IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 004277

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Michael James Woodhouse
Date of birth:	12 January 1987
Date of death:	26 August 2018
Cause of death:	1(a) Coronary artery disease in a man using synthetic cannabinoids
Place of death:	2/2 Pittaway Street, Kangaroo Flat, Victoria

INTRODUCTION

1. On 26 August 2018, Michael James Woodhouse was 31 years old when he was found deceased in his home. At the time of his death, he lived in Kangaroo Flat with his housemate Jason Wirihana.

2. Michael had a medical history of supraventricular tachycardia[1] since early childhood but was not receiving any active treatment for this condition. He had also been diagnosed drug induced schizophrenia and personality disorder for which he was prescribed antipsychotic medication. Michael was a frequent user of alcohol and synthetic cannabis.

THE CORONIAL INVESTIGATION

3. Michael'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.

4. 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.

5. 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.

6. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required.

[1] Supraventricular tachycardia (SVT) is an abnormally fast heartbeat.

7. 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]

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

Circumstances in which the death occurred

8. On 26 August 2018, Michael smoked synthetic cannabis and drank alcohol with friends at his home. He was last seen alive by his housemate Jason at approximately 2.30pm. Michael reportedly left his residence with his friends at about 3.00pm, while Jason went to his bedroom to sleep.

9. At about 6.00pm, Jason woke up and walked into the loungeroom where he saw Michael on the floor. He believed Michael was sleeping and so did not disturb him.

10. At approximately 6.30pm, Jason turned the light on and saw that Michael was blue. Jason immediately commenced cardiopulmonary resuscitation and called for help from his neighbours who contacted emergency services. Ambulance paramedics attended shortly afterwards and confirmed Michael was deceased.

Identity of the deceased

11. On 26 August 2018, Michael James Woodhouse, born 12 January 1987, was visually identified by his friend Jason Wirhana.

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

Medical cause of death

13. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on Michael's body on 31 August 2018 and provided a written report of his findings dated 17 December 2018.

14. The post-mortem examination showed coronary artery disease and mild myocardial fibrosis. There was no evidence of any injury which would have contributed to or led to death.

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

15. Toxicological analysis of post-mortem samples identified the presence of olanzapine[3] and zuclopenthixol[4], consistent with therapeutic use, as well as a synthetic cannabinoid, Cumyl-PeGACLONE.

16. Dr Burke commented that coronary artery disease refers to occlusion or blockage of the coronary arteries which supply blood to the heart. This may result in myocardial ischaemic and a sudden cardiac arrhythmia (heart attack). Risk factors for coronary artery disease include smoking, hypertension, diabetes mellitus, hypercholesterolaemia and familial factors.

17. Dr Burke further commented that synthetic cannabinoids are known to be associated with sudden death, but the exact physiological mechanism is unclear.

18. Dr Burke provided an opinion that the medical cause of death was '*1(a) Coronary artery disease in a man using synthetic cannabinoids*'.

19. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Michael James Woodhouse, born 12 January 1987;

    (b) the death occurred on 26 August 2018 at 2/2 Pittaway Street, Kangaroo Flat, Victoria from coronary artery disease in a man using synthetic cannbinoids; and

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

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

21. As part of my investigation, I sought assistance from the Coroners Prevention Unit (**CPU**) [5] to provide a report on the risks associated with the use of synthetic cannabinoids and

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[3] Olanzapine is an atypical antipsychotic used to treat symptoms of schizophrenia.

[4] Zuclopenthixol is an antipsychotic medication used to treat schizophrenia and other psychoses.

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

evidence/data regarding the risk of sudden death or overdose. CPU subsequently prepared a background briefing on Cumyl-PeGACLONE which was provided to a number of Coroners investigating deaths that involve synthetic cannabinoids and specifically Cumyl-PeGACLONE. A copy of this report is annexured to her Honour Coroner Jamieson's Finding into Death without Inquest of Mr P,[6] whose death was also caused from naturally occurring cardiac disease in the setting of synthetic cannabinoid use.

22. Coroner Jamieson identified that there is little definitive information about the effects of novel synthetic substances and no practicable way for a user to know precisely which illicit synthetic drugs are being consumed. Given the limited information and general ignorance about the potential risks of synthetic illicit drugs, Coroner Jamieson recommended that the Victorian Department of Health and Human Services (**DHHS**) review how education regarding synthetic cannabinoids is disseminated to health services, and if deemed appropriate and necessary, to develop a training package or similar resource for clinicians to equip them to have conversations with patients about synthetic cannabinoid risks and harm reduction.

23. In response to this recommendation, DHHS Secretary Kym Peake informed the Coroners Court on 21 September 2020, that DHHS currently funds a range of alcohol and other drug service providers to inform consumers and clinicians about drug harms and harm reduction strategies, including those associated with synthetic cannabinoids.

24. Ms Peake advised that DHHS is committed to supporting harm reduction approaches, especially for vulnerable cohorts. DHHS currently funds a range of harm reduction agencies to deliver services to prevent and reduce drug overdoses, including through distributing flyers and information sessions about synthetic cannabinoids to rough sleepers, targeted service providers and peer networks. DHHS has undertaken a number of further initiatives to promote drug information, including about synthetic cannabis, to Primary Health Networks, to support circulation to General Practitioners, and to relevant stakeholders, consumers and peer workers via alcohol and drug agencies. A COVID-19 education campaign focussed on harm reduction in people who use drugs is also currently under development in partnership with Penington Institute which will include information on synthetic cannabinoids.

25. Ms Peake noted that a number of indicators point to declining consumption and harms from synthetic cannabinoids in Victoria, with self-reported use declining from 1 per cent in 2013 to 0.3 per cent in 2019, synthetic cannabinoid-related ambulance attendances remaining

[6] See https://www.coronerscourt.vic.gov.au/sites/default/files/2020-07/2019%205437%20Mr%20P.pdf

consistently low since March 2018 and telephone calls to the Victorian Poisons Information Service regarding synthetic cannabinoids falling from 26 calls in 2017 to 9 calls in 2018.

26. DHHS considers that its existing suite of resources, including those developed by the Alcohol and Drug Foundation,[7] Harm Reduction Victoria and Youth Projects, sufficient to address current levels of harm. It does not consider it necessary to develop an additional synthetic cannabinoid training package for clinicians. However, Ms Peake informed the court that DHHS is currently considering a range of initiatives to better monitor and respond to alcohol and other drug consumption, harm and risk in a more systematic and timely manner.

27. I commend DHHS for the initiatives they have undertaken to inform consumers and clinicians about drug harms and harm reduction strategies in relation to synthetic cannabinoids. I acknowledge that there appears to be a declining consumption and harms from synthetic cannabinoids in Victoria based on self-reported use, ambulance attendances and calls to the Victorian Poisons Information Service in recorded data up to 2019. However, despite these figures, it is apparent that there continue to be deaths in Victoria associated with the use of synthetic cannabinoids, particularly in the setting of existing cardiac conditions.

28. I consider that further education in this area is warranted and support Coroner Jamieson's recommendation. Accordingly, I have made a recommendation in line with this for the Secretary of the Department of Health[8] to develop a training package or similar resource for clinicians to support them in educating patients with existing heart conditions on the cardiac effects of synthetic cannabinoids and the risks associated with their use.

RECOMMENDATIONS

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

(i) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Department of Health develop a training package or similar resource for primary health care providers to support them in educating patients with existing heart conditions on the cardiac effects of synthetic cannabinoids and the risks associated with their use.

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[7] See for example: fact sheet on Synthetic Cannabis published by the Alcohol and Drug Foundation on 7 October 2020: https://adf.org.au/drug-facts/synthetic-cannabis/

[8] In early 2021, the Department of Health and Human Services was separated into two new department: the Department of Health (**DoH**) and the Department of Families, Fairness and Housing. The Department of Health is responsible for the Health, Ambulance Services, Mental Health and Ageing portfolios and commenced operation from 1 February 2021.

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

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

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

Mrs Patricia O'Shea and Mr Gerard Woodhouse, Senior Next of Kin

Dr Neil Coventry, Office of the Chief Psychiatrist

Professor Euan Wallace, Secretary of the Department of Health

Signature:

Coroner Leveasque Peterson

Date: 12 April 2021

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.