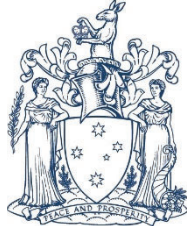

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001464

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Mr P
Date of birth:	[redacted] 1996
Date of death:	17 March 2022
Cause of death:	1(a) Brain death post mixed drug toxicity including MDMA and cocaine
Place of death:	The Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria, 3050

INTRODUCTION

1. On 17 March 2022, Mr P was 26 years old when he passed away at the Royal Melbourne Hospital (**RMH**) in Parkville, Victoria.

2. At the time of his death, Mr P lived with his father, [redacted] and his sister, [redacted] in the Australian Capital Territory. Mr P also had a long-term girlfriend, [redacted]

3. Mr P worked as an IT contractor for the Department of Foreign Affairs and was due to begin a similar role at the Australian Taxation Office at the end of March 2022. According to his family, Mr P was a very social person who had a large network of friends.

4. [redacted] stated that Mr P consumed illicit drugs socially with his friends at musical festivals and raves including MDMA and cocaine. [redacted] recalled that during 2020 and 2021, Mr P stopped using drugs socially as he wanted to focus on work. Mr P was not known to suffer from any mental health or physical health issues.

5. On 13 March 2022, Mr P and [redacted] attended the Karnival Music Festival at Flemington Racecourse with their friends. During the festival, Mr P overdosed on cocaine and MDMA. He received medical treatment at the Karnival Music Festival before he was transferred to RMH where he remained until he passed away on 17 March 2023.

THE CORONIAL INVESTIGATION

6. Mr P's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. 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.

8. 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.

9. Victoria Police assigned Senior Constable Dayna Tunbridge to be the Coroner's Investigator for the investigation of Mr P's death. The Coroner's 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.

10. This finding draws on the totality of the coronial investigation into the death of Mr P including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

11. On 17 March 2022, Mr P, born [redacted] 1996, was visually identified by his father, [redacted]

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

Medical cause of death

13. On 21 March 2022, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine, conducted an external examination and provided a written report of his findings dated 24 May 2022.

14. The post-mortem examination was considered to be unremarkable. The post-mortem CT scan showed cerebral oedema with herniation to be present.

15. Toxicological analysis of post-mortem samples identified the presence of cocaine and its metabolites indicating the recent use of cocaine. In addition, MDMA, atropine and midazolam were also identified. Atropine and midazolam are medications used in a medical setting.

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

16. Dr Bedford provided an opinion that the medical cause of death was 1 (a) *brain death post mixed drug toxicity including MDMA and cocaine.*

17. I accept Dr Bedford's opinion as to the cause of death.

Circumstances in which the death occurred

18. On 10 March 2022, Mr P travelled to Melbourne with a group of friends to attend the Karnival Music Festival. arrived in Melbourne the following day with a separate group of friends.

19. On 13 March 2022, and Mr P attended the Karnival Music Festival with a group of friends. At around 5:00pm that afternoon, noticed Mr P near the main stage at the festival with her group of friends. He was agitated, could not stand on his own and appeared to be drug affected. At this stage, Mr P could still communicate and told that he had taken illicit drugs. was told by others that Mr P had consumed cocaine and an MDMA pill described as a 'Blue Punisher'.

20. Mr P was having trouble bending his legs and his body was very rigid. He began grunting in response to communications and was no longer responding coherently. Mr P was assisted out of the crowd to the Secondary Medical Tent which was managed by Medical Edge Australia (**MEA**). MEA were contracted to provide medical services at the festival supported by Ambulance Victoria. At the time that Mr P arrived at the medical tent he was having a seizure.

21. Mr P was assessed by medical staff. He presented as pale, hot and sweaty profusely and had a temperature of 42.2°C. Mr P was given medication to treat his prolonged seizure, low blood sugar levels and to replenish his bodily fluids. Mr P's body temperature reduced slightly and follow up medications were given at 5:37pm.

22. At around 6:10pm, Mr P's heart rate had decreased to 50 beats per minute and cardiopulmonary resuscitation was commenced. Mr P was conveyed to RMH shortly thereafter. Upon arriving at RMH, he was transferred to the Intensive Care Unit (**ICU**).

23. On 14 March 2022, Mr P's father and girlfriend arrived in Melbourne and attended the RMH. Mr P's father was informed by the treating team that Mr P was suffering from multi-organ failure.

24. On the evening on 16 March 2022, the family were informed that there was swelling on Mr P's brain. By 12:00pm on 17 March 2022, the swelling on Mr P's brain had worsened and his

organs were no longer responding to treatment. In consultation with Mr P's family, he was taken off life support and sadly passed away at 9:10pm that evening.

25. Victoria Police did not identify any suspicious circumstances relating to Mr P's death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr P born, [redacted] 1996;

    b) the death occurred on 17 March 2022 at The Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria, 3050, from *brain death post mixed drug toxicity including MDMA and cocaine*; and

    c) the death occurred in the circumstances described above.

27. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of drugs.

COMMENTS

1. Having considered the circumstances in which Mr P's untimely death occurred, I requested advice from the Coroners Prevention Unit[2] (**CPU**) in relation to whether there were any prevention opportunities arising from Mr P's death.

2. The evidence indicates that proximate to his death, Mr P had ingested cocaine and an MDMA pill described as a 'Blue Punisher'. Whilst the reports that Mr P took a Blue Punisher pill are anecdotal,[3] the circumstances are consistent with him having consumed an excessive MDMA dose. The post mortem forensic testing indicates that Mr P died in the setting of brain death

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2 The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The CPU may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

3 No substances relating to the fatal incident were viewed, seized or tested. Anecdotal accounts of Mr P consuming a Blue Punisher pill are found in witness statements, in the Medical Edge patient care records (Medical Edge were the medical services provider contracted for the Karnival event) and in the medical records from Royal Melbourne Hospital (where Mr P was transported). For completeness, it is noted that one Royal Melbourne Hospital clinician recorded Mr P had consumed three MDMA tablets; however this is the only place three tablets are mentioned in the available material, and it is possible the clinician arrived at this count through misinterpreting a handwritten Medical Edge clinical note "Took blue punisher @ 3" (the '3' here referred to 3pm, not three tablets).

post mixed drug toxicity, with cocaine and MDMA being identified in the blood plasma samples taken from Mr P at Royal Melbourne Hospital. I am of the view that a significant contributing factor to Mr P's fatal overdose was his likely consumption of a high-dose Blue Punisher MDMA pill.

3. The CPU advised that the Blue Punisher is an MDMA pill design or pill form[4] which, over the past five or more years, has gained an international reputation for its strength. In 2018, the United Kingdom drug harm reduction organisation, 'The Loop' reported that Blue Punisher sample pills had been tested and contained 250mg MDMA on average: a dose approximately 2.5 times higher than the 100mg dose usually taken in recreational[5] settings. In 2021, the Manchester Drug Analysis and Knowledge Exchange drug checking service issued a warning after they tested multiple Blue Punisher pills and found that they each contained between 397 and 477mg of MDMA (the strongest ever documented dose in a single pill). In addition, in June 2023 two deaths and multiple MDMA overdoses in Germany were linked to the Blue Punisher, prompting warnings not only in Germany but across Europe and the United Kingdom about the risk of death from using the pill.

4. While no Blue Punisher pills were observed or seized at the Karnival Music Festival, an April 2022 report that several Blue Punisher pills were forensically tested interstate and found to contain high dosages of MDMA suggests that Blue Punisher pills were circulating in unregulated Australian drug markets around the time of Mr P's death.

5. The circumstances in which Mr P died highlight a major risk of consuming substances obtained from unregulated drug markets. Namely that the substance can be different to what was expected in terms of composition or dose strength, thus creating a heightened risk of adverse events causing harm such as an overdose.

6. The CPU advised that Victorian coroners have recently highlighted the risks of consuming substances obtained from unregulated drug markets in the following matters:

   - Coroner Paresa Spanos in the investigation into the deaths of five young people between July 2016 and January 2017 who had consumed a particularly dangerous

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[4] The CPU explained that the Blue Punisher is best described as a pill design or pill form rather than a "product" because (like many other MDMA pill designs) it has probably been manufactured illicitly by multiple producers across multiple countries using different combinations of ingredients. It is called a Blue Punisher because it is blue and it has an embossed design copied from the logo for Marvel character The Punisher.

[5] I use the term 'recreational' here to describe use of the drug outside clinical or therapeutic settings.

combination of tow novel psychoactive substances. In each case, the deceased believed that they were consuming MDMA or psilocybin.

- Coroner Sarah Gebert in the investigation into the death of a young male in 2020 who believed that he was using Xanax alphrazolam tablets. However, he instead consumed tablets containing benzodiazepines etizolam and flubromazolam.
- Coroner Sarah Gebert in the investigation into the death of a young male in 2020 who took a substance he believed to contain MDMA, but which instead contained synthetic cathinones.

7. In each investigation, the coroner concluded the risk of further deaths in similar circumstances could be reduced if a drug checking service was introduced in Victoria.

8. In these cases, the deceased used substances the contents of which were different to what they expected. The circumstances of Mr P's death are somewhat different to this as he expected to consume MDMA, but the tablet he consumed appears to have contained a higher dose of MDMA than expected. Notwithstanding this, the prevention potential of drug testing is directly applicable to Mr P's situation, as a properly equipped drug checking service can analyse submitted samples and establish not only their contents, but also the purity of the contents.[6]

9. A drug checking service (also known colloquially as a pill testing service) enables a person who obtains a substance from an unregulated drug market to submit a sample, where it is analysed to establish what it contains. This information can then be used to deliver harm reduction interventions such as education to the individual to submitted the substance. Additionally, when particularly risky substances are detected during testing, more general warnings can be disseminated publicly through a drug early warning system (usually a website or app or other online resource) so the broader community of people who use drugs are aware of the potential dangers.

10. In support of this conclusion, in each of the abovementioned cases, the coroner recommended that the Victorian Department of Health implement a drug checking service. The most recent recommendation was, as follows:

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6 The CanTEST service currently operating in the Australian Capital Territory provides purity information regarding several drugs (including MDMA) in submitted drug samples.

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 nonfatal harms) associated with the use of drugs obtained from unregulated drug markets.[7]

11. The Victorian Department of Health did not accept this recommendation, with its Secretary Euan Wallace responding on the most recent occasion that “there are no current plans to implement a drug checking service of the kind you have recommended in your findings”.[8]

12. I note that there are currently no plans to implement a drug checking service in Victoria. However, other jurisdictions in Australia have introduced or are in the process of introducing them. In the Australian Capital Territory (**ACT**), the CanTEST fixed-site drug checking service is currently being operated by a coalition of drug harm reduction services with support from the ACT Government.[9] In addition, in February 2023, the Queensland Government announced a combination of mobile and fixed-site pill testing and is currently developing protocols to implement this.[10]

13. If the Victorian Department of Health has any particular concern about the harm reduction potential of drug checking services in Victoria, they could potentially consider the type of staged implementation that has occurred in the ACT. Initial government-approved trials of drug checking occurred in 2018 and 2019 at the Grooving the Moo music festival in Canberra, and these informed the establishment of the CanTEST fixed-site drug checking service for an initial six-month pilot period between July 2022 to January 2023. The CanTEST pilot has now been extended twice, with lessons learned being used to inform future service design.

14. The final evaluation report focusing on the first six months of the CanTEST pilot was released in July 2023, and its key findings would appear to be directly relevant to the circumstances of Mr P’s death, as outlined below:

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7 Gebert S, *Finding into Death of Mr P without Inquest*, Coroners Court of Victoria, COR 2020 005219, delivered 20 May 2022.

8 Wallace E, Untitled response to recommendations in death of Mr P, Victorian Department of Health, 27 July 2022, https://www.coronerscourt.vic.gov.au/sites/default/files/2022-09/2020%205219%20Response%20to%20recommendations%20from%20Department%20of%20Health_Mr%20P.pdf.

9 Canberra Alliance for Harm Minimisation and Advocacy, “CanTEST Health & Drug Checking”, 2023, <https://www.cahma.org.au/services/cantest/>.

10 Queensland Minister for Health and Ambulance Services, the Hon Yvette D’Ath, “Pill testing gets the green light”, 25 February 2023, <https://statements.qld.gov.au/statements/97250.

"Over two-thirds (70%, n=168) of service users reported never previously accessing a healthcare worker for information or advice about drug use. Half the drugs were found to contain a substance not expected by the service user, evidencing the inconsistent drug market and need for drug checking to improve community safety."[11]

15. In addition, two-thirds of service users accepted a health intervention (for example harm reduction education or general drug education) alongside drug checking; and, where test results were different to what service users expected, they reported being less likely to use the substance.

16. It is impossible to know whether, had a drug checking service existed, Mr P would have submitted a sample of an MDMA pill for testing before taking it at Karnival. Notwithstanding this, a drug checking service would have at least created the opportunity for him to do so, and for him to receive tailored harm reduction information from the drug checking facility. It is likewise impossible to know whether, had Mr P been provided information of this type, he would have changed his drug consumption behaviour; but likewise in the absence of a drug checking service this was not a possible outcome.

RECOMMENDATIONS

17. I recommend pursuant to section 72(2) of the Act:

    i) The Secretary of the Victorian Department of Health, as the appropriate arm of the Victorian Government, implement a drug checking service in the State of Victoria to minimise the risks and the number of preventable deaths associated with the use of drugs obtained from unregulated drug markets.

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

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:

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[11] Olsen A, et al, *CanTEST Health and Drug Checking Service Program Evaluation: Final Report*, Canberra: Australian National University, 2023, p.1.

[redacted] Senior Next of Kin

Senior Constable Danya Tunbridge, Coroner's Investigator

Secretary of the Victorian Department of Health

Mary-Anne Thomas MP, Minister for Health Victoria

Signature:

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JUDGE JOHN CAIN
STATE CORONER
Date: 25 August 2023

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.