Media Release

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Trial of drug checking services could provide lifesaving insights, say two Victorian coroners

Two Victorian coroners have today released new recommendations that the Victorian Government trial a drug checking service to gather evidence into how to reduce risks and prevent deaths associated with the use of drugs obtained from unregulated drug markets.

The calls for a trial come after two independent coronial investigations into deaths that highlight the serious risks of using illegally sold drugs – due to the variability in their composition and strength.

Mr S L, 38, died of mixed drug toxicity on 5 December 2022. Mr S L had a history of heroin use and was found with drug injecting equipment. Post-mortem toxicology indicated the presence of several prescription drugs (all at therapeutic levels) as well as methamphetamine, however heroin was not present in his system.

Instead, the toxicology returned a positive result for metonitazene. Metonitazine is a member of the nitazene drug family – a group of highly potent novel synthetic opioids which can be 300 times stronger than morphine. Nitazenes first began circulating in markets across Europe, the USA, and Canada around 2019 and are often sold as other drugs such as heroin, oxycodone or MDMA.

Coroner Ingrid Giles investigated Mr S L's death and found that at the time of use, he appeared to have believed he was injecting heroin and was unaware that he was consuming the dangerous synthetic opioid. Her Honour further found that Mr S L's death was one of at least 16 Victorian overdose deaths involving nitazenes since the start of 2021; there was direct evidence in some of the cases that the deceased believed they were consuming substances other than nitazenes.

Mr K M, 18, died at the Royal Melbourne Hospital on 27 April 2023, five days after collapsing at the Dreamstate music festival at Flemington Racecourse. At the festival, witnesses saw Mr K M consume several MDMA tablets of unknown origin over the course of three hours before he became distressed and was treated by St John Ambulance.

Coroner Simon McGregor found that Mr K M died of an unintentional overdose of MDMA and methylone, the latter being a synthetic cathinone drug with stimulant effects. Methylone and other synthetic cathinones have been implicated in at least 17 overdose deaths in Victorian since 2013. His Honour found that it was possible that the capsules Mr K M consumed contained a higher dose of MDMA than he expected, and/or contained methylone without his knowledge.

In both their findings, Coroner Giles and Coroner McGregor determined that while there was no guarantee that a drug checking service may have been utilised by either of the men, or would have acted as a deterrent if they had, such a service would have at least provided them an opportunity to learn more about the drugs in their possession and make informed decisions.

Since 2021, five coronial recommendations have been made for drug checking services in Victoria, to reduce the risk of similar deaths occurring in the future.

In response to the previous coronial recommendations, the Victorian Department of Health acknowledged the death prevention potential of such a service, but indicated there are currently no plans for drug checking in Victoria.

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Noting that the Victorian Department of Health has not supported the five previous recommendations made by Victorian coroners, Coroner Giles and Coroner McGregor determined not to call directly for implementation of drug checking but rather an initial trial of a drug checking service to be considered.

Coroner Giles, in her finding, noted the success of the ACT CanTEST pilot which has now been extended twice and has provided invaluable insights that will now inform future service design in the territory. Her Honour said, “a similar pilot in Victoria would assist in building the evidence base for drug-checking services in this state, and build on learnings from other jurisdictions.”

A copy of the finding into the death of Mr S L can be accessed here.

A copy of the finding into the death of Mr K M can be accessed here.

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