, Raymond reported that he wished to cease opioid

[1] Referred to throughout this finding as 'Raymond', unless more formality is required.

[2] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available here). I will therefore use the term 'passing' in this finding, save where I am required to use the word 'death' as used in the *Coroners Act 2008*.

replacement therapy, as he had not used non-prescribed opioids for a long time and considered his risk of relapsing low.

6. Raymond also received treatment from clinicians at Cohealth in relation to his benzodiazepine dependence from approximately 2017. Clinicians noted that Raymond had previously been prescribed alprazolam by a psychiatrist for a number of years to treat his anxiety disorder. Once treatment was taken over by Cohealth, the plan was to rotate Raymond from alprazolam to diazepam, and then to gradually reduce his diazepam dose with the intention of ceasing benzodiazepine prescribing. However, these attempts were punctuated by relapses in Raymond's use of non-prescribed benzodiazepines requiring a further period of stabilisation. Further detail is discussed below with regard to Raymond's use of benzodiazepines.

7. As noted above, Raymond also reportedly had a history of mental ill health and had been diagnosed with an anxiety disorder with panic and treated with alprazolam under the guidance of a psychiatrist for many years, until this treatment was ceased following an incident in which Raymond left an "*unacceptable*" message on his answering machine.

8. At the time of his passing, Raymond was prescribed amitriptyline 50mg tablet 1 daily; diazepam 5mg tablet 1 daily for weekly dispensing; and cephalexin 500mg capsule 1 three times a day.

9. Raymond had close and supportive relationships with family members until his passing, including his sister who would message him regularly on social media, and his mother with whom he often stayed for periods of time while attempting to abstain from drug use. I note that during the final period of his life, Raymond's mother often took steps to check up on Raymond and on one occasion, called the Crisis Assessment and Treatment (**CAT**) team when she became concerned for his welfare. Raymond had limited contact with his daughter, which reportedly affected him deeply.

THE CORONIAL INVESTIGATION

10. Raymond's passing 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.

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coronial Investigator, Senior Constable Rory Cowgill, for the investigation of Raymond's passing. 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.

14. Following a review of the available evidence, and toxicological results which identified the presence of the illicit novel psychoactive substance (**NPS**) bromazolam, I determined to conduct further investigations including directing for relevant exhibits to be transferred to the Victorian Institute of Forensic Medicine (**VIFM**) for testing, obtaining a number of additional statements, and referring the matter to the Coroners Prevention Unit for advice with regard to any opportunities for prevention. These investigations are set out in further detail below.

15. This finding draws on the totality of the coronial investigation into the passing of Raymond John Flaherty 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.[3]

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

Circumstances in which the death occurred

16. Raymond's family noted that his mental health appeared to have declined in the month before his passing. His sister stated that she was aware that Raymond had been acting in an "*increasingly erratic and paranoid manner,*" had been having "*run-ins*" with other residents

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

around Holden Court, and in one instance, had reportedly been seen running around Holden Court carrying knives. Raymond had also become increasingly withdrawn from his family, who noted that it had become harder and harder to communicate with him. Raymond had also talked to his family about having "*had enough*" and expressed to friends a desire to end his life.

17. On one occasion during the final period of his life, Raymond's mother sought support from the CAT team who reportedly attended and conducted an assessment.[4] Raymond's sister stated that she was not aware of Raymond seeking support from any other mental health support services during this period.

18. On 15 January 2024, Raymond presented to Cohealth requesting further scripts for diazepam. The clinician noted this indicated increased use,[5] in response to which Raymond noted that he had experienced stress associated with ongoing issues rated to bedbugs in his residence. The clinician stated that given increased use, diazepam could only be prescribed with weekly pick up from his regular pharmacy. Raymond was reportedly "*adamant*" that this was an aberration and requested a full further 50 tablets be prescribed and released. A prescription was provided for 50 tablets for weekly dispensing.

19. Pharmaceutical Benefits Scheme (**PBS**) records indicate this script was supplied on 16 January 2024.[6]

20. On 1 February 2024, Raymond attended a phone consultation with a clinician at Cohealth. Raymond reported that his housing block was affected by bed bugs and was provided with a script for cephalexin. Raymond reported that he had last used methylamphetamine one week ago, was using marijuana a few times per week, and no heroin use long term.

21. In the days prior to his passing, Raymond's sister described that it seemed Raymond was further "*spiralling*" in his mental health, as he had "*completely shut himself off from the outside world"* and reportedly hadn't left his apartment for days.

22. On 12 February 2024, a pharmacist at the pharmacy where medications were usually dispensed to Raymond contacted Cohealth and indicated that Raymond had been banned from

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4 No further evidence is available in regard to this incident.

5 I note that Raymond had been prescribed a supply of 50 diazepam on 15 December 2023 which would be anticipated to last 50 days if taken as prescribed at 1 Tablet daily, but instead had lasted Raymond only 31 days, indicating an average of 1.6 Tablets daily.

6 The PBS records do not capture information on a staged supply of a medication. However, it is assumed that Raymond received his medication in accordance with the direction of the prescribing clinician for weekly dispensing.

the store, on the basis that he had accused pharmacists of taking his diazepam, had been going through their bins looking for medication or scripts, and presented as verbally aggressive. The pharmacist requested that a script be written to a different pharmacy.

23. Medical records from Cohealth in relation to this incident note that Raymond was due for his weekly diazepam pick up on Thursday, 15 February 2024 and so the plan was to arrange for a new pharmacy with Raymond before this date. A Cohealth clinician attempted to contact Raymond via phone call and text but received no response.

24. The following day, on 13 February 2024, another Cohealth clinician attempted to contact Raymond via phone call but did not receive any answer and left a voicemail. A plan was recorded to try again later in the day, although there are no further notes recorded in the medical records to confirm whether this, or any further efforts to contact Raymond, occurred.

25. PBS records indicate Raymond was not supplied with any medications on 15 February 2024.

26. That evening, at around 8pm on 15 February 2024, Raymond's friend and neighbour (**the friend**) visited him at his residence at Holden Court and found that he was drug affected and appeared to be consuming "*numerous 'Xanax' and 'Valium' pills*".[7] The friend returned to his nearby apartment, noting later to police that this behaviour was "*common*".

27. At around midnight, the friend returned to check on Raymond. When there was no answer at the door, the friend let himself in using his spare set of keys and located Raymond unresponsive on a bed in the living room.

28. The friend noted that his phone battery was flat, and so he immediately ran to a nearby property to request that a neighbouring resident call '000'.

29. The friend and neighbouring resident both returned to Raymond's unit, shifted him onto the ground, administered naloxone (a drug that can temporarily reverse the effects of an opioid overdose or adverse reaction) and commenced cardiopulmonary resuscitation (**CPR**) at the direction of the call operator until the arrival of Ambulance Victoria.

30. Upon arrival, Ambulance Victoria confirmed that Raymond was deceased at the scene.

31. Victoria Police also attended and processed the scene, locating numerous empty blister packs of prescription medication and drug paraphernalia including a depressed syringe. A number

[7] The friend reportedly told police at the scene that Raymond had been "*smashing*" Xanax by "*chugging*" the bottle.

of exhibits were seized including a white plastic tablet bottle with a black, white and blue label reading "Pfizer Xanax alprazolam tablets, USP 2mg 50 tablets" discussed further below.

Identity of the deceased

32. On 15 February 2024, Raymond John Flaherty, born 14 December 1966, was visually identified by his uncle.

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

Medical cause of death

34. On 19 February 2024, Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post mortem computed tomography (**CT**) scan and the VIFM toxicology report. Dr Zhou also reviewed relevant materials including the Victoria Police Report of Death (**Form 83**), six scene photographs and the VIFM contact log. Dr Zhou provided a written report of her findings dated 29 July 2024.

35. Dr Zhou found that the mechanism of death was likely to be drug-induced depression of the central nervous system (**CNS**) leading to respiratory depression, apnoea (cessation of breathing), and death.

36. Dr Zhou noted that post-mortem examination showed stigmata of injecting drug use, and toxicological analysis of post-mortem samples showed evidence of recent heroin use prior to death. She explained that within minutes of injection into a person, heroin (diacetylmorphine) is rapidly metabolised to morphine via the intermediate compound 6-monoacetylmorphine, which was detected in urine samples. Morphine was also detected in the post-mortem blood and urine samples, as well as codeine, a common impurity in heroin. Dr Zhou noted that heroin (and morphine) are CNS depressants.

37. Toxicological analysis also showed the presence of bromazolam and desalkylgidazepam within blood. Dr Zhou noted that these are novel benzodiazepines and are not approved for medicinal use, and therefore have no established therapeutic dose. Dr Zhou considered that the desalkylgidazepam detected may be an artifact of bromazolam.

38. Additional drugs detected within blood that have CNS depressant effects included methadone (an opioid), diazepam (a benzodiazepine) and its metabolite nordiazepam, oxazepam (a

benzodiazepine which can also be a metabolite of diazepam), amitriptyline (an anti-depressant) and its metabolite nortriptyline, and olanzapine (an anti-psychotic).

39. Dr Zhou noted that the combined use of drugs with CNS depressant effects may have a synergistic depressant effect, even though the levels of some of these drugs themselves were not elevated. CNS depression leads to stupor, coma, and eventual decreased respiratory drive leading to apnoea and death.

40. Additional drugs detected within blood that did not contribute towards death included ticagrelor (an inhibitor of platelet aggregation indicated for acute coronary syndrome), naloxone (a synthetic opioid antagonist used in the treatment of opioid dependency by preventing or reversing the adverse effects including respiratory depression, sedation and hypotension), and delta-9-tetrahydrocannabinol (the active form of cannabis) and its metabolite.

41. Detected within urine but not within blood were methylamphetamine (a CNS stimulant) and its metabolite amphetamine, norbuprenorphine (a metabolite of buprenorphine, a mixed opioid agonist/antagonist), temazepam (a benzodiazepine and metabolite of diazepam), sertraline (an anti-depressant), irbesartan (an anti-hypertensive), and metoprolol (a β-blocker).

42. Dr Zhou commented that methylamphetamine use has been added as a contributory factor in Raymond's passing because the combined use of CNS depressants and stimulants can increase the risk of toxicity compared to when either are used alone. Stimulants can counteract some effects of depressants, which may lead to a false sense of tolerance. This may lead to respiratory depression when the effects of stimulants decrease.

43. Taking into account all available information, Dr Zhou provided an opinion that the medical cause of death can reasonably be formulated as:

> *1(a) Mixed drug toxicity (heroin, methadone, benzodiazepines including novel benzodiazepines, amitriptyline, olanzapine)*
>
> *Contributing factors: Methylamphetamine use.*

44. I accept Dr Zhou's opinion.

FURTHER INVESTIGATION

45. Raymond's passing, like most Victorian overdose deaths,[8] was not caused by any single drug but rather the combined effects of multiple drugs he had consumed. These included the illicit drug heroin; the opioid methadone (not prescribed to him); the benzodiazepines diazepam (prescribed to assist in managing his benzodiazepine dependence) and oxazepam (not prescribed to him); the antidepressant amitriptyline (prescribed to him); the antipsychotic olanzapine (not prescribed to him); and the illicit novel psychoactive substance (**NPS**) bromazolam.

46. As I learned more about the history of Raymond's substance use, this last drug, bromazolam, became the primary focus of my further investigation.

Bromazolam

47. NPS are a diverse family of drugs that have risen to prominence in unregulated (illegal) drug markets around the world over the past 20 years. There is no single universally accepted definition for NPS, but they are generally agreed to have certain properties:

    a) They are not approved for therapeutic use, instead being used in recreational[9] and other settings outside the health system.

    b) They are new or novel in the sense that they have not historically circulated in unregulated drug markets. Some NPS are literally novel, having only been synthesised in the last few years (or even months). Others were discovered decades ago but have only recently been introduced into unregulated drug markets.

    c) They produce similar or identical effects to 'classic' illegal drugs and therapeutic psychoactive drugs, and are known or suspected to pose similar risks with respect to dependence, misuse, toxicity and effect on mental health. Reflecting this, one synonym for NPS is "designer drugs", because chemists often synthesise (or 'design') them as functional or structural analogues of classic drugs to mimic their effects.

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[8] Approximately three-quarters of Victorian overdose deaths each year result from combined drug toxicity rather than the acute toxic effects of a single drug. See Coroners Court of Victoria, *Victorian overdose deaths, 2015-2024*, Southbank: Coroners Court of Victoria, 12 August 2025, p.8.

[9] The term "recreational use" is deployed here in a neutral sense to distinguish it from clinical or therapeutic drug use.

d) They are highly transient. Research in Australia and internationally has shown that specific NPS will usually only appear in unregulated drug markets for a short time, before manufacturers cease producing them and switch to other drugs.[10]

48. Bromazolam is a novel benzodiazepine (an NPS of the benzodiazepine class). The first Victorian overdose death confirmed to involve a novel benzodiazepine occurred in 2015, and concern about the risks they present intensified between 2019 (when 10 novel benzodiazepine-involved overdose deaths occurred in Victoria) and 2022 (when 40 such overdose deaths occurred).[11]

49. The pattern of novel benzodiazepine involvement in Victorian overdose deaths over time illustrates clearly the transient properties of NPS. To date, 16 different novel benzodiazepines have been identified as contributors to Victorian overdose deaths, and they have tended to contribute in waves.[12] For example, between 2019 and mid-2020, the primary or only novel benzodiazepine contributing to Victorian overdose deaths was a drug called etizolam. In mid-2020 flubromazolam appeared and contributed to a handful of overdose deaths, then flualprazolam came to prominence between 2021 and mid-2022, followed by clonazolam across the course of 2022. The first Victorian overdose death involving bromazolam occurred in 2021, but bromazepam did not become a frequent contributor until 2022; and in 2023 and 2024 it has been overwhelmingly the most frequent novel benzodiazepine implicated in Victorian overdose deaths.

Raymond's use of benzodiazepines and novel benzodiazepines

50. I was grateful to Dr Dean Membrey (**Dr Membrey**) for his two statements outlining the care he provided as Raymond's treating general practitioner at Cohealth. Dr Membrey's second statement, dated 2 July 2025, was particularly helpful for understanding Raymond's use of prescribed and non-prescribed (including novel) benzodiazepines.

51. Dr Membrey explained that Raymond's history of benzodiazepine use stretched back to when he was a teenager, and over the years he was at various times engaged in treatment to address

[10] See for example Winstock A and Barratt M, "Synthetic cannabis: a comparison of patterns of use and effect profile with natural cannabis in a large global sample", *Drug and Alcohol Dependence*, 131, 2013, pp.106-111; Baumeister D et al, "Legal highs: staying on top of the flood of novel psychoactive substances", *Therapeutic Advances in Psychopharmacology*, 5(2), 2015, pp.97-132; Schumann JL et al, "Changes over time in novel benzodiazepines contributing to fatal overdoses in Victoria, Australia", *Drug and Alcohol Review*, 44(4), 2025, pp.1285-1289.

[11] Coroners Court of Victoria, *Victorian overdose deaths, 2015-2024*, Southbank: Coroners Court of Victoria, 12 August 2025, p.21.

[12] See Schumann JL et al, "Changes over time in novel benzodiazepines contributing to fatal overdoses in Victoria, Australia", *Drug and Alcohol Review*, 44(4), 2025, pp.1285-1289.

this, including inpatient admissions in 2005 and 2007 to assist him to reduce his benzodiazepine use, as well as specialist support services and counselling.

52. Dr Membrey stated that when he first started seeing Raymond regularly at Cohealth in 2017, a psychiatrist had been prescribing alprazolam to Raymond for some years to treat his anxiety disorder. Dr Membrey rotated Raymond from alprazolam to diazepam and then gradually reduced his diazepam dose with the intention of ceasing benzodiazepine prescribing, however this treatment goal was difficult to achieve, because:

> *[Raymond] appeared to display a cyclical pattern of stabilising on a dose of prescribed diazepam, before relapsing to non-prescribed use (often reported as alprazolam) when the dose reduced, necessitating an increase in his maintenance dose before another attempt at reduction/cessation was attempted.*

53. Early on in this therapeutic relationship, Raymond told Dr Membrey that he could obtain benzodiazepines from friends or buy alprazolam on the internet.

Raymond's use of bromazolam in the fatal incident

54. Investigating Victoria Police members who attended the scene of Raymond's passing seized several exhibits including a white plastic tablet bottle with a black, white and blue label reading "Pfizer Xanax alprazolam tablets, USP 2mg 50 tablets".[13] The label displayed an NDC number, the first eight digits of which were "0009-0094".[14] The bottle was accompanied by one complete rectangular white tablet with the letters "XANAX" embossed on one side, and a further seven pieces of rectangular tablets with the letters "XA" embossed on one side.

55. I am aware that Xanax is a brand name for the benzodiazepine alprazolam owned by the pharmaceutical company Pfizer, and Xanax tablets are pressed in a distinctive rectangular shape often described as a bar with the letters "XANAX" embossed along one side. I am also aware that following a Therapeutic Goods Administration decision to move alprazolam from Schedule 4 to Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons in February 2014, in response to concerns about it being disproportionately implicated

[13] The letters USP on a prescription drug label indicate the drug was made to the standards of the United States Pharmacopeia.

[14] The NDC number on a prescription drug label is the drug's National Drug Code number, a unique identifier assigned to the drug by the United States Food and Drug Administration.

in benzodiazepine-related harms,[15] Pfizer withdrew the Xanax brand from the Australian market.

56. Therefore, I strongly suspected that the apparent Xanax container and tablets seized at the scene of Raymond's passing may not be what they seemed, and I directed for the tablets to be forwarded to the VIFM for testing. Alprazolam was not detected in the tablets, but bromazolam was detected, confirming my suspicions that, just prior to his passing, Raymond consumed counterfeit Xanax tablets containing bromazolam.

Counterfeit Xanax and novel benzodiazepines

57. While I was able to confirm the form in which Raymond consumed the bromazolam, I was not able to establish with the same degree of confidence what he may have believed he was consuming. With Raymond's history of alprazolam use, it might reasonably be assumed he thought he was using Xanax-branded alprazolam, and did not realise the Xanax-embossed bar tablets were counterfeits containing bromazolam. However, after seeking advice from the Coroners Prevention Unit (**CPU**), I cannot conclude this with any certitude.

58. The CPU has been tracking the rise of novel benzodiazepines in Victorian overdose deaths for several years, and has examined systematically the available evidence regarding the types of substances implicated in these deaths. They advised me that in most cases where there was a witness account of what the deceased had used, the description was some variant of "Xanax" or "street Xanax" or "Xannies". In a smaller number of cases, witnesses gave accounts of the deceased having used "alprazolam" (noting that alprazolam itself was not detected in post-mortem toxicology in any of these cases), "Kalma" (which is another alprazolam brand name), "Valium" (a brand name of the benzodiazepine diazepam) or "Mylan" (the name of a pharmaceutical company that manufactures alprazolam). However, particularly in recent (2022-2024) deaths, Xanax was by far the most common description that the CPU encountered.

59. From its review of these cases, and particularly the analysis of how witnesses talked about and described the substances consumed in these cases, the CPU observed that the terms "Xanax" and "alprazolam" appear to be in the process of becoming disconnected in meaning

[15] For the background to the alprazolam rescheduling, its rationale and impact, see Deacon R et al, "Alprazolam use and related harm among opioid substitution treatment clients - 12 months follow up after regulatory rescheduling", *International Journal of Drug Policy*, 36(3), 2016, pp.104-111.

from the drug alprazolam, and undergoing a semantic shift to designate more generally benzodiazepines obtained from unregulated drug markets.

60. Furthermore, the CPU noted that this shift appears to be reinforced through the way benzodiazepines are being packaged and offered for sale in unregulated drug markets. The CPU combed through coronial briefs in novel benzodiazepine-involved overdose deaths to collate photographs from 34 cases showing containers that were confirmed or suspected to contain novel benzodiazepines.[16] In 19 cases the containers carried a Xanax label; in eight cases the labels carried a Kalma label; and in 12 cases the containers carried a label indicating they contained alprazolam but without a specific brand.[17] There were additionally photographs collated in 11 cases showing tablet contents of these containers; in eight of 11 cases the tablets were in the Xanax bar form.

61. Of particular interest to my investigation, the CPU collated photographs from 16 cases (including Raymond's passing) showing white plastic bottles bearing the black, white and blue label reading "Pfizer Xanax alprazolam tablets, USP 2mg 50 tablets". The earliest such container was photographed in a March 2022 death, and the most recent in a December 2024 death. The CPU informed me that the contributing novel benzodiazepines across these 16 deaths were bromazolam in eight deaths, a combination of bromazolam and clonazolam in five deaths, clonazolam only in two deaths, and a combination of bromazolam and clobromazolam in one death. The CPU also informed me that this bottle label design appeared in a New South Wales drug safety alert about counterfeit or fake alprazolam.[18]

62. Considered in the context of the above, Raymond's references to obtaining alprazolam from friends or the internet may have indicated he was seeking and using illicit benzodiazepines generally rather than the drug alprazolam specifically.

The risks of using novel benzodiazepines

63. The general risks attendant in using benzodiazepines are well documented. Benzodiazepines are central nervous system depressants, which is how they produce clinically useful effects

[16] Tablet containers were counted as relevant if they did not have dispensing labels on them, and their label design either (a) did not match known authorised Australian tablet container designs, or (b) has been confirmed counterfeit in published drug alerts in Victoria or elsewhere in Australia.

[17] Multiple different tablet container designs were photographed in some cases, which is why these numbers sum to greater than 33.

[18] See NSW Health, "Update on harmful drugs in fake alprazolam", updated 1 August 2022, accessed at <https://www.health.nsw.gov.au/aod/public-drug-alerts/Pages/counterfeit-alprazolam.aspx>, accessed on 9 August 2025.

such as reducing anxiety and excitement, and inducing sleep and amnesia; but their depressant effect can also cause over-sedation and respiratory depression, which may be fatal. Benzodiazepines interact with other central nervous system depressants (including alcohol) to produce additive and synergistic respiratory depression, which substantially heightens the risk of fatal overdose. People who use benzodiazepines regularly can develop dependence, and may experience cravings and withdrawal symptoms if they reduce or cease using benzodiazepines. On a related point, regular benzodiazepine use can result in tolerance such that a person requires more of the drug to achieve the same effect, and experiences greater adverse effects if the benzodiazepine use is subsequently reduced or ceased. Reflecting these risks, benzodiazepines are the most frequent contributing drug class to overdose deaths in Victoria.[19]

64. Together with these general risks, there are a number of specific risks associated with the use of novel benzodiazepines compared to pharmaceutical benzodiazepines. These risks can be broadly divided into the intrinsic and the practical.

65. Intrinsic risks here refer to risks emerging from the properties of the drugs themselves. Some research suggests that novel benzodiazepines may present a greater risk of overdose than pharmaceutical benzodiazepines because their chemical structure produces more potent effects. Evidence from observational studies also suggests that certain novel benzodiazepines are more potent and have more profound sedative effects than pharmaceutical benzodiazepines. Overall, though, evidence for the intrinsic risk of using a novel benzodiazepine over a pharmaceutical benzodiazepine is at present unclear, because very little is known clinically about novel benzodiazepines, their distribution and absorption in the body when consumed, their metabolism, excretion, and subjective effects.[20]

66. Practical risks refer to risks associated with how the drugs are made available and how they are used. In these respects, there is reason to be concerned that novel benzodiazepines are more risky than pharmaceutical benzodiazepines on the bases that:

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[19] Coroners Court of Victoria, *Victorian overdose deaths, 2015–2024*, Southbank: Coroners Court of Victoria, 12 August 2025, p.9.

[20] Brunetti P, et al, "Designer Benzodiazepines: A Review of Toxicology and Public Health Risks", *Pharmaceuticals*, 14(6), 2021, p.560; Greenblatt HK, Greenblatt DJ, "Designer Benzodiazepines: A Review of Published Data and Public Health Significance", *Clinical Pharmacology in Drug Development*, 8(3), 2019, pp.266-269; World Health Organisation Expert Committee on Drug Dependence, *Critical Review Report: Etizolam*, Geneva: World Health Organisation, October 2019, p.6; Ntoupa P, et al, "A fluorine turns a medicinal benzodiazepine into NPS: the case of flualprazolam", *Forensic Toxicology*, 39(2), 2021, pp.368–376.

a) Benzodiazepine effects including sedation and respiratory depression are dose-dependent. Pharmaceutical benzodiazepines are manufactured and sold according to strict quality standards that ensure consistent dosages of active ingredients. Novel benzodiazepines are not subject to these standards, and their dose strength may vary from batch to batch, and even from tablet to tablet, increasing the risk of toxic effects because the user cannot accurately gauge the dose consumed.

b) Related to the above (and as discussed earlier), the novel benzodiazepines available in unregulated drug markets are highly transient, with specific drugs emerging and being replaced by others constantly. If a person expects a benzodiazepine substance obtained from an unregulated drug market to have a certain effect based on previous experience, but in the interim the composition of the substance (i.e. the type of novel benzodiazepine it contains) has changed, this may contribute to heightened overdose risk.

c) Novel benzodiazepines are sold in a variety of forms, from factory-produced tablets to street-pressed pills to powders, liquids and blotters. These forms mean it is difficult to measure dosage, heightening the risk of taking more than intended and experiencing overdose.[21]

67. In addition to the above, another feature of novel benzodiazepines that in practice carries with it a heightened risk of harm compared to pharmaceutical benzodiazepines, is how they are supplied to people who use them.

68. Generally, pharmaceutical benzodiazepines are supplied to people in Australia via the health system: a doctor assesses a clinical need for benzodiazepines, writes a script, and the person then takes the script to a pharmacy where the drug is dispensed. This process has a number of built-in safeguards designed to ensure as much as possible that the benzodiazepines are accessed by people who have a genuine clinical need for them; and that these people use the drugs in line with clinical advice.

[21] Laing MK, et al, "An outbreak of novel psychoactive substance benzodiazepines in the unregulated drug supply: Preliminary results from a community drug checking program using point-of-care and confirmatory methods", *International Journal of Drug Policy*, 93(3), 2021, 103169; Zawilka JB and Wojcieszak J, "An expanding world of new psychoactive substances: designer benzodiazepines", *Neurotoxicology*, 73(2), 2019, pp.8-16; Darke S, et al, "Characteristics of fatal 'novel' benzodiazepine toxicity in Australia", *Forensic Science International*, 331, 2022, 111140; Schumann JL et al, "Changes over time in novel benzodiazepines contributing to fatal overdoses in Victoria, Australia", *Drug and Alcohol Review*, 44(4), 2025, pp.1285-1289.

69. For example, the Royal Australian College of General Practitioners has produced a comprehensive clinical guideline to assist doctors, titled *Prescribing Drugs of Dependence in General Practice: Part B – Benzodiazepines*. The Victorian Department of Health has implemented the SafeScript real-time prescription monitoring system, which collects information on prescribing and dispensing of benzodiazepines and makes it available to clinicians so they can understand who is prescribing to a person and what drugs they are being dispensed, to ensure they do not access benzodiazepines in excess of therapeutic need. Pharmacists have a range of dispensing options including staged supply, which they can use to limit the quantity of benzodiazepines a person has at once when they are concerned at the risk of providing an entire script to that person.

70. Novel benzodiazepines, by contrast, are accessed via unregulated drug markets (often online), and they are not subject to any analogous controls. Assuming a person has sufficient funds and is able to avoid Australian law enforcement countermeasures, they can purchase as many benzodiazepines as they wish through unregulated drug markets and use them however they wish.

Novel benzodiazepine use complicates clinical treatment

71. Dr Membrey's account of his attempts to manage, reduce and cease Raymond's benzodiazepine use, brings into sharp relief how the availability of novel benzodiazepines via unregulated drug markets can undermine clinical goals. Dr Membrey explained that:

> *[Raymond] was rotated to a longer acting benzodiazepine (diazepam) and gradually reduced with the intention of cessation, however these attempts were punctuated by periods of use of non-prescribed benzodiazepines requiring a further period of stabilisation.*

72. In Dr Membrey's second statement, I invited him to expand upon his experience treating people for benzodiazepine dependence, and how novel and other non-prescribed benzodiazepine use complicates the treatment process. He stated that a number of his patients use non-prescribed benzodiazepines, and he identified three basic groups. The first group is predominantly older clients who obtain and use pharmaceutical benzodiazepines obtained through trade or diversion. The second group is predominantly younger clients who have an active interest in novel benzodiazepines and attempt to source them intentionally from the internet. The third group is people who obtain "alprazolam" to use, most of whom "*have some knowledge that it is likely the substance they are using is not alprazolam*".

73. Asked about what the emergence of easily accessible non-prescribed benzodiazepines including novel benzodiazepines in unregulated markets has meant for treating patients, he wrote:

> *The emergence of novel benzodiazepines has certainly provided a new challenge in the treatment of people with substance use disorders. In instances where patients have accessed our service seeking help for their use of non-prescribed benzodiazepines, it has at times been difficult to work to establish the substance and dose they have been taking. As the approach to benzodiazepine use disorder is generally to stabilise on a longer acting, staged supply, prescribed benzodiazepine before embarking on a gradual deprescribing regimen, deciding on an equivalent dose that is likely to alleviate withdrawal symptoms and eliminate the risk of withdrawal seizures but not create a risk of over-sedation is particularly difficult.*

Insights from Reconnexion

74. To learn more about novel benzodiazepines and the challenges they present for managing benzodiazepine dependence in people, I wrote to Reconnexion, which is a service of 'Each' and, I am informed, is Australia's only specialist benzodiazepine treatment and support service. I received a detailed response from Ruben Ruolle, who is Manager of AOD Specialist Programs at Each. Ruben Ruolle confirmed that around half of callers to Reconnexion's benzodiazepine support line report using non-prescribed benzodiazepines, and that:

> *Xanax and Diazepam appear to be what people are most often seeking. There are some reports of getting them in gummy form, but mostly in pressed pills. The sources where these novel benzodiazepines are obtained vary widely and include online (and on the dark web) diverted use through their peers and family, or through others selling them (and illicit street supply).*

75. Ruben Ruolle confirmed that:

> *[…] the increasing presence of non-prescribed benzodiazepines, particularly those sourced through unregulated online markets, has made the identification and treatment of benzodiazepine dependence significantly more complex. These substances are often counterfeit or illicit analogues of pharmaceutical benzodiazepines, with highly variable strength and unknown composition.*

Individuals using these drugs frequently have little or no understanding of the exact substances they are taking, including the dosage, frequency, or potential interactions. This uncertainty severely limits our ability to conduct accurate assessments and safely stabilise individuals, particularly when managing withdrawal, where there is a heightened risk of seizures and other serious complications.

The unregulated nature of these substances poses a considerable challenge to healthcare and alcohol and other drug (AOD) services. It not only compromises clinical decision-making but also increases the risk of harm to the client. From a public health and clinical perspective, this issue is deeply concerning and continues to complicate the provision of safe and evidence-based care.

Potential prevention opportunities

76. I asked both Dr Membrey and Ruben Ruolle whether they had any insights into what else might be done in Victoria to identify people at risk of transitioning from prescribed to non-prescribed benzodiazepine use, and to put in place interventions to prevent this from occurring. Both responded to highlight potential areas for action or further investigation. In reviewing these, I had close regard to Dr Membrey's observation that:

> *This is a particularly challenging discussion and has been a contentious issue among doctors working in the addiction field.*

77. This observation served as a timely reminder for me that the broader clinical issues emerging from the circumstances of Raymond's passing require expert consultation and input beyond the scope of my investigation. My understanding and appreciation of this point has informed my comments and recommendations in this case.

78. Harm reduction principles are the other important influence on my comments and recommendations. Harm reduction is underpinned by a recognition that people use psychoactive drugs for a range of reasons, and will commence and continue drug use despite any efforts (legal, medical or otherwise) to prevent them from doing so. Accepting this, harm reduction approaches focus on identifying the specific risks and harms that are associated with different types of drug use, and strategies that can be used to mitigate these harms when drug use occurs.

79. Harm reduction principles have informed Victorian coroners' examination of a range of public health issues relating to drug use, including their recommendations calling for supervised

injecting and drug checking (both of which are considered to be 'classic' drug harm reduction interventions). I am of the view that harm reduction is also the most appropriate lens through which to approach novel and counterfeit benzodiazepines circulating in unregulated drug markets in Victoria.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Raymond John Flaherty, born 14 December 1966;

    b) the death occurred on 16 February 2024 at Holden Court Fitzroy North Victoria 3068, from *1(a) mixed drug toxicity (heroin, methadone, benzodiazepines including novel benzodiazepines, amitriptyline, olanzapine),* with a contributing factor of *methylamphetamine use*; and

    c) the death occurred in the circumstances described above.

81. Having considered all of the circumstances, I am satisfied that Raymond's passing was the consequence of the deliberate ingestion of a combination of illicit drugs (heroin and bromazolam), medications which had been prescribed to him (diazepam and amitriptyline), and medications which had not been prescribed (methadone, oxazepam and olanzapine).

82. On the evidence available, it appears that Raymond's passing occurred in the context of longstanding drug misuse and a recent decline in his mental health, whereby Raymond had exhibited erratic behaviours and had withdrawn from family relationships. Noting that Raymond had reportedly expressed a recent desire to end his life, I consider that it is possible that Raymond may have consumed the combination of illicit drugs and prescription medications with either an intention to end his life or reckless indifference as to this outcome.

83. However, taking into account all available evidence, I consider it is most likely that Raymond passed as the result of an accidental overdose in the context of recreational drug use in which he was likely unaware of the cumulative impact of the drugs he was ingesting. I have formed this conclusion on the basis that Raymond's behaviours on the night of his passing were not inconsistent with his longstanding history of illicit and prescription drug misuse, and that Raymond's friend who observed him on that night considered his behaviours were "*common*".

84. Notably, the illicit drugs consumed by Raymond included a novel psychoactive substance (**NPS**), bromazolam, which appears to have been contained in counterfeit Xanax tablets

obtained from an unknown source. I consider that such circumstances raise unique and pressing public health risks which demand urgent attention by the Secretary of the Victorian Department of Health. Pertinent comments and recommendations will follow.

85. I further note that, while unsuccessful, the administration of naloxone to Raymond by his friend and neighbouring resident highlights the value and importance of Victoria's Take-Home Naloxone program, whereby free naloxone is available to consumers, their families, carers and supporters from participating Needle and Syringe Programs, Mental Health and Wellbeing Locals, community pharmacies, the Medically Supervised Injecting Room and the Victorian Pill Testing Service.

86. Finally, I note that Raymond's passing occurred in the context of longstanding drug dependence, in relation to which Raymond had received treatment over many years under the care of clinicians at Cohealth.

87. It is unfortunate that Raymond appears to have experienced a short interruption to his care in the final days of his life, whereby his usual pharmacy declined to continue to dispense to Raymond due to challenging behaviours, and his clinicians at Cohealth, despite their best efforts, were unable to contact him to organise for a new pharmacy to dispense his weekly diazepam pick up on 15 February 2024, the day of his death. This is particularly concerning in circumstances where Raymond had previously told Cohealth clinicians that receiving prescribed diazepam "*stops him from sourcing illicit diazepines*". However, I consider that there is insufficient evidence to find that this short interruption to care had any significant contributing role in the circumstances of Raymond's passing, noting Raymond's long-term use of illicit drugs and non-prescription benzodiazepines.

88. Furthermore, when considering Raymond's overall circumstances, I am satisfied that the care provided to Raymond by Cohealth was patient-centred, reasonable and appropriate in managing his long term opioid and benzodiazepine dependences. In particular, I consider that Dr Membrey's treatment efforts represented a considered, caring and holistic approach, in which he strove to continually optimise Raymond's treatment in the context of challenges arising from his ongoing access to illicit benzodiazepines.

COMMENTS

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

89. In the period leading up to Raymond's passing, his treating general practitioner Dr Membrey at Cohealth spent substantial effort trying to rationalise, reduce and cease his benzodiazepine use. Dr Membrey's efforts were challenged by Raymond's ability to obtain non-prescribed benzodiazepines from unregulated drug markets. Raymond's passing by way of overdose resulted from the combined toxic effects of multiple drugs including the non-prescribed novel benzodiazepine bromazolam, which was contained in counterfeit Xanax tablets he obtained from an unknown source.

90. Counterfeit benzodiazepine products that are labelled and pressed to look like Xanax (or other forms of alprazolam), but which contain novel benzodiazepines, are implicated in a growing number of Victorian overdose deaths. Benzodiazepines have always presented risks of misuse, dependence and overdose, but counterfeit benzodiazepine products and novel benzodiazepines appear to present new types of risks that our community has not encountered in the past.

91. Therefore, I am of the view that there is some urgency in the task of ensuring that clinical guidance on prescribing benzodiazepines and treating benzodiazepine dependence reflects an understanding of these risks; and likewise ensuring that the Victorian health system is equipped to recognise and address these risks in treating people who may experience benzodiazepine dependence and/or may be using counterfeit or other non-prescribed benzodiazepines. This task in turn will undoubtedly require expert input from a range of areas including addiction medicine, psychiatry, specialist benzodiazepine treatment services, general practice, harm reduction, and people with lived experience of benzodiazepine use and dependence. I have made **Recommendation 1** to further this important work.

92. In the main body of my finding, I referred to the Royal Australian College of General Practitioners' (**RACGP**) comprehensive clinical guideline to assist doctors in prescribing benzodiazepines, titled *Prescribing Drugs of Dependence in General Practice: Part B – Benzodiazepines*. The RACGP plays a vital role supporting general practitioners in prescribing drugs of dependence. Therefore, I have distributed this finding for information to the RACGP Faculty of Specific Interests in Addiction Medicine, in case they wish to consult with their members as well as other relevant clinical bodies (such as Reconnexion) about the implications of the growth in availability of novel and illegal benzodiazepines in unregulated

drug markets, and whether general practitioners might need any further support to address the new harms associated with these substances.

93. Ruben Roule drew my attention also to Turning Point, which published the current (third) edition of its *Alcohol and Drug Withdrawal Guidelines* in June 2018, when concerns about use of counterfeit and novel benzodiazepines obtained from unregulated drug markets were not prominent. Between 2018 and 2024 the annual number of Victorian overdose deaths involving novel benzodiazepines grew from one to 35, and unregulated drug markets became an important source of non-prescribed benzodiazepines among patients treated for benzodiazepine dependence. Therefore, I have distributed this finding for information to Turning Point, in case they wish to review their guidance on benzodiazepine withdrawal in light of the growth in availability of novel and counterfeit benzodiazepines in unregulated drug markets as well as any new developments in the evidence base for treating benzodiazepine dependence.

94. Education for people who use drugs in understanding and managing the risks associated with the drugs they are using is a key element of the harm reduction approach. Reaching people who use non-prescribed benzodiazepines to provide them information and education regarding the 'Xanax' or 'alprazolam' they might be intending to use is a crucial opportunity to reduce the negative impacts that non-prescribed and novel benzodiazepines are having in Victoria. People using benzodiazepines from unregulated markets come from all walks of life, and, given that the drugs are similar in appearance to prescription medications, may be given a false sense of security in consuming them, being largely unaware of the risks of such consumption.

95. Further to this point, the commencement of operation of the fixed-site Victorian Pill Testing Service trial in Fitzroy presents an enhanced opportunity to reach and educate this group of people. In April 2022 my colleague Coroner Sarah Gebert delivered her finding in the overdose death of a young male who had used counterfeit Xanax tablets (described as 'Xannies' by witnesses) containing the novel benzodiazepines etizolam and bromazolam. Coroner Gebert noted that one of the major risks in using counterfeit benzodiazepine substances obtained from unregulated drug markets, is not knowing what the substances actually contain. She wrote:

> *A drug checking service would enable people to learn what NPS benzodiazepines and other drugs are contained within a substance, so they can make better-informed*

decisions about drug use. During this process, NPS benzodiazepines with higher risk profiles can be flagged, and contact with the service presents opportunities to deliver other harm reduction interventions.[22]

96. Coroner Gebert accordingly recommended, *inter alia*, that a drug checking service be established in Victoria as a matter of urgency, to reduce the number of preventable deaths associated with use of drugs obtained from unregulated drug markets.

97. Dr Membrey also mentioned drug checking in his second statement as a service that would allow people to learn what is contained in the substances they are consuming, though he noted also that "*ensuring utilisation by this at-risk group*" is of great importance. Regarding this last point, I have not to date encountered any specific public messaging about how the Victorian Pill Testing Service can support people who use benzodiazepines obtained from unregulated drug markets. I have made **Recommendation 2** to address both harm reduction education and the potential role that the Victorian Pill Testing Service might play in this area.

98. Finally, I thank once again Dr Dean Membrey and Ruben Ruolle for their efforts in assisting me to understand how access to novel and counterfeit benzodiazepines is contributing to benzodiazepine-related harms and making more difficult the efforts of clinicians and others to address these harms. The recommendations I have made may require an expanded Victorian health system response, noting in particular that Reconnexion, is currently the only specialist benzodiazepine treatment and support service in Victoria (and Australia). I have made **Recommendation 3** to address this issue.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

i. That the **Secretary of the Victorian Department of Health** commission the **Chief Addiction Medicine Advisor** to investigate the risks presented by the expanding availability of novel and counterfeit benzodiazepines in unregulated drug markets and consider what initiatives may be needed to address these risks and reduce harms associated with use of these substances.

[22] Gebert S, Finding into death of Mr S (anonymised) without inquest, Coroners Court of Victoria, reference COR 2020 003434, delivered 29 April 2022, p.9.

ii. That the **Secretary of the Victorian Department of Health** commission the **Chief Addiction Medicine Advisor** to undertake appropriate consultation to determine whether there is a need for a specific strategy to:

    a. reach people who are using novel and counterfeit benzodiazepines accessed via unregulated drug markets; and

    b. provide them information and education about risks presented by these substances, the role of drug checking in learning what substances contain, and pathways to treatment and support if they wish to address their use of benzodiazepines.

iii. That the **Secretary of the Victorian Department of Health** consult with specialist services and stakeholders (such as Reconnexion) on what would be needed to support an enhanced Victorian health system response to novel and illegal benzodiazepine use and related harms.

I convey my sincere condolences to Raymond's loved ones for their loss, and note in particular the tragedy of his passing for his mother and sister who provided him with extensive support over many years. I note also that Raymond's passing will no doubt have immensely impacted his friends and neighbouring residents, whose efforts to save his life are to be commended.

ORDERS AND DIRECTIONS

I order that this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

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

Kaye Flaherty, Senior Next of Kin

Emily Flaherty, Other Applicants

Senior Constable Rory Cowgill, Coronial Investigator

RACGP Faculty of Specific Interests in Addiction Medicine

Secretary, Victorian Department of Health

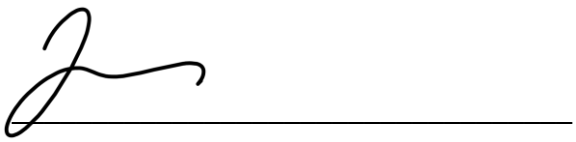
Chief Addiction Medicine Advisor of Victoria

Reconnexion

Turning Point

Harm Reduction Victoria

Signature:



Ingrid Giles

CORONER

Date: 4 December 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.