IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000475

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	FJL[1]
Date of birth:	1996
Date of death:	25 January 2021
Cause of death:	1(a) Mixed drug toxicity (25C-NBOME, 4-fluoroamphetamine, LSD, MDMA, cocaine, ketamine)
Place of death:	Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004

1 This Finding has been de-identified by order of Coroner Simon McGregorto replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and to redact identifying information

INTRODUCTION

1. On 25 January 2021, FJL was 24 years old when he died at the Alfred Hospital (**the Alfred**) in Melbourne. At the time of his death, FJL lived home with his parents.

2. FJL was a healthy young man and did not have any ongoing medical conditions. He regularly attended the gym with his friends, enjoyed playing sport, and worked part time at [2] He had recently completed an internship at and had been offered a full-time graduate position.[3]

3. FJL's parents stated that their son did not drink very often, and they had never seen him under the influence of drugs.[4] FJL's friend stated that he was aware that FJL had used cannabis in the past.[5]

THE CORONIAL INVESTIGATION

4. FJL'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of FJL's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

[2] Coronial Brief, statement of OCQ dated 27 September 2021, pages 1-3.
[3] Coronial Brief, statement of FJL's friend dated 28 October 2021, page 3.
[4] Coronial Brief, statement of OCQ dated 27 September 2021, pages 1-3.
[5] Coronial Brief, statement of FJL's friend dated 28 October 2021, page 4.

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of FJL including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[6]

9. In considering the issues associated with this finding, I have been mindful of FJL's basic human rights to dignity and wellbeing, as espoused in the Charter of Human Rights and Responsibilities Act 2006, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 24 January 2021, FJL was collected from his parents' residence in Toorak by his friend at about 3.00pm.[7] The two took an Uber into the city to meet with friends for lunch before travelling to the 'Piknic Electronic Music Festival' that was being held at the Sidney Myer Music Bowl.[8]

11. At some point during the day, FJL told his friend that he had ingested MDMA[9] and ketamine. Later that evening, FJL's friend noticed he was acting erratically and attempted to walk him to the entrance of the event to go home, however FJL fell over several times on the way to the gate.[10]

12. At about 9.05pm, FJL collapsed and suffered a seizure near the entrance gate. St John Ambulance (**SJA**) first aiders attended, finding FJL to be actively seizing, with an abnormal cardiac rhythm and a high temperature of greater than 40 degrees.[11]

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

[7] Coronial Brief, statement of OCQ dated 27 September 2021, page 4.

[8] Coronial Brief, statement of FJL's friend dated 28 October 2021, page 3.

[9] 3,4-methylenedioxy-N-methylamphetamine.

[10] Coronial Brief, statement of FJL's friend dated 28 October 2021, pages 4-5.

[11] Coronial Brief, statement of Simon O'Grady dated 1 October 2021, page 1.

13. SJA personnel began treating FJL and requested assistance from Ambulance Victoria (**AV**) paramedics who attended the scene at 9.23pm.[12] FJL was then transported to the Alfred Emergency Department (**ED**) by AV paramedics, arriving at 10.10pm.[13]

14. On arrival, FJL was diagnosed with profound mixed respiratory and metabolic acidosis.[14] He was noted to have fixed and dilated pupils and was in a state of peri-arrest with multiorgan failure.[15] During his time in the ED, FJL suffered two cardiac arrests which were successfully resolved with defibrillation.[16]

15. FJL's blood pressure continued to fluctuate, and he was admitted to the Intensive Care Unit (**ICU**). Despite intensive therapy, FJL developed worsening profound hypotension, disseminated intravascular coagulation, cardiogenic and vasoplegic shock, and acute kidney injury. Over the next few hours, his condition rapidly deteriorated with features consistent with serotonin syndrome.[17]

16. On 25 January 2021 at 5.00am, FJL passed away in the ICU with his family present.[18]

Identity of the deceased

17. On 25 January 2021, FJL, born in 1996, was visually identified by his mother.

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

Medical cause of death

19. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 27 January 2021 and provided a written report of her findings dated 6 April 2021.

20. The post-mortem examination revealed findings consistent with the history given.

21. Toxicological analysis of ante-mortem samples identified the presence of 25C-NBOME, 4-fluoroamphetamine, lysergic acid diethylamide, 3,4-methylenedioxy-N-methylamphetamine

[12] Coronial Brief, statement of Julien Gobert dated 28 September 2021, pages 1-2.
[13] Alfred Health E-Medical Deposition dated 25 January 2021, page 1.
[14] Alfred Health E-Medical Deposition dated 25 January 2021, page 1.
[15] Coronial Brief, statement of Dr David MacDonald dated 16 September 2021, page 1.
[16] Alfred Health E-Medical Deposition dated 25 January 2021, pages 1-2.
[17] Alfred Health E-Medical Deposition dated 25 January 2021, page 2; Coronial Brief, statement of Dr David MacDonald dated 16 September 2021, pages 1-2.
[18] Alfred Health E-Medical Deposition dated 25 January 2021, pages 1-2.

(MDMA), methylenedioxyamphetamine (MDA), cocaine, benzoylecgonine, ecgonine methyl ester, and cocaethylene (cocaine metabolites), midazolam, nordiazepam, temazepam, oxazepam, ketamine, 11-nor-delta-9-carboxy-tetrahydrocannabinol (THC-COOH), lignocaine, and qinine.[19]

22. 25C-NBOME and 4-Fluoroamphetamine detected are Novel Psychoactive Substances (NPS). These drugs have been linked to several deaths around Australia. 25C-NBOME is a serotonin agonist, and toxicity from these hallucinogenic drugs (NBOMES) can cause symptoms similar in presentation to serotonin syndrome.

23. Dr Iles provided an opinion that the medical cause of death was from 1 (a) mixed drug toxicity (25C-NBOME, 4-fluoroamphetamine, LSD, MDMA, cocaine, ketamine).

24. I accept Dr Iles's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was FJL, born in 1996;

    b) the death occurred on 25 January 2021 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from mixed drug toxicity (25C-NBOME, 4-fluoroamphetamine, LSD, MDMA, cocaine, ketamine); and

    c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that FJL's death was the unintended consequence of the deliberate ingestion of drugs.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations, including recommendations relating to public health and safety or the administration of justice.

27. On 31 March 2021, Coroner Spanos made several recommendations in the matter of *Anson* [20] regarding the issue of the implementation of a drug checking service and early warning

[19] The presence of some of these drugs (midazolam and lignocaine) as being administered by emergency/hospital staff should be considered.
[20] COR 2016 3441.

network to reduce the number of preventable deaths associated with the use of illicit substances.

28. I note the response received from the Department of Health (**the Department**) on 6 July 2021 in which the Secretary, Professor Euan Wallace AM, reiterated the Department's commitment to the reduction of harm caused by alcohol and drugs through the provision of harm reduction initiatives such as the Victorian Needle and Syringe Program, opioid-substitution treatment and training, and the use of peer educators such as the DanceWize service at parties, festivals, and nightclubs.

29. I further note that the Department has provided funding to the Victorian Poisons Information Centre to monitor substances involved in drug-related hospital emergency department presentations and provide reports to the Department to aid in longer-term planning for enhanced drug surveillance in Victoria.

30. It is unfortunate, however, that there is still no active plan for the implementation of a drug-checking service as recommended by Her Honour in *Anson*. For this reason, I recommend:

    a) That the Department of Health, as the appropriate arm of the Victorian Government, implements a drug checking service in the State of Victoria as a matter of urgency, to reduce the number of preventable deaths (and other lesser harms) associated with the use of drugs obtained from unregulated drug markets.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published in a redacted format 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:

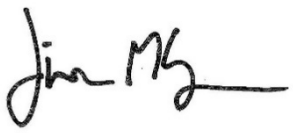
OCQ & KHG, Senior Next of Kin

Professor Euan Wallace AM, Department of Health

Keren Day, Alfred Health

Senior Constable Lauren Palombi, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 28 March 2022

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.