IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003535
COR 2024 003536
COR 2024 003537
COR 2024 003538

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATHS OF

CARLY MORSE

THOMAS VALE

MICHAEL HODGKINSON

ABDUL EL SAYED

Findings of:	Coroner David Ryan
Delivered on:	17 April 2025
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	15 April 2025
Counsel Assisting the Coroner:	Susanna Locke of counsel Instructed by Katrina Sonneveld Coroners Court of Victoria
Secretary to the Department of Families, Fairness & Housing:	Jelena Adamovic Acting Principal Solicitor Department of Families, Fairness & Housing
Keywords:	Drug overdose – protonitazene – in care

INTRODUCTION

1. On 24 June 2024, Carly Morse (42yo), Thomas Vale (32yo), Michael Hodgkinson (37yo) and Abdul El Sayed (17yo) passed away in a unit in Broadmeadows, Victoria. They are warmly remembered and deeply mourned by their families.

2. In moving Coronial Impact Statements delivered to the Court, the families of the deceased conveyed with honesty, warmth and affection their experience and memory of their loved ones, and their grief, devastation and loss at their passing.

BACKGROUND

Carly Morse

3. Carly is survived by her daughter, Jaya Broadhurst, her parents, Robert and Lorna Morse, and her sister, Kristy Morse. She was born in St Albans but grew up in Lancefield, before moving to Kyneton where she worked in the childcare industry.

4. In 2017, Carly suffered an injury at work which required her to undergo a hip replacement. She struggled to work consistently after this injury. Her mother recalled that Carly became addicted to oxycodone after struggling to manage the pain from her injury. She also engaged in illicit drug use. Further, her mental health was also affected around this time by her separation from her long-term partner, Jaya going to live with her father, and the deaths of her maternal grandfather and her niece.

5. Carly's medical history included endometriosis, sarcoidosis, hypothyroidism, menorrhagia and anxiety. At the time of her death, she was being prescribed ferric carboxymaltose, mefenamic acid and oxycodone. She had been experiencing chronic pain in the months before her death and had been referred by her General Practitioner (**GP**) to a gynaecologist for follow-up investigations and treatment. Carly had an elective procedure at the Northern Hospital on 30 May 2024 (including a hysteroscopy) and was considering the option of a hysterectomy.

6. In around 2021, Carly commenced a relationship with Thomas and they moved into an apartment together in Collingwood. A couple of years later, she and Thomas moved into a caravan on her parents' property in Lancefield before moving into a unit managed by the Department of Housing at 3/32 Bicknell Court in Broadmeadows (**Unit 3**) in late 2023.

Thomas Vale

7. Thomas is survived by his daughter, Annabelle Vale, his parents, Craig Vale and Caroline Cathcart, and his siblings, Cassie Vale and Aleziah Nudelman. His parents separated when he was young and he spent his early childhood in Flowerdale with his mother. He also spent time living with his father in the Preston area before returning to live with his mother in Whittlesea.

8. Thomas left school when he was 15 years of age and trained as an apprentice plasterer. Around this time, he commenced a relationship with Annabelle's mother which ended in around 2020. During the relationship, Annabelle went to live with her maternal grandparents.

9. Thomas had no recent or relevant medical history but he reportedly experienced trauma as a child. He had a long history of illicit drug use and had also experienced periods of incarceration. He was last released from custody in late 2021.

10. Thomas struggled to obtain consistent employment and housing during his adult life. In around 2021, he commenced a relationship with Carly and as outlined above, they moved into Unit 3 in late 2023.

Michael Hodgkinson

11. Michael is survived by his mother, Suzanne La Velle, his siblings (including Nicole and Jamie Hodgkinson), and his partner, Sharny Guerra. His parents separated when he was young and he experienced trauma and instability as a child. Michael spent his early childhood in Melbourne before moving to Tasmania with his mother and siblings. His father passed away when he was 14 years old. Michael went to live in Melbourne after leaving secondary school, returning to Tasmania to work for a period of two years when he was 19 years of age.

12. Michael had a loving and long-term relationship with Hannen Elzaibak and they had been engaged. They separated in 2023 in the context of Michael's ongoing drug use. He also had a previous relationship with Abdul's maternal aunt, Bianca Lewis.

13. Michael's medical history included bipolar disorder, adjustment disorder, attention deficit and hyperactivity disorder (**ADHD**) and depression. He had been prescribed medication in the past but reportedly ceased using it, preferring to manage his conditions in his own way. He had a long history of illicit drug use and had also experienced periods of incarceration, including with Abdul's father, with whom he had previously committed a number of offences. His

offending related mainly to his drug use. Michael was last released from custody on 11 February 2024 and was subject to a Community Corrections Order at the time of his death.

14. Michael was friends with Thomas and Carly. He was also friends with Cory Lewis (Abdul's maternal uncle), who lived at 4/32 Bicknell Court (**Unit 4**). Michael had been regularly staying at Unit 3 and Unit 4 since being released from custody.

Abdul El Sayed

15. Abdul is survived by his partner Georja Harper, his daughter, Amaiah, his parents, Layel[1] and Tarek El Sayed, his siblings and extended family. His parents separated soon after he was born. He grew up in Hadfield and was exposed to neglect and family violence as a child which attracted the involvement of Child Protection, which is part of the Department of Families, Fairness and Housing (**DFFH)**. Abdul struggled with attendance at secondary school and his living arrangements were inconsistent and insecure.

16. Abdul's medical history included ADHD. He also had a history of illicit drug use, particularly cannabis.

17. On 31 July 2023, Georja gave birth to Amaiah and Abdul would regularly spend time at Georja's house where she lived with her parents. Abdul was a proud and loving father.

18. In the month before his death, Abdul had been dividing his time between various addresses, including his uncle's place at Unit 4, and Georja's house.

Abdul's involvement with Child Protection

19. The Director of Child Protection of the Hume Merri-bek Area of DFFH provided a statement to the Court dated 8 October 2024 which set out Abdul's involvement with Child Protection. Abdul's parents also had a history of trauma and were known to Child Protection as children.

20. Abdul was subject to nine reports to Child Protection and three section 38 consultations[2] between 21 August 2007 and 18 September 2019. The protective concerns identified by Child Protection included exposure to substance abuse, family violence, environmental neglect and

[1] Also known as Jessica Lewis.

[2] Section 38 of the *Children, Youth and Families Act 2005* enables a registered community and family service to consult and seek advice from the department's community-based Child Protection Practitioners to inform decision making as to whether a Child Protection or community support response will address identified risk and wellbeing issues. This process provides opportunities to offer effective earlier intervention and prevention services before there is a need for Child Protection intervention. It also supports the earlier identification of cumulative harm to children, as well as providing families access to appropriate services to improve outcomes for vulnerable children and their families.

absenteeism from school. Throughout DFFH's intervention, Abdul's parents were resistant to engagement with the department and other services.

21. Abdul's living arrangements were unstable and inconsistent. Apart from spending time living with his mother, he was also cared for at times by extended family and family friends, including his aunt Bianca Lewis and his paternal grandmother, Hanna Omar, with whom he had a strong bond.

22. On 12 December 2022, Abdul was charged with robbery offences and possession of cannabis which were resolved by way of a Diversion.[3] He was also referred to the Youth Projects Alcohol and other Drug Service for assessment as a result of his cannabis use. Abdul resisted attempts to get him to attend secondary school, despite assistance from the Navigator[4] program, and indicated that he wished to obtain employment.

23. On 15 September 2023, Abdul become subject to a Care by Secretary Order[5] as a result of an order made by the Magistrates' Court of Victoria. He was case managed by Anglicare Victoria from February 2024 and he was also referred to Better Futures.[6] Abdul did not engage well with his case managers and he often cancelled or failed to attend appointments.

24. On 12 March 2024, Abdul's accommodation arrangement with his carers broke down and Abdul stated to Child Protection that he would be staying at Georja's house and with his uncle at Unit 4. He requested support with housing and Child Protection advised that they would work with Anglicare to locate long-term accommodation for him. Options explored included a Lead Tenant[7] arrangement, however he was assessed as not being eligible as he did not meet the criteria of school attendance and part-time employment. Accordingly, a decision was made to explore further kinship options before residential care would be considered.

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[3] An option for low-level offenders to avoid a criminal record by undertaking conditions that benefit the victim, the community and themselves.

[4] The Department of Education Navigator program supports disengaged young people to return to education and learning.

[5] A Care by Secretary Order is made under the *Children, Youth and Families Act 2005* and gives parental responsibility for a child's care to the Secretary or delegate to the exclusion of all other persons.

[6] Better Futures supports young people who are making the transition from care to adulthood until they reach the age of 21.

[7] Lead Tenant is the provision of semi-independent support and accommodation for young people aged 15-18 years who are unable to live with their family due to issues of abuse or neglect and who are in transition to independent living. A volunteer lead tenant lives in a residential unit with a small group of young people and provides them with support and guidance in developing their independent living skills.

25. In April 2024, it was recorded that Abdul was seeking a placement with a family friend. Assessment of the placement was prolonged as the family friend had a criminal history which needed to be scrutinised by Child Protection. At the same time, Anglicare expressed concern to Child Protection that Abdul had been homeless for a number of weeks and requested urgent assessment and discussion in relation to his housing options.

26. On 13 May 2024, negotiations for Abdul's proposed placement with his family friend temporarily broke down because of conflict between her and Adbul's mother. Later that month, Abdul's living skills were assessed and it was noted that he required support around his housing knowledge, money management, education and employment. Housing options were recommended including living with an approved carer, a Lead Tenant placement, support for a private rental and a youth justice housing support program. Anglicare had difficulties in contacting and engaging with Abdul but he indicated that he was frustrated with the delays in sourcing accommodation.

27. In late May 2024, Abdul requested that negotiations resume for him to be placed with his family friend. This placement was ultimately approved by Child Protection on 12 June 2024 but they subsequently had difficulties in contacting the family friend and were advised on 17 June 2023 that she was in Adelaide and would call them in a few days.

28. On 25 June 2025, Child Protection were notified that Abdul had passed away.

29. Child Protection made the following acknowledgments:

    a) Abdul experienced cumulative harm from a young age and trauma due to the effects of multiple harmful circumstances including emotional harm, neglect, including his basic needs for education, food and supervision, exposure to family violence, substance use and criminal activity; and

    b) There were gaps in practice in Abdul's case.

30. Child Protection identified the following areas of improvement:

    a) Over time, the delay in determining what was in Abdul's best interests through the case planning process denied him the opportunity to find a stable and safe place to live. This was impacted by the limited engagement of his parents in court processes, however Child Protection had the opportunity to intervene and support an earlier decision that may have led to a different outcome for Abdul; and

b) DFFH should have acted earlier in response to Abdul's requests to locate a placement for him either with his family friend or in residential care in the months leading up to his death.

THE CORONIAL INVESTIGATION

31. These deaths were reported to the coroner as they 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. Further, as Abdul was in the care of the Secretary at the time of his death and pursuant to section 52(b) of the Act, an inquest was required to be held into his death. Given their common factual circumstances, it was appropriate that the deaths be investigated together and that they all be subject to an inquest. The inquest occurred on 15 April 2025.

32. 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.

33. 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.

34. Victoria Police assigned an officer to be the Coronial Investigator for the investigations. The Coronial Investigator conducted inquiries on my behalf, including analysing the deceased's mobile phones, taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

35. At the inquest, a summary of the evidence was provided to the Court by Counsel Assisting. The individual witnesses who provided statements in the briefs were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no significant factual disputes or controversies which were capable of being resolved by the calling of oral evidence and I had sufficient information to enable me to make the findings required under section 67 of the Act. Oral evidence was given by

Associate Professor Dimitri Gerostamoulos, Chief Toxicologist at the Victorian Institute of Forensic Medicine (**VIFM**).

36. This finding draws on the totality of the coronial investigation including evidence contained in the coronial briefs, the submissions of the interested parties and correspondence from the families of the deceased. While 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.[8]

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

Circumstances in which the death occurred

37. In the early morning on 24 June 2024, Michael drove with Abdul to the Central Business District in Melbourne where Michael had arranged through Signal (an encrypted messaging platform) to purchase some MDMA[9] and cocaine. It appears from an analysis of Michael and Abdul's phones that the purchase took place at around 1.37am. They then returned to Unit 4.

38. Cory recalled that at around 2.00am, Michael drove him to a friend's house in Hadfield. Cory did not return home until around 7.00pm that evening. Michael and Abdul were not there at that stage but Michael's car was parked outside Unit 3. The last outgoing communications from Michael and Abdul's phones were recorded at 3.07am and 2.40am respectively. There were no outgoing communications recorded on Carly or Thomas's phones on 24 June 2024.

39. At around 8.00pm, Cory knocked on the door of Unit 3 but there was no answer. He assumed that the occupants were sleeping as he stated that they had been smoking methylamphetamine over the weekend. He then sent a text message to Michael but he did not respond.

40. At around 1.00am on 25 June 2024, Cory recalled that Chloe Delaney, the mother of one of Abdul's friends, attended Unit 3 looking for Abdul. She was concerned about his welfare as it had been arranged for him to visit their house and they had not heard from him. She and Cory knocked on door of Unit 3 but there was no answer. Chloe then left the address.

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[8] 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.

[9] 3,4-Methylenedioxymethamphetamine, also known as ecstasy or molly.

41. Cory recalled that he then attempted to wake the occupants of Unit 3 by blowing his trumpet outside their unit. When he received no response, he became concerned and climbed into the rear yard of Unit 3 where he was able to observe Adbul through the kitchen window sitting on the floor against the pantry with froth coming from his mouth. He took a short video on his mobile phone recording his view through the window as he was concerned that he may need to provide justification for breaking into the unit. Cory then broke a window with a mallet to gain access to the property.

42. When Cory entered Unit 3, he located Michael, Thomas, Abdul and Carly unresponsive in the open plan kitchen and lounge room. They were clearly deceased. Karen Purchase, who resided at Unit 4 with Cory and his uncle, also observed the deceased and took Carly and Tom's dog back to Unit 4. Cory then telephoned his brother, Brendan Lewis and also spoke on the phone with his sister Bianca Lewis, notifying them of what he had found. At around 1.46am, Bianca notified Layel who was in Sydney at the time staying with her sister Maria Ahmad. Bianca then attended the scene and contacted emergency services after observing the deceased. Maria's husband also contacted emergency services.

43. Victoria Police arrived at the scene at 2.06am shortly followed by Ambulance Victoria and Fire Rescue Victoria. I also attended the scene later that morning. After examining the occupants, paramedics pronounced them deceased. Victoria Police located a plate on the bench in the kitchen which contained a beige coloured powder arranged in lines. They also located a rolled foreign currency note on a stool in the lounge which appeared to have been used by the occupants to inhale drugs. Toxicological analysis of the powder located at the scene detected the presence of cocaine and nitazine compounds, including protonitazene. Police also located a number of bags containing green vegetable matter, a small bottle of clear liquid and drug paraphernalia, including uncapped syringes and a bong.

44. Victoria Police did not identify any suspicious circumstances. Further, they have been unable to obtain sufficient evidence at this stage to charge any person in relation to the supply of the drugs to Michael on 24 June 2024 and no criminal proceedings have been commenced. However, the criminal investigation is ongoing.

Identity of the deceased

45. The deceased were visually identified by relatives or fingerprint identification.

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

Medical cause of death

47. Senior Forensic Pathologist Dr Michael Burke from the VIFM performed an autopsy on the body of one of the deceased and an external examination in relation to the remaining deceased and reviewed the results of post-mortem computed tomography (**CT**) scans.

48. Dr Burke did not find any evidence of injuries or natural disease which could have caused or contributed to the deaths.

49. Toxicological analysis of post-mortem samples of each of the deceased identified the presence of illicit drugs including cocaine (and/or its metabolites), methylamphetamine and protonitazene. Cannabis was also detected in samples taken from Abdul, Carly and Thomas. Dr Burke noted that protonitazene[10] is a novel synthetic opioid with no legitimate therapeutic use which can cause significant respiratory depression and lead to sudden unexpected death. No common drugs or poisons were detected in the liquid contained in the small bottle seized from the scene.

50. Dr Burke provided an opinion that the medical cause of death for each of the deceased was *1(a) Toxicity to protonitazene.*

51. I accept Dr Burke's opinion.

NITAZENES

52. Protonitazene belongs to a broader class of drugs called nitazenes. The Coroners Prevention Unit (**CPU**)[11] has conducted research in relation to nitazene-related deaths in Victoria. Nitazenes are a subclass of synthetic opioid[12] under the broader umbrella of novel psychoactive substances (**NPS**) which have become established in unregulated drug markets around the world in the past five years. Nitazenes come in many forms, and you cannot tell from the form or appearance of a substance whether it contains nitazenes.

[10] Protonitazene is three times more potent than fentanyl. Given its availability as a water-soluble powder, it is expected that it is often recreationally administered by intranasal or intravenous administration.

[11] The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research matters related to public health and safety 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.

[12] They are opioids because they act on (bind to) opioid receptors in the brain to produce analgesic, psychoactive and other effects. They are synthetic because they are synthetised or 'made in a lab' rather than having a natural origin (morphine being the classic natural opioid manufactured from the opium poppy).

53. Nitazenes have similar effects to other opioids. At lower doses they can relieve pain, stress and anxiety while imbuing users with a sense of euphoria. At higher doses, their central nervous system depressant effects can cause sedation, drowsiness and respiratory depression, leading to loss of consciousness and (at high enough doses) death.

54. Associate Professor Gerostamoulos emphasised in evidence that a key difference between nitazenes and most other opioids is their extreme potency: the amount of the drug required to produce a particular effect. Due to their potency and attendant profound risk of respiratory depression and death, nitazenes have never been approved anywhere for use in clinical medicine. Protonitazene is 100 times more potent than heroin.

55. Nitazenes were developed by the pharmaceutical industry in the 1950s but were practically unknown outside laboratory research settings until around 2019, when they started to appear in unregulated drug markets across Europe and North America. They have since spread to Australia.

56. The CPU actively tracks nitazene-involved overdose deaths in Victoria through the Overdose Deaths Register (**the Register**). There have been 23 confirmed nitazene-involved overdose deaths recorded in the Register. There were two nitazene-involved overdose deaths in 2021, followed by five in 2022, nine in 2023, and seven confirmed in 2024. There have been 13 deaths involving protonitazene (including the deaths the subject of this inquest), with the first death occurring in 2022.

57. Dr Gerostamoulos stated in evidence that protonitazene has been found to be contained in drugs purchased illicitly in both pill and powder form where users have thought they were purchasing other drugs such as oxycodone and cocaine respectively. The presence of any amount of nitazenes within an illicitly prepared drug will expose a user to a high risk of death.

58. Dr Gerostamoulos identified in evidence various drug prevention measures including the use of naloxone,[13] drug testing services, and nitazene testing strips. He also explained the ongoing work being conducted in Victoria, elsewhere in Australia, and overseas to effectively identify nitazenes (including new and emerging variations) circulating in the community.

[13] Naloxone, sold under the brand name Narcan, is an opioid antagonist that can be used to reverse or reduce the effects of opioids, including nitazenes. However, as nitazenes are so potent, multiple doses may be required.

FINDINGS AND CONCLUSION

59. From an examination of the evidence at the scene, it appears that the deceased have all become unresponsive very soon after ingesting the drugs in the early morning on 24 June 2024.

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

    a) the identities of the deceased were:

        i. Carly Morse, born on 14 April 1982;

        ii. Thomas Vale, born on 31 May 1992;

        iii. Michael Hodgkinson, born on 8 April 1987; and

        iv. Abdul El Sayed, born on 30 March 2007;

    b) the deaths occurred on 24 June 2024 at 3/32 Bicknell Court, Broadmeadows, Victoria, from toxicity to protonitazene; and

    c) the deaths occurred in the circumstances described above.

61. Having considered all of the circumstances, I am satisfied that their deaths were the unintended consequence of their deliberate ingestion of illicit drugs. I am satisfied that Michael thought that the drugs he purchased on 24 June 2024 were MDMA and cocaine when in fact, the cocaine had also been mixed with nitazene compounds, including the extremely potent protonitazene. It is likely that the deceased have inhaled what they thought was cocaine early in the morning on 24 June 2024 and they have all become unresponsive and passed away shortly afterwards within minutes of each other.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

62. This case illustrates the risk associated with the use of illicitly purchased drugs where there is no guarantee that what has been agreed to be purchased does not contain other more potent and lethal substances. The risk exists with both illicit drugs and pharmaceutical drugs that have been illicitly prepared, whether in powder or pill form.

63. It also highlights the risk when a group of people all ingest drugs from the same batch at the same time in an unsafe environment, leaving no person who may remain unaffected to contact emergency services and/or administer naloxone in the case of overdose.

64. On 2 July 2024, the Department of Health issued a Drug Alert warning the community about a white powder sold in Melbourne containing the potent opioid "*protonitazene*".[14] The Alert noted that protonitazene is an extremely potent novel synthetic substance (over 100 times that of heroin) which can produce strong effects in very small amounts.[15]

65. The Alert identified the signs of opioid overdose which include breathing slowly and reduced consciousness and tiny pupils. In addition to contacting emergency services in cases of suspected overdose, it also recommended the use of naloxone which can reverse opioid overdose. Naloxone can be accessed free of charge at participating pharmacies, needle and syringe exchange programs and the medically supervised injecting centre in Richmond.

66. In April 2025, Queensland Health issued a Drug Alert warning the community about green pills being sold as oxycodone in Brisbane which contained protonitazene. The drug was detected at a drug checking service.[16]

67. In November 2023, NSW Health issued a warning about people who had overdosed (including one death) using nitazenes contained in vape refills sold as synthetic cannabinoids.[17]

[14] https://www.health.vic.gov.au/drug-alerts/cocaine-adulterated-with-protonitazene/
[15] A previous alert was issued by the Department of Health in September 2022 which warned about a yellow powder being sold as ketamine in Melbourne, which contained protonitazene.
[16] A previous alert was issued by Queensland Health in May 2023 which warned about tablets that were branded and sold as pharmaceutical drugs including alprazolam, which contained protonitazene
[17] https://pathology.health.nsw.gov.au/articles/overdoses-linked-to-illicit-vape-juice/

68. Coroners have previously recommended the introduction of drug checking services in Victoria.[18] The Victorian government has started running trial drug checking services at some music festivals, with a trial fixed-site drug checking service to be established in mid-2025. If nitazenes are identified in a submitted sample at a drug checking service, the person who supplied the sample can be alerted (so they can make an informed decision about consuming or discarding the substance) and other drug harm reduction services can be alerted to the possibility of nitazenes being in circulation.

69. Nitazene test strips are an emerging technology that have the potential to enable people to find out rapidly whether they possess substances of concern. The strips can be placed in a solution with a sample of a dissolved substance and will change colour or give some other visual indicator if the substance contained nitazenes. A benefit of nitazene test strips is they can be used at home by people to check the contents of substances they obtained. However, there are some limitations and uncertainties associated with testing strips in relation to their specificity and sensitivity.

RECOMMENDATIONS

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

1. The Department of Health consider the effectiveness of nitazene test strips and whether they can be made available to the community as a measure to reduce unintentional overdose.

I convey my sincere sympathy to the families of the deceased for their loss.

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

[18] COR 2022 006970, *Investigation of death of Mr SL*, 13 March 2024.

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

Senior Next of Kin

Commissioner for Children and Young People

Department of Families, Fairness and Housing

Department of Health

Senior Constable Nick Andrews, Coronial Investigator

Signature:

Coroner David Ryan

Date: 17 April 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.