IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000954

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr XML[1]
Date of birth:	[redacted] 1964
Date of death:	17 February 2024
Cause of death:	1a: Mixed drug (methylamphetamine, deschloro-n-ethyl-ketamine) toxicity in a man with cardiovascular disease
Place of death:	Potter Road Ouyen Victoria 3490

[1] This finding has been de-identified to replace the name of the deceased with a pseudonym of a randomly generated two-letter sequence for the purposes of publication.

INTRODUCTION

1. On 17 February 2024, Mr XML was 60 years old when he was located deceased on the side of Potter Road, Ouyen. At the time of his death, Mr XML lived in Nangiloc, Victoria.

2. Throughout his life, Mr XML worked a number of jobs including as a mineral analyst at Mile End, doing labouring work at the South Australian desalination plant, and operating his own gardening business. In approximately 2018, Mr XML moved to the Nangiloc area and began working in the orchids. However, Mr XML subsequently ceased working and had been living with Centrelink assistance in the period leading to his death.

3. Mr XML's father described that Mr XML was "*very artistic*" and "*mechanically minded*". Mr XML was passionate about dirt bikes, and loved riding and working on his bike, as well as attending drag racing with his brother. In the period leading up to his death, he had been doing up the veranda at the front of his house and seemed "*very happy and content with where he was*." Mr XML kept in regular contact with his family and had plans to attend the drag racing with his brother the week following his death.

4. In relation to medical history, Mr XML's General Practitioner (**GP**), Dr Donald Hartley (**Dr Hartley**) of Sunraysia Medical Centre, Red Cliffs, stated that Mr XML had a history of narcolepsy and had been investigated by a sleep physician and prescribed phentermine (a stimulant) as treatment. Mr XML had also been recommended treatment with a continuous positive airway pressure (**CPAP**) device but did not pursue this due to financial constraints. Mr XML's father noted that Mr XML had sometimes requested money for medical needs, although he was unsure of any details in this regard. Mr XML's father noted also that they had received correspondence since Mr XML's death which made reference to "*vascular issues*".

5. In relation to mental health, Mr XML's father stated that he was aware that Mr XML had experienced some mental health issues during his life. Mr XML had not provided any further details but had not indicated that he was depressed or engaging in self-harm. Medical records confirm that Mr XML had completed a GP Mental Health Care Plan in September 2023 and been referred to a psychologist, including in relation to a possible diagnosis of Attention-Deficit Hyperactivity Disorder (**ADHD**). Medical records also indicate that Mr XML had requested dexamphetamine, although Dr Hartley had declined to provide a prescription "*unless a specialist authorises*".

6. Mr XML's medical records do not otherwise make reference to any history of illicit or prescription drug use. Mr XML's father was also unaware of any drug use, noting that he had understood that Mr XML was "*always against taking drugs*."

7. Mr XML's last contact with his father was on his birthday on [redacted] 2024. During this interaction, Mr XML presented as "*happy as always*" and had seemed excited about racing his motorbike.

THE CORONIAL INVESTIGATION

8. Mr XML'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer, Senior Constable Madeleine Moschetti, to be the Coronial Investigator for the investigation of Mr XML'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.

12. This finding draws on the totality of the coronial investigation into the death of Mr XML 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.[2]

[2] 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

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

Circumstances in which the death occurred[3]

13. On 16 February 2024, Mr XML made a plan with a man named 'Hong' to drive to Melbourne for the purpose of making a purchase of cannabis, which was reportedly for personal use. Mr XML and Hong had reportedly met through associates and had known each other for approximately 6-7 months.

14. Mr XML picked up Hong from his address in Mildura and continued onwards to Melbourne, making a few stops at service stations along the way. Mr XML was the allocated driver for the entirety of the journey and was driving his white Mitsubishi Express Panel van.

15. Upon arriving in Keilor, a suburb of Melbourne, Hong stated that he and Mr XML met up with an unknown person and made a purchase of approximately 2 pounds (or approximately $3000 worth) of cannabis. Hong stated that he paid for the cannabis and all expenses, and that they were in Melbourne for a total of approximately one hour. Mr XML then proceeded to drive them back, while Hong fell asleep for most of the return journey.

16. At some stage, Hong observed that Mr XML pulled up on a dirt road at an unknown location, which was later determined to be Potter Road, Ouyen. Hong described:

> *[Mr XML] had something in a syringe which he put in his arms. I looked away though when he did this. He never said what it was in the syringe. I think his heart then gave out cos he was gasping for breath. He had already opened the door and got out. Mr XML was lying on the ground at the side of the van. He was shaking and having a fit sort of thing. He was gasping for air. I tried to resuscitate him but. I just pumped on his chest but nothing was changing he was still shaking.*

17. Hong stated that he tried calling '000' but had no reception on his mobile phone. He then tried pulling Mr XML into the van but found that he was too heavy. Hong then decided to leave Mr XML on the side of the dirt road, and to drive in the van in order to find help or phone reception. As Hong had been sleeping and had not seen from which direction Mr XML had driven, he soon became lost.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] There is limited evidence available with regard to the circumstances leading to Mr XML's death. These findings are based primarily on evidence provided by Hong in his statement to the Court.

18. While turning around a corner on the dirt road, Hong rolled the van. Hong subsequently got out and began walking in an attempt to find his way, taking some water and two shopping bags full of cannabis. Hong stated that he walked for a long time, before he determined to sleep on the side of the road.

19. On 17 February 2024, at approximately 3pm, a farmer who owned a property nearby located a body, which was subsequently identified as Mr XML, near Wood Road and Potter Road, Ouyen. The farmer notified Victoria Police.

20. Emergency services subsequently attended the scene. Upon examination, Ambulance Victoria paramedics confirmed that Mr XML was deceased.

21. Victoria Police commenced an investigation, processing the scene and notifying the Homicide Squad, on the basis that the circumstances of death were unknown. Police members noted that Mr XML was located lying on the side of a dirt road, wearing only a pair of shorts. There was no evidence of physical injury, or any other evidence of suspicious circumstances.

22. In processing the scene, police located a small, empty syringe with no needle and an alcohol wipe nearby. They also located a number of pieces of rubbish, including a Coles brown paper bag, a flavoured milk bottle, and a cinnamon swirl 2-pack which was labelled as having been baked at Coles on 16 February 2024. Photographs were taken of the scene, which have been included in the Coronial Brief.

23. Following consultation with the Homicide Squad, it was determined that Mr XML's body could be transferred to the Victorian Institute of Forensic Medicine (**VIFM**) for post mortem examination.

24. On 18 February 2025, at approximately 8.50am, a passerby was riding a motorbike along Trinita Road through Ouyen when he observed a man on the side of the road, who was later identified as Hong. Hong appeared "*really dehydrated or tired*", had a limp, and was walking very slowly. Hong asked the passerby for directions to the A97. The passerby realised that Hong must have meant the Calder Highway and offered to provide a lift on his motorbike.

25. Upon reaching the corner of Trinita Road and the Calder highway, the passerby offered Hong a further lift to Ouyen or Hattah but Hong declined, stating that he planned to hitch another ride to Ouyen. The passerby offered Hong a drink of water and Hong consumed the entire 1.25 litre bottle. The passerby asked Hong why he was in such a remote location, noting that the circumstances were very strange, and Hong replied that he had been in a car crash in the

bush. The passerby offered him assistance with the car, but Hong declined, stating that his friend had come and picked the car up. Hong did not disclose any further details about the crash, thanked the passerby for his assistance, and walked southbound along the Calder highway toward Ouyen.

26. At approximately 11.33am that morning, Victoria Police located Hong on the side of Calder Highway, in possession of 2 large bags of cannabis and a wallet belonging to Mr XML. Hong was arrested and interviewed in relation to the possession of cannabis and the circumstances surrounding Mr XML's death.[4]

27. That afternoon, at approximately 1.40pm on 18 February 2025, the same farmer who had located Mr XML's body notified Victoria Police that he had located a van turned on its side, approximately 15-20kms west from the location where Mr XML's body had been located. Police attended the site of the van and confirmed that it belonged to Mr XML. Victoria Police processed the scene and took photographs which have been included in the Coronial Brief. Victoria Police also seized a number of exhibits, including two capped syringes located nearby the vehicle.

28. Victoria Police completed further investigations, including taking statements from witnesses, speaking to family members of Mr XML, requesting that the Victorian State Emergency Service (**SES**) assist with a line search of the areas both north and south of the body location, conducting searches of multiple addresses connected with Mr XML and Hong,[5] obtaining CCTV footage which showed the last time that Mr XML was seen at Nangiloc Store on 16 February 2024, and making unsuccessful enquiries in relation to any recent purchases from Coles.

29. Victoria Police also transferred all three syringes seized to the Victorian Institute of Forensic Medicine (**VIFM**) for toxicological testing, including that syringe located near Mr XML's body and the two syringes located near the overturned van. However, no common drugs or poisons were able to be identified from these exhibits.

[4] Hong initially told police that he was the only one involved in the accident but later provided an updated version of events which included Mr XML's involvement as described above. Hong explained that the reason he had not initially told police what happened to Mr XML was because he had affected by cannabis which he had consumed while he was in the bush.

[5] Upon searching Mr XML's address, police noted two zip lock bags of what appeared to be cannabis located in the fridge.

30. Following the completion of all investigations, Victoria Police did not identify any evidence of suspicious circumstances. Hong was charged in relation to possessing cannabis. However, no criminal charges were laid in relation to the circumstances of Mr XML's death.

Identity of the deceased

31. On 23 February 2024, Mr XML, born [redacted] 1964, was identified via fingerprint identification.

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

Medical cause of death

33. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and reviewed a post mortem computed tomography (**CT**) scan and relevant materials, including the Victoria Police Report of Death (**Form 83**), Request for Immediate Autopsy (**Section 27 Request**), scene photographs and the VIFM contact log. Dr Fronczek provided a written report of her findings dated 2 September 2024.

34. Toxicological analysis of post mortem blood samples showed methylamphetamine and its metabolite amphetamine. Dr Fronczek commented that the interpretation of methylamphetamine levels is problematic as there is a big overlap between toxic and non-toxic concentrations. She noted that overdose may cause cardiac arrhythmias, circulatory collapse, coma, confusion, convulsions, hypertension and hyperthermia, and that chronic methylamphetamine users also have an increased risk of cardiovascular and cerebrovascular disease.

35. Toxicological analysis of blood samples also detected deschloro-N-ethyl-ketamine (**2-oxo-PCE**) which is a synthetic ketamine derivative and novel psychoactive substance (**NPS**). Dr Fronczek noted that the interpretation of levels of 2-oxo-PCE is difficult because the pharmacology and toxicology of 2-oxo-PCE is not well known. However, a study of 56 instances of 2-oxo-PCE associated acute poisonings suggested that the substance may be more potent and related to a greater risk of toxicity than ketamine, with instances of impaired consciousness, confusion, abnormal behaviour, convulsion and several adverse cardiovascular effects including hypertension and tachycardia more frequently observed.

36. The autopsy also identified significant cardiovascular disease, namely severe atherosclerosis of a coronary artery with significant stenosis (blockage), aortic valve calcification with fusion

of 2 cusps, and an enlarged heart (cardiac hypertrophy). Dr Fronczek noted that cardiac hypertrophy and ischaemic heart disease are both associated with sudden cardiac death due to lethal arrhythmia.

37. Taking into account all available information, including evidence that the deceased allegedly collapsed after taking drugs, Dr Fronczek provided an opinion that a reasonable formulation for the cause of death is:

> *1(a) Mixed drug (methylamphetamine, deschloro-n-ethyl-ketamine) toxicity in a man with cardiovascular disease.*

38. I accept Dr Fronczek's opinion.

CPU REVIEW REGARDING USE OF NOVEL PSYCHOACTIVE SUBSTANCES

39. Taking into account the circumstances of this matter, and in particular the contributing role of 2-oxo-PCE, a rare and unusual drug, I determined to seek input from the Coroners Prevention Unit (**CPU**) in order to better understand relevant context in regard to the use of this drug, and any relevant opportunities for prevention.

40. The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

41. The CPU's advice is summarised below.

What is 2-oxo-PCE?

42. The drug 2-oxo-PCE belongs to a diverse group of drugs called novel psychoactive substances (**NPS**). In simplified terms, NPS are drugs that have become established in unregulated drug markets around the world over the past two decades. They are "novel" because they have not historically featured in recreational and other non-clinical drug use. Sometimes they are referred to as "*new synthetics*", reflecting that they are synthesised in (usually clandestine or grey market) laboratories, rather than having natural origins.

43. NPS first appeared as contributing drugs in Victorian overdose deaths in 2013, and in recent years the number of overdose deaths in which they were involved has grown steadily, from

17 deaths in 2019 to 48 deaths in 2024. The number of NPS-involved overdose deaths appears to have plateaued in recent years, after steadily increasing between 2017 and 2022.

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

45. The transience of NPS in unregulated drug markets creates a particular challenge for prevention efforts, whereby it may be ineffective to focus prevention efforts on any single NPS due to a strong possibility that manufacturers may soon cease producing that substance and switch to another novel substance.

46. Based on its effects, 2-oxo-PCE is usually described as a dissociative anaesthetic. Dissociatives are a class of drugs that can alter perception, mood, emotions and thoughts, as well as producing feelings of detachment (dissociation) from the self and reality. At lower doses, consumption of dissociatives such as 2-oxo-PCE results in a sense of wellbeing, visual and auditory effects (including hallucinations and impaired depth perception), altered patterns of thinking and unusual thought content. At higher doses, effects such as sedation and anaesthesia and amnesia emerge, along with bizarre behaviours, delirium and delusional thoughts.

47. At high enough doses, dissociative anaesthetics like 2-oxo-PCE can also cause potentially life-threatening respiratory depression, hypotension, bradycardia, myocardial infarction, and seizure. However, most documented deaths have resulted from the toxic effects of the dissociative(s) in combination with other drugs used (i.e.. combined drug toxicity), rather than the toxic effects of dissociative(s) alone.

The emergence of 2-oxo-PCE in unregulated drug markets

48. 2-oxo-PCE was first discovered in 1962 by research chemists who were exploring potential candidate drugs for anaesthesia; NPS are sometimes referred to as "*research chemicals*", reflecting that many of them were first discovered and documented in this way. It did not progress to testing on humans at the time because other drugs were seen to have greater

potential (including ketamine, which was discovered soon after 2-oxo-PCE and is now an important medicine).

49. Interest in experimenting with 2-oxo-PCE's effects arose among psychonauts (people who use drugs to explore altered states of consciousness) and clandestine chemists around 2009, but 2-oxo-PCE was not detected in unregulated drug market supply until some years later. It was reported for the first time in Europe in 2016, and then in North America and Hong Kong in 2017. Evidence from these detections suggested that in many cases of 2-oxo-PCE, people thought they were using ketamine instead. This suggests 2-oxo-PCE may circulate and be passed off in unregulated drug markets as ketamine.

50. So far as the Court is aware, there have only been two publicly reported detections of 2-oxo-PCE in unregulated drug supply in Australia. The first was at the CanTest drug checking service in Canberra in late 2024, where the person who submitted the sample believed it was ketamine. The second was 2-oxo-PCE being detected at the drug checking service at Beyond the Valley Festival (Barunah Plains Victoria, 28-31 December 2024), where the person who submitted the sample believed it to be ketamine. These reported detections provide further evidence that 2-oxo-PCE is passed off as ketamine in unregulated drug markets.

51. If 2-oxo-PCE is being passed off as ketamine, this presents a serious potential risk to the health of people who may obtain 2-oxo-PCE while believing it to be ketamine. The risk is, 2-oxo-PCE appears to have similar effects to ketamine, but evidence from multiple sources suggests it is up to five times more potent than ketamine, increasing the potential for overdose.

2-oxo-PCE in Victorian deaths

52. Mr XML's death is one of four deaths investigated by Victorian coroners to date where 2-oxo-PCE was detected in post-mortem toxicology. All four of these deaths were reported in 2024, suggesting 2-oxo-PCE may be only a very recent entrant to Victoria's unregulated drug markets.

53. In all four deaths, 2-oxo-PCE was detected in combination with other substances. Three of the four deaths were overdoses where the toxic effect of the 2-oxo-PCE was determined to have played a role in combination with other drugs, i.e.. the cause of death was "*combined drug toxicity*". In the fourth death, the forensic pathologist could not clearly ascertain the cause of death.

54. In two of the deaths, a substance seized from the scene of the fatal incident was tested and found to contain 2-oxo-PCE in combination with another NPS dissociative anaesthetic called 2-fluoro-2-oxo-PCE. This potentially suggests that both deceased obtained the substance they used from the same supply.

55. Unfortunately, at the time of writing, there was little information in any of the four deaths about what the deceased thought they might have taken (though in one case the deceased had an established history of ketamine use). This means it cannot be confirmed whether each deceased wrongly believed they were using ketamine, or another drug, at the time that they used 2-oxo-PCE.

Opportunities for prevention

56. In considering any potential prevention insights which may emerge from the circumstances of Mr XML's death, it would be ineffective to focus narrowly on 2-oxo-PCE given the transience of NPS and the strong possibility that producers to Victoria's unregulated drug markets may quickly move beyond 2-oxo-PCE to other, new NPS.

57. Rather, I consider that the circumstances of Mr XML's death raise a broader call for members of the public to exercise caution when obtaining substances from unregulated drug markets, noting that it is often not possible for drug users to know what any substance might contain.

58. In this context, I consider that the Victorian Pill Testing Service,[6] which is currently being trialled and recently commenced its fixed site phase on 21 August 2025, is a crucial drug harm reduction initiative.

59. The Victorian Pill Testing Service provides a free, confidential and anonymous drug checking service, which aims to detect life-threatening substances and reduce potential harms by giving people the information they need to make safer and informed decisions. It follows numerous coronial recommendations made in Victoria regarding the need for implementation of a drug-checking service in this state as a critical harm reduction measure, including in the face of dangerous, potent and potentially fatal substances such as nitazenes being 'passed off' as other drugs such as heroin, ketamine, oxycodone or similar.

60. Building on the recommendations made by my fellow Coroners, on 13 March 2024, I delivered the finding into the death of Mr SL (which involved the unknowing ingestion of a

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

nitazene),[7] in which I recommended the trial of a drug checking service in the State of Victoria to gather evidence, experience and insights into how drug checking might reduce risks (including preventable deaths) associated with the use of drugs obtained from unregulated drug markets. I also commented on the importance of any drug checking service being made available to all Victorians including those living in regional areas and using drugs outside of a music festival context. My colleague Coroner Simon McGregor made similar recommendations in his finding into the death of Mr KM, which he delivered on the same day.[8]

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

62. The first stage of the trial has recently been completed, which involved a mobile service attending five music festivals and events across Victoria between 1 January 2025 and 25 April 2025. The next stage of the trial, a fixed-site service in Fitzroy called the Victorian Pill Testing Service, commenced on 21 August 2025. The service is described on the Department's website as follows:

> *At the pill testing service, people are asked to provide a small sample of their drugs. This is usually a tiny scraping of a pill or a bit of powder that a chemist will analyse. The drug checking technology at services can test the make-up of most pills, capsules, powders, crystals, or liquids and identify substances such as dangerous synthetic opioids, like fentanyl and nitazenes. A harm reduction worker provides the test results and offers tailored advice. This includes information about potential risks and how the drug may interact with prescription medications and existing health conditions. For many, this will be the first time they've had a chance to talk openly with a health professional about drug use in a private, judgement-free space.*[9]

63. As outlined on the website, there is data to support the effectiveness of pill testing as a method of reducing harms from illicit drugs. For example, a 2023 evaluation of the Australian Capital Territory drug checking service, CanTEST, revealed only 53% of substances tested matched

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

the expected drug. For those where an additional drug, a different drug or an inconclusive result was found, one-third reported that they *'definitely will not'* use the drug.

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

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

66. However, in making the above comments, I note that Mr XML resided in the regional location of Nangiloc, over five hours from the current fixed-site pill testing service located in Fitzroy, Melbourne.[10] This amplifies my previous comments made in the finding into the death of SL that drug checking services ought to be made available to all Victorians, not only those living in metropolitan Melbourne, and that it ought to be considered whether different types of service delivery are needed to meet the needs of people who reside in regional areas.

67. I reiterate my comments included in that finding and encourage the Victorian Department of Health to consider these issues as part of the current drug checking trial, by ensuring that any evaluation or roll-out plan considers how drug checking can be delivered effectively to all Victorians to reduce drug-related harms across the entire state. I have determined to provide a copy of this finding to the Department of Health in this regard.

[10] While I note that Mr XML had recently visited Melbourne in order to purchase cannabis from Keilor, his residence in regional Victoria may still have limited his ability to make use of any drug checking service. I also note that it is speculative as to whether Mr XML would have availed himself of any drug-checking service however I make no assumptions as to those who may seek to access such a service.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr XML, born [redacted] 1964;

    b) the death occurred on 17 February 2024 at Potter Road Ouyen Victoria 3490, from 1(a) *mixed drug (methylamphetamine, deschloro-n-ethyl-ketamine) toxicity in a man with cardiovascular disease*; and

    c) the death occurred in the circumstances described above.

69. Having considered all of the circumstances, I am satisfied that Mr XML's death occurred as a result of the unintended consequence of the deliberate use of drugs, in the setting of significant cardiovascular disease. Unfortunately, in a context where little is known about Mr XML's history of drug use or his intentions in using drugs on that occasion, it is not possible to determine whether Mr XML may have ingested 2-oxo-PCE believing it to be another drug, such as ketamine or methylamphetamine. However, I consider this to be a distinct possibility.

70. After careful consideration, despite the unusual circumstances of Mr XML's death, I am satisfied that there is no evidence of suspicious circumstances or any third-party involvement in his untimely passing. In this respect, I note that the associate he was with in the lead-up to death, Hong, ultimately provided a version of events which is consistent with other evidence available. I consider that Victoria Police has exhausted all reasonable investigations to piece together the events in the hours before Mr XML's death, and the hours that followed.

71. However, in the event of additional information or evidence coming to light, this case may be re-opened if the conditions of section 77 of the Act are met.

I convey my sincere condolences to Mr XML's loved ones, and in particular, recognise the tragedy faced by Mr XML's father in grieving his loss during a time of ill health, and note in particular the difficulties in comprehending such a loss where Mr XML had not disclosed any use of illicit substances to his loved ones.

ORDERS AND DIRECTIONS

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

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

[redacted], Senior Next of Kin

[redacted], Father

Victorian Department of Health

Senior Constable Madeleine Moschetti, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 16 September 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.