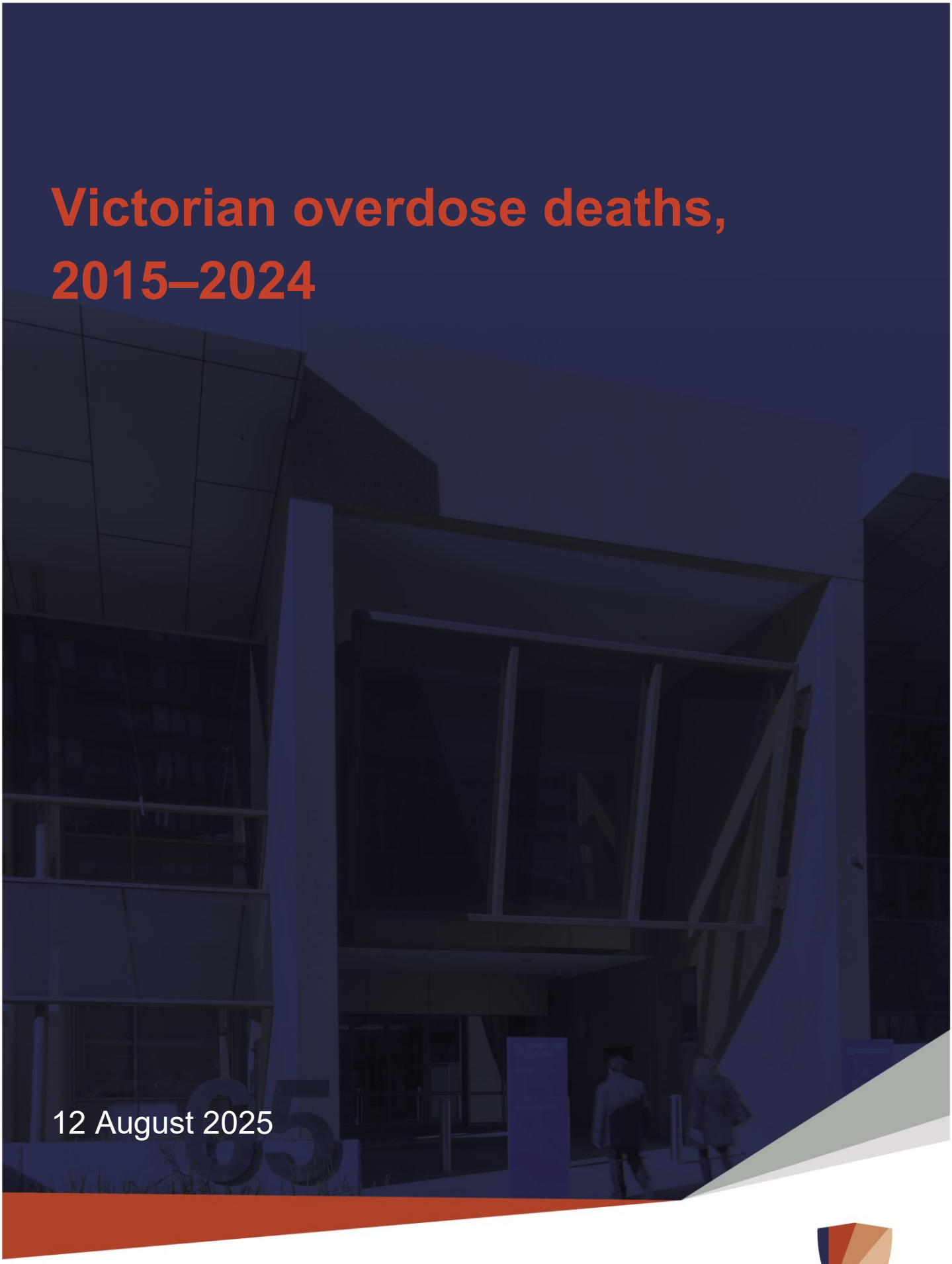
Victorian overdose deaths, 2015–2024



12 August 2025

Coroners Court of Victoria

Contents

1. Purpose

This report presents the 2024 update to Victorian overdose death statistics. It was prepared under the Coroners Court of Victoria's initiative to make mortality data accessible to the community and to organisations engaged in reducing preventable deaths.

Data for this report was collated from the Victorian Overdose Deaths Register (**VODR**) maintained by the Court. The design and operation of the VODR, together with relevant definitions and inclusion criteria and considerations for data interpretation, are described in **Attachment A**. The following are particularly important to note:

- Deaths are only included in the VODR after the forensic medical cause of death has been established. In some cases, this can take days or weeks, but in other cases (particularly where multiple potential causes of death are considered) the forensic pathologist may require some months. Approximately 90% of forensic medical causes of death in fatal overdoses are confirmed within three months of death report; this rises to around 98% after six months. This is why the Court cannot release overdose deaths data immediately and instead must wait to ensure the data is as accurate as possible before publication.
- The contents of the VODR are continually reviewed and deaths re-coded as coroners' investigations progress and more is known about the circumstances in which they occurred. Therefore, some of the data reported here may differ slightly from what has been reported previously.
- Variations over time in the data should be interpreted with caution. Sometimes an apparent increase or decrease in the numbers may reflect a shift in underlying trends and patterns in drug use and related harms; but equally it might result from random factors.
- Particular care is required when interpreting any apparent increase or decrease that involves low frequencies (for example 20 or fewer deaths per year), because the influence of random factors is far greater at lower frequencies and can create the illusion of a trend where there is none.

2. Overdose deaths, Victoria 2015–2024

There were 5268 overdose deaths in Victoria between 2015 and 2024. This section provides an overview of basic numbers and the socio-demographics of the deceased.

2.1. Annual number and rate by sex

Table 1 shows the annual number and proportion of Victorian overdose deaths by sex of the deceased person for the period 2015–2024. There was a steady increase in overdose deaths between 2015 and 2018, reaching 543 deaths in 2018. The annual number then retreated slightly to 501 in 2021, before rising again to reach 584 overdose deaths in 2024. Males consistently accounted for around two-thirds of overdose deaths throughout the period, noting some slight variation from year to year.

Table 1: Annual number and proportion of overdose deaths by deceased sex, Victoria 2015–2024.

Sex	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number										
Male	305	332	341	347	332	350	354	351	344	398
Female	155	163	188	196	188	187	147	201	203	186
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**
Proportion										
Male	66.3	67.1	64.5	63.9	63.8	65.2	70.7	63.6	62.9	68.2
Female	33.7	32.9	35.5	36.1	36.2	34.8	29.3	36.4	37.1	31.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Figure A shows the crude annual overdose death rate per 100,000 people in Victoria for the period 2015–2024.[1] The rate was relatively steady across this period, suggesting that the increase in overdose deaths observed over time was related to growth in Victoria's population.

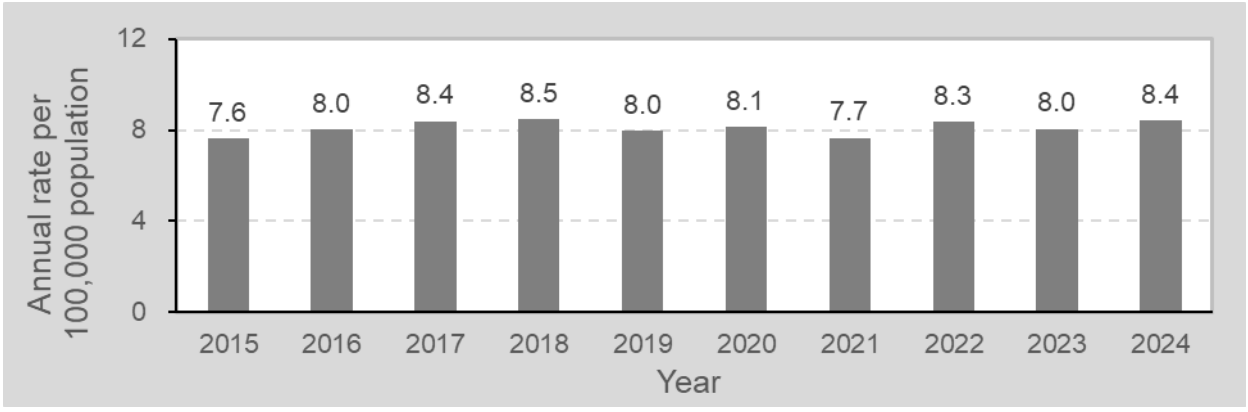


Figure A: Crude annual overdose death rate per 100,000 population, Victoria 2015–2024.

1 Rates were calculated using the Australian Bureau of Statistics "Population - states and territories" Victorian estimated resident population at June each year (workbook 3101.0 released 19 June 2025).

2.2. Annual number by sex and age group

Table 2 shows the annual number of Victorian overdose deaths by sex and age group of the deceased person, 2015–2024.

Table 2: Annual number of overdose deaths by deceased sex and age group, Victoria 2015–2024.

Age group by sex	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Males										
Under 18 years	-	3	1	-	4	-	-	2	4	1
18 to 24 years	12	20	11	16	16	27	17	24	22	23
25 to 34 years	58	52	69	68	47	60	76	59	46	68
35 to 44 years	111	112	113	106	93	93	93	86	90	105
45 to 54 years	85	83	82	98	92	99	97	94	96	106
55 to 64 years	25	40	36	43	47	44	47	61	57	62
65 years and over	14	22	29	16	33	27	24	25	29	33
Total	**305**	**332**	**341**	**347**	**332**	**350**	**354**	**351**	**344**	**398**
Females										
Under 18 years	1	1	3	1	1	-	-	-	3	1
18 to 24 years	7	6	8	13	8	5	7	6	6	10
25 to 34 years	16	25	23	28	22	35	23	23	37	26
35 to 44 years	47	47	44	48	39	52	36	43	48	48
45 to 54 years	37	39	45	36	54	47	42	61	49	41
55 to 64 years	27	29	36	41	32	24	22	40	30	33
65 years and over	20	16	29	29	32	24	17	28	30	27
Total	**155**	**163**	**188**	**196**	**188**	**187**	**147**	**201**	**203**	**186**
All people										
Under 18 years	1	4	4	1	5	-	-	2	7	2
18 to 24 years	19	26	19	29	24	32	24	30	28	33
25 to 34 years	74	77	92	96	69	95	99	82	83	94
35 to 44 years	158	159	157	154	132	145	129	129	138	153
45 to 54 years	122	122	127	134	146	146	139	155	145	147
55 to 64 years	52	69	72	84	79	68	69	101	87	95
65 years and over	34	38	58	45	65	51	41	53	59	60
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**

When annual numbers were broken down in this way, it was challenging to identify consistent trends. For most age-sex groups there was a general increase in the annual number when comparing 2015 to 2024 (which mirrored the overall annual growth in overdose deaths), but fluctuations from year to year were quite marked and no apparent underlying pattern was able to be discerned. This reinforces the need for caution in interpreting the data: changes over time might reflect shifting drug-related harms in the Victorian population but might simply reflect volatility in the numbers themselves.

Perhaps the most notable difference between 2023 and 2024 was the 16% increase in overdose deaths among males, from 344 in 2023 to 398 in 2024. This was reflected in the male overdose death rate, which reaching its highest level in a decade in 2024 (11.6 overdose deaths per 100,000 population of males – see Figure B). By comparison, the annual overdose death rate among

females in 2024 was quite similar to previous years (5.3 deaths per 100,000 population of females, as shown in Figure B).

The reasons why the overdose death rate among males was elevated in 2024 are still not clear, and additionally there is a possibility that this apparent elevation is the result of natural variation in the data rather than an underlying external cause. Sharp temporary rate changes have been observed in the past (for example the overdose death rate among females dropped from 5.6 per 100,000 population in 2020 to 4.4 in 2021 before rising again to 6.0 in 2022), which reinforces the need for caution when interpreting these results.

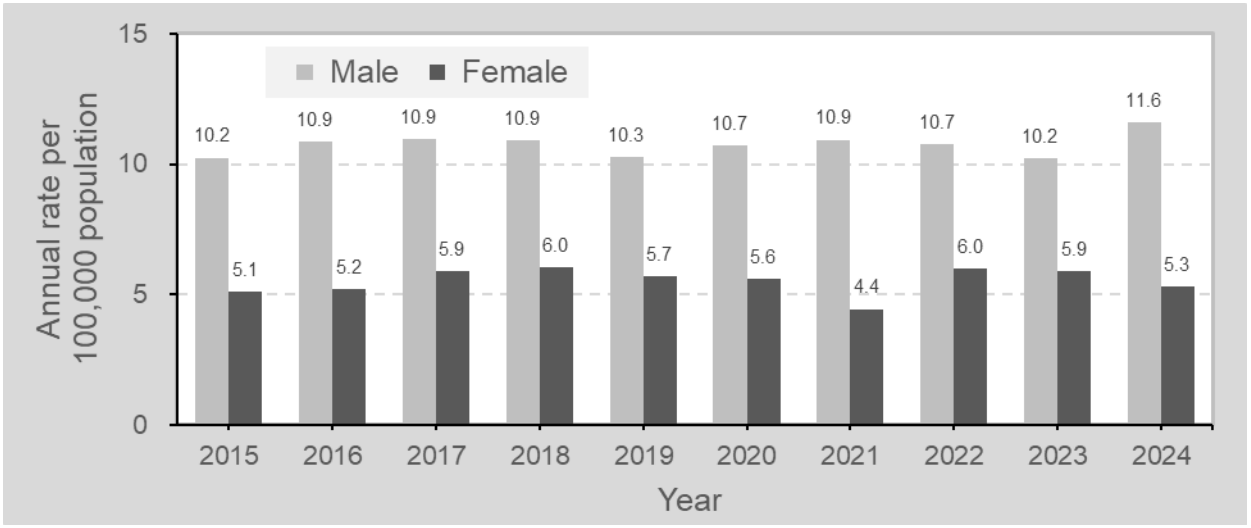


Figure B: Sex-specific annual overdose death rate per 100,000 population, Victoria 2015–2024.

Figure C shows the sex-specific and age-specific average annual rate of overdose deaths per 100,000 Victorians across the 10-year period. For both males and females, the lowest rate was among those aged under 18 years. The rate then increased steadily to peak in males aged 35–44, and in females aged 45–54, before declining among older Victorians.

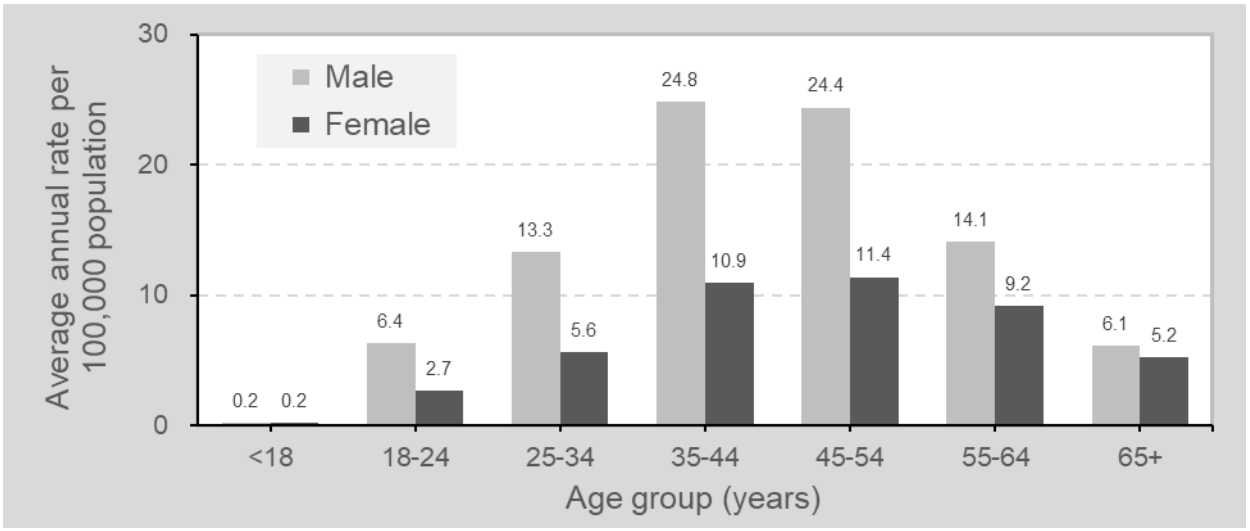


Figure C: Average annual overdose death rate per 100,000 population by sex and age group, Victoria 2015–2024.

2.3. Metropolitan Melbourne and Regional Victoria

Table 3 shows the annual number and proportion of Victorian overdose deaths occurring in Metropolitan Melbourne and Regional Victoria, as well as the small number of deaths where the fatal overdose location could not be confirmed.

Table 3: Annual number and proportion of overdose deaths by fatal incident location, Victoria 2015–2024.

Fatal incident location	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number										
Metropolitan Melbourne	352	374	393	394	385	396	400	416	409	435
Regional Victoria	108	119	133	148	133	141	101	136	136	146
Unconfirmed	-	2	3	1	2	-	-	-	2	3
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**
Proportion										
Metropolitan Melbourne	76.5	75.6	74.3	72.6	74.0	73.7	79.8	75.4	74.8	74.5
Regional Victoria	23.5	24.0	25.1	27.3	25.6	26.3	20.2	24.6	24.8	25.0
Unconfirmed	-	0.4	0.6	0.2	0.4	-	-	-	0.4	0.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

The annual number of overdose deaths in both Metropolitan Melbourne and Regional Victoria generally trended upwards over time, reflecting the overall increasing trend in the annual number of Victorian overdose deaths. Just over a quarter of Victorian overdose deaths each year occurred in Regional Victoria, with very little variation in this proportion over the 10-year period except for 2021, when the proportion dropped to 20% of all overdose deaths.

Supplementing Table 3, please see **Attachment B** for the annual number of overdose deaths by local government area of fatal incident.

3. Contributing drugs

This section provides an overview of main drug types, drug groups and individual drugs that contributed to the 5268 overdose deaths in Victoria between 2015 and 2024.

3.1. Single drug and multiple drug toxicity

Table 4 shows the annual number and proportion of overdose deaths in Victoria for the period 2015–2024 which were due to the acute toxic effects of a single drug versus multiple drugs (the latter is also known as combined drug toxicity).

Table 4: Annual number of single drug and multiple drug overdose deaths, Victoria 2015–2024.

Contributing drugs	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number										
Single	135	136	126	132	131	140	133	125	156	155
Multiple	325	359	403	411	389	397	368	427	391	429
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**
Proportion										
Single	29.3	27.5	23.8	24.3	25.2	26.1	26.5	22.6	28.5	26.5
Multiple	70.7	72.5	76.2	75.7	74.8	73.9	73.5	77.4	71.5	73.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

On average three-quarters of Victorian overdose deaths each year involved multiple contributing drugs, which underscores the importance of highlighting drug combinations when delivering harm reduction education and other overdose prevention initiatives.

3.2. Contributing drug types

Contributing drugs across all Victorian overdose deaths were classified into three main types for further analysis, being pharmaceutical drugs, illegal drugs and alcohol. Definitions of these drug types are found in **Attachment A**, together with a discussion of classification challenges.

Table 5: Annual number of overdose deaths by contributing drug types, Victoria 2015–2024.

Contributing drugs	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number										
Pharmaceutical	359	385	419	428	409	404	378	406	379	405
Illegal	228	265	270	260	275	276	260	303	322	383
Alcohol	107	124	151	161	146	155	147	173	153	141
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**
Proportion										
Pharmaceutical	78.0	77.8	79.2	78.8	78.7	75.2	75.4	73.6	69.3	69.3
Illegal	49.6	53.5	51.0	47.9	52.9	51.4	51.9	54.9	58.9	65.6
Alcohol	23.3	25.1	28.5	29.7	28.1	28.9	29.3	31.3	28.0	24.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 5 shows the annual number and proportion of Victorian overdose deaths involving pharmaceutical drugs, illegal drugs and alcohol. Most overdose deaths were from multiple drug

toxicity, which is why the annual numbers for each drug type in Table 5 sum to greater than the overall annual number.

Overall, pharmaceutical drugs were the most frequent contributors to Victorian overdose deaths, though the annual proportion of overdose deaths in which they played a contributory role declined over time, from 78% in 2015 to 69.3% in 2023 and 2024. Across the same period the proportion of Victorian overdose deaths involving illegal drugs was relatively stable (around 51% annually on average) between 2015 and 2021 but then rose quite substantially from 2022 to reach 65.6% of deaths in 2024. Alcohol involvement fluctuated during the period without any clear trend and contributed to on average around 27% of overdose deaths per year.

The trend over time in illegal drug involvement in Victorian overdose deaths is analysed further in Section 5 of this report.

3.3. Contributing drug groups

Pharmaceutical drugs were further disaggregated into drug groups for more detailed analysis of contributing drugs, using a modified version of the US Drug Abuse Warning Network (DAWN) Drug Vocabulary level two groupings.[2]

Table 6: Annual number and proportion of overdose deaths in which major pharmaceutical drug groups (plus alcohol and illegal drugs) contributed, Victoria 2015–2024.

Drug group	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number										
Illegal drugs	228	265	270	260	275	276	260	303	322	383
Benzodiazepines	240	263	307	304	285	286	266	268	265	269
Pharmaceutical opioids	186	183	201	207	208	194	182	183	180	183
Antidepressants	162	165	197	196	172	181	159	174	146	183
Alcohol	107	124	151	161	146	155	147	173	153	141
Antipsychotics	93	107	137	109	103	113	99	111	108	129
Anticonvulsants	52	54	77	87	86	93	86	101	93	108
Non-benzo anxiolytics	61	40	57	47	54	51	46	51	51	54
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**
Proportion										
Illegal drugs	49.6	53.5	51.0	47.9	52.9	51.4	51.9	54.9	58.9	65.6
Benzodiazepines	52.2	53.1	58.0	56.0	54.8	53.3	53.1	48.6	48.4	46.1
Pharmaceutical opioids	40.4	37.0	38.0	38.1	40.0	36.1	36.3	33.2	32.9	31.3
Antidepressants	35.2	33.3	37.2	36.1	33.1	33.7	31.7	31.5	26.7	31.3
Alcohol	23.3	25.1	28.5	29.7	28.1	28.9	29.3	31.3	28.0	24.1
Antipsychotics	20.2	21.6	25.9	20.1	19.8	21.0	19.8	20.1	19.7	22.1
Anticonvulsants	11.3	10.9	14.6	16.0	16.5	17.3	17.2	18.3	17.0	18.5
Non-benzo anxiolytics	13.3	8.1	10.8	8.7	10.4	9.5	9.2	9.2	9.3	9.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

2 The main modifications were that the DAWN ‘anxiolytics’ group was divided into benzodiazepine and non-benzodiazepine anxiolytics, and the DAWN ‘analgesics’ group was divided into pharmaceutical opioids and non-opioid analgesics.

Table 6 shows the annual number and proportion of Victorian overdose deaths between 2015–2024 involving each of the major contributing pharmaceutical drug groups, with illegal drugs and alcohol included for context. Most overdose deaths were from combined drug toxicity, which is why the annual numbers for each drug group in Table 6 sum to greater than the overall annual number of overdose deaths.

Across the 10-year period, benzodiazepines were overall the most frequent contributing pharmaceutical drug group, playing a role in an average 52.4% of overdose deaths per year, though noting also that this proportion was lower than average in the most recent years 2022-2024. The next most frequent contributing pharmaceutical drug groups was opioids (an average 36.2% of overdose deaths annually across the period) and antidepressants (annual average 32.9%), both of which also saw declines over time in the annual proportion of overdose deaths to which they contributed.

The continuing decline in the proportion of overdose deaths involving pharmaceutical opioids and benzodiazepines is a very positive development. While it is not possible to attribute the decline to any specific initiative, the work of the Royal Australian College of General Practitioners (which has made a concerted effort over an extended period to support clinicians' opioid and benzodiazepine prescribing practices, including through the development of comprehensive guidelines for prescribing drugs of dependence), and the Victorian Department of Health (which through its SafeScript system assists clinicians to understand and monitor benzodiazepine and opioid prescribing to patients) must be acknowledged.

3.4. Individual contributing drugs

Table 7 shows the annual number of overdose deaths involving each of the most frequent contributing individual drugs. The individual drugs are tabulated by the major drug groups to which they belong, and within each drug group they are arranged in descending order by total number of deaths to which they contributed during the period.

Table 7: Annual number of overdose deaths in which individual drugs contributed, Victoria 2015–2024. (*Noting that new psychoactive substances are actually a drug group rather than an individual drug; these are analysed further in Section 4 of the Data Summary.)

Contributing drug	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Illegal drugs										
Heroin	172	190	221	203	212	187	173	230	204	248
Methamphetamine	76	120	95	96	111	116	138	142	164	215
New psychoactives*	4	8	4	8	17	33	35	48	41	48
Cocaine	15	11	10	17	21	28	23	19	32	48
GHB	-	5	6	5	7	18	10	22	24	31
MDMA	5	13	7	4	14	17	11	9	8	19
Total	**228**	**265**	**270**	**260**	**275**	**276**	**260**	**303**	**322**	**383**

(Table 7 continued over page)

(Table 7 continued from previous page)

Contributing drug	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Benzodiazepines										
Diazepam	194	204	245	235	232	220	217	213	213	219
Clonazepam	33	31	49	40	35	43	45	42	51	35
Alprazolam	23	23	27	31	28	31	26	18	22	22
Oxazepam	35	27	24	35	28	17	27	20	15	19
Temazepam	25	26	33	29	20	18	18	17	10	17
Nitrazepam	17	22	11	16	13	14	12	14	9	14
Lorazepam	2	7	8	6	9	12	10	5	8	10
Total	**240**	**263**	**307**	**304**	**285**	**286**	**266**	**268**	**265**	**269**
Pharma opioids										
Methadone	67	72	73	72	75	68	67	72	66	59
Oxycodone	58	54	66	62	60	60	47	57	41	60
Codeine	48	46	38	34	42	40	26	31	24	24
Tramadol	33	26	32	35	37	28	20	17	12	13
Tapentadol	-	-	1	9	13	20	19	18	38	26
Buprenorphine	4	2	8	20	11	17	10	17	23	26
Morphine	9	13	18	19	18	10	13	11	17	9
Fentanyl	23	14	14	18	5	5	13	2	6	7
Total	**186**	**183**	**201**	**207**	**208**	**194**	**182**	**183**	**180**	**183**
Antidepressants										
Mirtazapine	50	25	42	59	45	57	50	69	34	56
Amitriptyline	28	34	48	40	42	32	33	33	37	37
Citalopram	26	28	35	26	26	34	25	29	27	32
Venlafaxine	10	22	27	18	20	19	20	25	14	22
Sertraline	12	11	18	19	20	14	12	15	11	16
Duloxetine	12	15	12	19	20	17	18	12	8	12
Desvenlafaxine	15	19	15	18	12	15	8	14	10	9
Fluoxetine	12	16	10	12	12	10	13	8	13	19
Total	**162**	**165**	**197**	**196**	**172**	**181**	**159**	**174**	**146**	**183**
Alcohol										
Alcohol	107	124	151	161	146	155	147	173	153	141
Alcohol	**107**	**124**	**151**	**161**	**146**	**155**	**147**	**173**	**153**	**141**
Antipsychotics										
Quetiapine	51	57	75	53	50	53	44	43	47	48
Olanzapine	30	36	41	42	33	44	34	45	45	59
Risperidone	9	14	9	13	10	4	6	18	7	17
Aripiprazole	4	3	6	6	4	5	6	8	10	13
Zuclopenthixol	5	4	14	4	7	8	3	5	3	9
Total	**93**	**107**	**137**	**109**	**103**	**113**	**99**	**111**	**108**	**129**

(Table 7 continued over page)

(Table 7 continued from previous page)

Contributing drug	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anticonvulsants										
Pregabalin	34	34	54	69	67	70	66	66	78	92
Lamotrigine	3	3	6	10	7	8	8	12	5	8
Gabapentin	4	2	5	5	2	11	7	8	5	12
Valproic Acid	9	6	7	5	7	7	6	9	2	-
Total	**52**	**54**	**77**	**87**	**86**	**93**	**86**	**101**	**93**	**108**
Non-benzo anxiolytics										
Zopiclone	18	13	17	13	22	18	15	17	15	20
Doxylamine	14	13	18	18	16	10	9	13	16	15
Diphenhydramine	5	4	6	6	7	10	11	15	13	13
Zolpidem	11	6	8	6	8	8	9	9	5	7
Pentobarbitone	18	9	11	6	9	4	8	2	4	5
Total	**61**	**40**	**57**	**47**	**54**	**51**	**46**	**51**	**51**	**54**
Other drugs of interest										
Paracetamol	42	30	32	32	47	33	18	18	16	25
Promethazine	11	11	16	27	18	18	16	21	30	19
Propranolol	12	8	17	13	12	11	14	9	10	11
Ketamine	5	3	3	11	6	11	12	10	18	15
Insulin	2	6	7	12	10	7	8	4	5	7
Amphetamine	9	1	3	5	3	4	6	5	11	6

Some notable themes and issues emerging from the data presented here, are discussed in more detail in Section 5.

4. Intent

This section provides an overview of deceased intent in the Victorian overdose deaths. Intent is coded into the VODR using the following (mutually exclusive) options:

- Unintentional, if the available evidence on the balance of probabilities indicated the deceased did not intend to die in the fatal drug consumption incident. (These are sometimes referred to colloquially as 'accidental' overdoses.)
- Intentional self-harm, if the available evidence on the balance of probabilities indicated the deceased intended to die in the fatal drug consumption incident and understood that death was the likely result of the drug consumption. (These are suicides.)
- Unable to be determined, if there was insufficient evidence or conflicting evidence regarding the deceased's intent.

Intent is coded in line with the principles and practices of the Victorian Suicide Register (VSR) team at the Coroners Court of Victoria, and intent coding is regularly reconciled between the VODR and the VSR to ensure accuracy and consistency.[3]

4.1. Annual number

Table 8 shows the annual number of Victorian overdose deaths by deceased intent. While there was some variation from year to year in the numbers, the proportion of overdose deaths by intent was reasonably consistent, with around 75% of overdose deaths each year being unintentional, 20% resulting from intentional self-harm, and there being insufficient evidence (or conflicting evidence) such that the deceased's intent could not be determined in 5% of cases.

Table 8: Annual number and proportion of overdose deaths by deceased intent, Victoria 2015–2024.

Intent	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Number											
Unintentional	327	348	395	396	402	416	388	431	399	423	3925
Undetermined	39	54	32	38	24	33	16	15	32	43	326
Intentional	94	93	102	109	94	88	97	106	116	118	1017
Total	**460**	**495**	**529**	**543**	**520**	**537**	**501**	**552**	**547**	**584**	**5268**
Proportion											
Unintentional	71.1	70.3	74.7	72.9	77.3	77.5	77.4	78.1	72.9	72.4	74.5
Undetermined	8.5	10.9	6.0	7.0	4.6	6.1	3.2	2.7	5.9	7.4	6.2
Intentional	20.4	18.8	19.3	20.1	18.1	16.4	19.4	19.2	21.2	20.2	19.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

3 For detailed information on the Victorian Suicide Register and intent classification and coding at the Coroners Court of Victoria, please see State of Victoria, *Response to NTG-VIC-002*, Royal Commission into Defence and Veteran Suicide, Exhibit B-01.003, published 28 July 2022.

4.2. Intent and sex

Table 9 shows the number and proportion of overdose deaths by deceased sex and intent. The most prominent finding was that the proportion of unintentional overdose deaths was higher among male (81.8%) than females (60.5%); and conversely the proportion of intentional overdose deaths was far higher among females (31.4%) than males (13%).

Table 9: Overall number and proportion of overdose deaths by deceased sex and intent, Victoria 2015–2024.

Intent	Male		Female		Total	
	N	%	N	%	N	%
Unintentional	2827	81.8	1098	60.5	3925	74.5
Undetermined	179	5.2	147	8.1	326	6.2
Intentional	448	13.0	569	31.4	1017	19.3
Total	**3454**	**100.0**	**1814**	**100.0**	**5268**	**100.0**

4.3. Intent, sex and contributing drug types

Focusing specifically on the 3925 unintentional overdose deaths, Table 10 shows the proportion of these deaths among males and females involving each of pharmaceutical drugs, illegal drugs and alcohol (noting that multiple drug types could contribute in a single death). For males, illegal drugs contributed in a slightly higher proportion of unintentional overdose deaths (70.6%) than pharmaceutical drugs (65.3%), whereas for females pharmaceutical drugs contributed in more unintentional overdose deaths (76.9%) than illegal drugs (56.7%).

Table 10: Overall number and proportion of unintentional overdose deaths by deceased sex and contributing drug type, Victoria 2015–2024.

Drug type	Male		Female		Total	
	N	%	N	%	N	%
Pharmaceutical	1846	65.3	844	76.9	2690	68.5
Illegal	1997	70.6	623	56.7	2620	66.8
Alcohol	885	31.3	302	27.5	1187	30.2
Total	**2827**	**100.0**	**1098**	**100.0**	**3925**	**100.0**

Table 11 presents the same analysis as in Table 10, except for intentional overdose deaths. As with unintentional overdose deaths, the proportion of deaths involving illegal drugs was higher among males (16.3%) than females (6.3%).

Table 11: Overall number and proportion of intentional overdose deaths by deceased sex and contributing drug type, Victoria 2015–2024.

Drug type	Male		Female		Total	
	N	%	N	%	N	%
Pharmaceutical	426	95.1	561	98.6	987	97.1
Illegal	73	16.3	36	6.3	109	10.7
Alcohol	95	21.2	105	18.5	200	19.7
Total	**448**	**100.0**	**569**	**100.0**	**1017**	**100.0**

Comparing the totals between the two tables, the most notable finding was that in unintentional overdose deaths the proportion of deaths involving pharmaceutical drugs (68.5%) was very similar to the proportion involving illegal drugs (66.8%), but for intentional overdose deaths the proportion

involving pharmaceutical drugs (97.1%) was far higher than illegal drugs (10.7%). This finding may reflect that some major classes of pharmaceutical drugs implicated in Victorian overdose deaths are prescribed for medical conditions implicated in heightened suicide risk. For example:

- Antidepressants are prescribed to treat depression, which is the mental health condition most frequently associated with suicidal thoughts and actions. Antidepressants contributed in 27.6% of unintentional overdose deaths, but in 49.2% of intentional (suicidal) overdose deaths.
- Antipsychotics are prescribed to treat symptoms of psychosis. Psychotic illnesses are associated with greatly increased suicide risk. Antipsychotics contributed in 18.7% of unintentional overdose deaths, but in 27.3% of intentional overdose deaths.
- Pharmaceutical opioids are prescribed to treat chronic pain conditions, and chronic pain carries heightened suicide risk. Pharmaceutical opioids contributed in 34.4% of unintentional overdose deaths, but in 40.1% of intentional overdose deaths.

Deceased intent can offer an extra layer of insight when analysing overdose deaths and considering drug harm reduction opportunities, particularly in circumstances where harm reduction strategies may be intent-specific: for example, supervised injecting and drug checking are initiatives to reduce unintentional drug harms, whereas medication access controls may be more suited in some circumstances to prevent intentional overdose.

5. Themes and issues

The following is a selection of themes and issues that emerge from consideration of the Victorian overdose deaths data presented above.

5.1. Illegal drug involvement

In 2024, the number and proportion of Victorian overdose deaths involving illegal drugs reached a 10-year high. This peak was seen across multiple illegal drugs: heroin, methamphetamine, MDMA, cocaine and GHB. Figure D shows that the peak occurred both in Metropolitan Melbourne and Regional Victoria.

Figure D: Annual number of overdose deaths involving illegal drugs in Metropolitan Melbourne and Regional Victoria, 2015–2024.

At the same time this was occurring, the proportion of Victorian overdose deaths involving pharmaceutical drugs was reaching a 10-year low. Figure E shows how the annual proportion of overdose deaths involving illegal drugs and pharmaceutical drugs respectively converged gradually between 2015 and 2024.

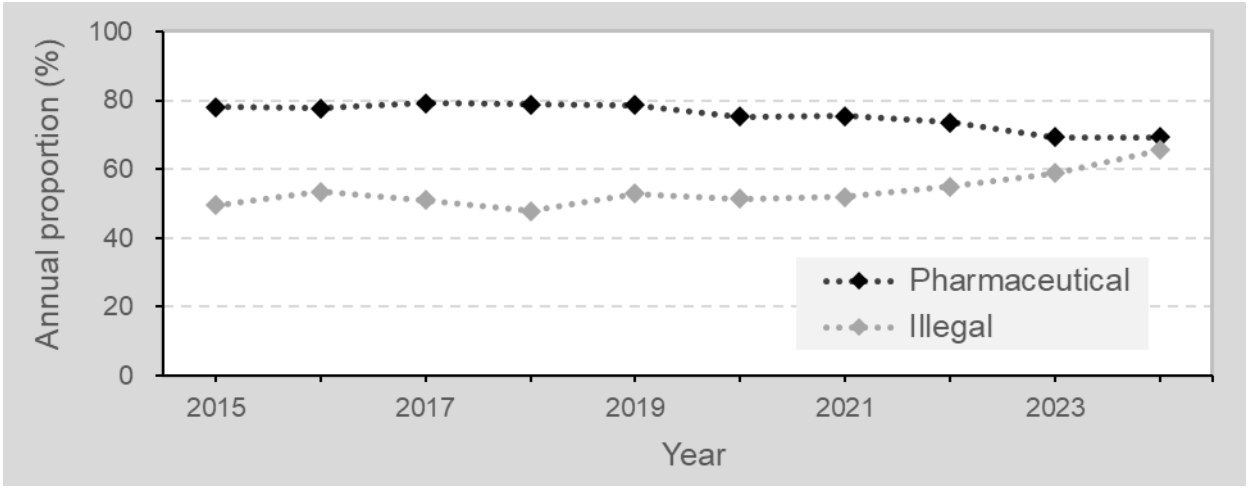


Figure E: Annual proportion of overdose deaths involving pharmaceutical drugs and illegal drugs, Victoria 2015–2024.

As discussed in section 3.3 above, a number of initiatives (such as the Royal Australian College of General Practitioners disseminating its prescribing guidelines and the SafeScript implementation) may have been responsible for this decline in the proportion of Victorian overdose deaths involving pharmaceutical drugs.

Similarly, there are many possible reasons why the number and proportion of Victorian overdose deaths involving illegal drugs has grown over time. Illegal drug-related harms are known or believed to be influenced by international factors (such as changes in global drug production, changes in composition of drug supply), national factors (such as border policing and other law enforcement activities) and local factors (such as access to drug treatment, access to needle and syringe programs, education in overdose identification and response).

Additionally, the fact that Victoria's overdose death rate has remained relatively steady while the gap between illegal and pharmaceutical drug involvement in Victorian overdose deaths has closed, suggests that there may be an interaction between illegal and pharmaceutical drug involvement in the deaths. More specifically, it raises the possibility that people may be substituting illegal drugs for pharmaceutical drugs, potentially driven in part by the above-mentioned initiatives making pharmaceutical drugs more difficult to access.

This potential substitution effect is raised only as a hypothesis at present, although there is some evidence to support that it is occurring. Victorian coroners have recently seen a surge in overdose deaths involving novel benzodiazepines (see Section 5.4 below for further information on this), and in many of these cases the deceased had originally developed a dependence on pharmaceutical benzodiazepines before shifting to novel benzodiazepines obtained from illegal drug markets.

Understanding what might underpin the trends reported here in pharmaceutical and illegal drug involvement will require insights from Alcohol and Other Drugs services, law enforcement, people who use drugs, and many other areas.

5.2. Heroin

The annual number of heroin-involved overdose deaths reached 248 in 2024, up from 204 and 2023 and 230 in 2022. Just over 80% of the deaths in 2024 occurred in Metropolitan Melbourne rather than Regional Victoria, which is slightly lower than average (over the period 2015–2024 an average 85% of heroin-involved overdose deaths occurred in Metropolitan Melbourne.

While the annual numbers (presented in Table 7) are useful for showing the general movement in the number of heroin-involved overdose deaths over time, they may potentially conceal some of the pattern of variation. To explore this variation, Figure F (over page) shows the monthly number of heroin-involved overdose deaths in Victoria for the period 2020–2024 (the light grey bars indicate January of each year to assist in interpreting variation). The figure suggests that heroin-involved overdose deaths might tend to vary or oscillate over time scales that run in months rather than years; for example increasing between November 2020 and March 2021, then decreasing in subsequent months, then occurring with greater frequency over time from February 2023 through to around June 2024, then possibly decreasing again.

The numbers might not be sufficiently large to be confident that any pattern observed is the result of some underlying cause rather than random factors, but it may be fruitful to compare the variation in heroin-involved overdose deaths over time with other measures of heroin-related harms and Victoria's heroin market (for example non-fatal overdose, heroin seizures, heroin purity testing) to explore whether any correlations emerge.

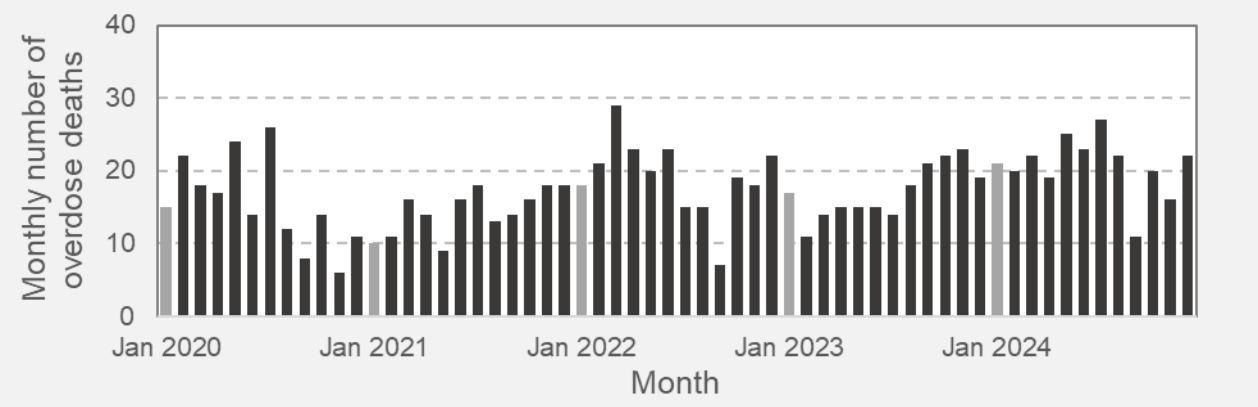


Figure F: Monthly number of overdose deaths involving heroin, Victoria 2015–2024.

Table 12 shows the 12 local government areas (LGAs) that were the most frequent locations for heroin-involved overdose deaths during the period 2015–2024, as well as the annual number of such deaths that occurred in each LGA.

Table 12: Annual number of heroin-involved overdose deaths in 12 LGAs that were most frequent locations for these deaths, Victoria 2015–2024.

LGA of fatal incident	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Yarra	19	20	16	26	17	10	11	14	19	21	173
Brimbank	6	13	19	10	15	17	8	19	14	13	134
Melbourne	12	7	15	13	10	14	9	24	7	23	134
Port Phillip	9	11	9	18	9	8	11	15	12	14	116
Greater Dandenong	11	11	11	10	14	9	10	7	17	14	114
Greater Geelong	4	12	6	10	12	5	10	7	10	14	90
Maribyrnong	9	5	9	7	5	6	5	14	9	13	82
Darebin	8	9	9	8	7	5	3	6	7	11	73
Merri-bek	5	4	8	9	8	5	3	9	9	7	67
Frankston	8	4	6	8	9	3	4	1	11	10	64
Wyndham	5	5	6	5	2	3	4	7	7	13	57
Stonnington	2	2	5	7	2	5	10	5	10	3	51

Yarra was the location where the highest number of heroin-involved overdose deaths occurred across the 10-year period, followed by Brimbank and Melbourne. It is notable that these three LGAs were also where the highest proportion of heroin-involved overdose deaths occurred in non-residential locations such as parks, alleys, toilet blocks and similar: 49.7% of heroin-involved overdose deaths in Yarra occurred in non-residential locations, followed by 43.3% in Melbourne, then 25.4% in Brimbank.

5.3. Methamphetamine

After heroin, methamphetamine was the next most frequent contributing illegal drug in Victorian overdose deaths in 2024, as well as across the decade 2015–2024 more broadly. The annual number of methamphetamine-involved overdose deaths in Victoria reached 215 in 2024, up from 164 in 2023 and 142 in 2022.

To explore whether the geographic distribution of methamphetamine-involved overdose deaths was similar to or different from the distribution of heroin-involved overdose deaths, the annual number of methamphetamine-involved overdose deaths during the period 2015–2024 was collated by LGA of fatal incident. Table 13 shows the 12 LGAs that were the most frequent locations for these deaths across the period.

Table 13: Annual number of methamphetamine-involved overdose deaths in 12 LGAs that were most frequent locations for these deaths, Victoria 2015–2024.

LGA of fatal incident	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Melbourne	3	6	6	8	4	9	10	9	11	21	87
Greater Dandenong	4	2	8	5	9	4	12	6	11	12	73
Port Phillip	5	6	3	7	3	8	11	11	7	12	73
Brimbank	5	4	6	2	8	6	9	11	14	7	72
Yarra	3	9	3	3	7	7	7	5	8	9	61
Greater Geelong	3	8	4	1	5	1	5	5	6	20	58
Frankston	5	9	5	7	7	4	4	2	5	9	57
Wyndham	3	6	2	1	5	4	5	5	4	9	44
Maribyrnong	1	2	3	5	3	1	4	8	5	7	39
Darebin	3	3	2	3	2	3	3	4	4	10	37
Monash	0	5	2	6	3	4	2	5	4	4	35
Merri-bek	2	3	4	2	1	1	2	7	8	5	35

While the LGAs in Table 13 were largely similar to those in Table 12, their order was in some respects quite different. For example, Melbourne was the LGA where most methamphetamine-involved deaths occurred, and Yarra (the site of the highest number of heroin-involved overdose deaths) was the fifth-highest LGA for methamphetamine-involved deaths.

These findings suggest there may be different patterns of use and harms relating to different illegal drugs across Victoria, and therefore harm reduction initiatives might need to take into account local contexts and an understanding of the people who use drugs in the local area.

5.4. Transience of new psychoactive substances (NPS)

NPS are a highly diverse family of drugs that have become established in illegal drug markets internationally over the past 20 years. NPS were first identified as contributing drugs in Victorian overdose deaths in 2013, and in recent years (see Table 7 above) the number of overdose deaths in which they were involved has grown steadily, from 17 deaths in 2019 to 48 deaths in 2024.

While NPS are ‘new’ or ‘novel’ in the sense that they usually have only entered illegal drug markets over recent years (or months or even in some cases weeks), they for the most part produce similar effects to (and often are specifically designed to mimic) 'classic' illegal drugs and pharmaceutical drugs. Therefore, in the academic and policy literature they tend to be grouped and described by the effects they produce: for example, novel cannabinoids (producing similar effects to cannabis), novel stimulants (producing similar effects to cocaine or amphetamine), novel benzodiazepines, and so on.

From a drug harm reduction perspective, one of the most important — and challenging — features of NPS is their transience. Research in Australia and internationally has shown that specific NPS will usually only appear in illegal drug markets for a short time, before manufacturers cease

producing them and switch to other drugs.[4] The transience of NPS is also clearly demonstrated when examining Victorian overdose deaths. Between 2015 and 2024, 59 individual NPS contributed to overdose deaths in Victoria. Figure G shows the number of overdose deaths to which each of these 59 NPS contributed. Among these, 24 NPS (41%) only contributed in a single overdose death during the period 2015–2024 in Victoria; and a further eight only contributed in two overdose deaths.

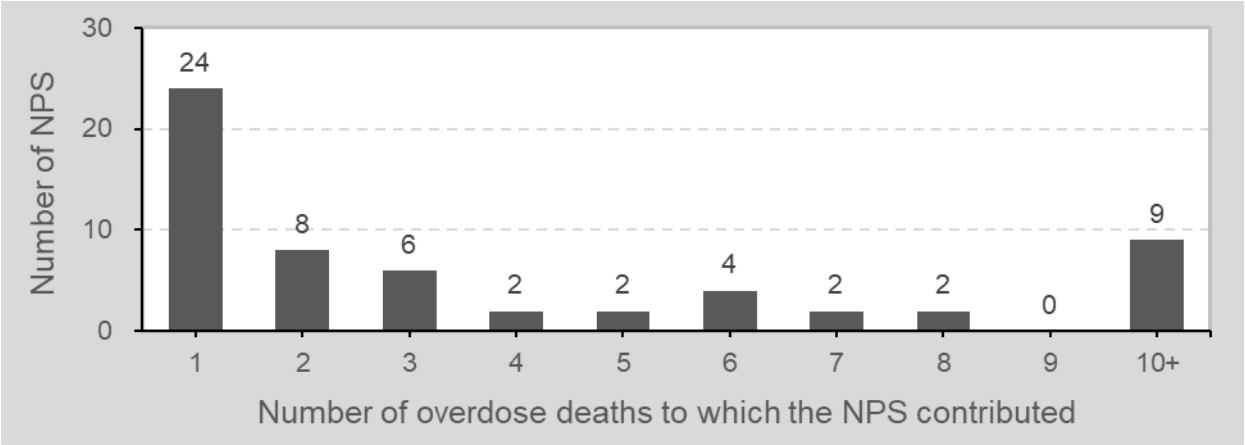


Figure G: Number of distinct NPS that contributed to Victorian overdose deaths, plotted against number of Victorian overdose deaths to which they contributed, 2015–2024.

The transience of NPS in Victorian overdose deaths (where a particular NPS might only appear and contribute in a handful of deaths at most before dropping out of Victoria's illegal drug markets and potentially never being seen again) means that our strategies for reducing NPS-related harms need to focus not narrowly on specific NPS, but broadly on understanding what NPS are entering and leaving our drug markets. This is why multiple coroners have called for drug checking services to be implemented, so that people who use drugs and organisations engaged in harm reduction activities can learn what NPS are present in the drug supply.

Given this transience, and the sheer number and diversity of NPS, it is often easier and more meaningful to report not on the individual NPS that are contributing to overdose deaths, but rather on the categories or groups of contributing NPS. Table 14 (over page) shows the annual number of NPS-involved overdose deaths in Victoria across the period 2015–2024 by the main categories of contributing NPS.

Novel benzodiazepines contributed most often to NPS-involved overdose deaths in 2024, as with previous years going back to 2019. Coroners are now regularly encountering them in death investigations, with evidence in multiple cases suggesting that novel benzodiazepines were packaged up for sale as counterfeit versions of established pharmaceutical benzodiazepines such as alprazolam and clonazepam. Novel dissociatives and novel opioids were equal second most frequent contributors in 2024, followed by novel stimulants.

4 See for example Winstock A and Barratt M, "Synthetic cannabis: a comparison of patterns of use and effect profile with natural cannabis in a large global sample", *Drug and Alcohol Dependence*, 131, 2013, pp.106-111; Baumeister D et al, "Legal highs: staying on top of the flood of novel psychoactive substances", *Therapeutic Advances in Psychopharmacology*, 5(2), 2015, pp.97-132; Schumann JL et al, "Changes over time in novel benzodiazepines contributing to fatal overdoses in Victoria, Australia", *Drug and Alcohol Review*, 44(4), 2025, pp.1285-1289.

Table 14: Annual number of NPS-involved overdose deaths by contributing categories, Victoria 2015–2024.

NPS category	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Benzodiazepine	1	-	-	1	10	28	26	40	33	35
Stimulant	1	7	2	-	-	4	3	4	8	6
Cannabinoid	2	-	2	7	6	2	2	-	-	1
Opioid	-	1	-	-	1	-	3	6	9	7
Psychedelic	-	3	2	-	-	1	3	-	-	1
Empathogen	-	-	-	-	-	5	1	-	-	-
Dissociative	-	-	-	-	-	2	-	1	1	7
Other and unknown	-	-	-	-	-	-	-	-	-	-
Total	**4**	**8**	**4**	**8**	**17**	**33**	**35**	**48**	**41**	**48**

5.5. Pregabalin

Pregabalin contributed to 92 Victorian overdose deaths in 2024, up from 78 deaths in 2023 and 66 in 2022. This was an unexpected finding, given pregabalin was included in the SafeScript real-time prescription monitoring system (following calls over a long period from Victorian coroners and others) on 3 July 2023, which was hoped to curb associated harms.

Pregabalin-involved overdoses are overwhelmingly the result of combined drug toxicity; Table 15 shows that between 2015 and 2024 there were 630 such overdose deaths in Victoria, and only one of them involved pregabalin alone. Pharmaceutical drugs such as diazepam, methadone, oxycodone and quetiapine featured among the top co-contributors, as did the illegal drugs heroin and methamphetamine.

Table 15: Overall number and proportion of overdose deaths involving pregabalin alone versus in combination with other drugs (including most frequent co-contributing drugs), Victoria 2015–2024.

Contributing drugs	N	%
Pregabalin alone	**1**	**0.2**
Pregabalin in combination	**629**	**99.8**
- with diazepam	409	64.9
- with heroin	180	28.6
- with methadone	172	27.3
- with oxycodone	136	21.6
- with methamphetamine	134	21.3
- with quetiapine	114	18.1
- with mirtazapine	108	17.1
- with clonazepam	107	17.0
- with amitriptyline	100	15.9
- with olanzapine	93	14.8
Total	**630**	**100.0**

These findings appear to be consistent with the circumstances in which people use pregabalin in Victorian coronial matters.

In the Coroners Prevention Unit's experience assisting coroners with investigations into overdose deaths involving prescribed pregabalin, it was very rarely if ever prescribed as a primary treatment for any condition. Instead it was an adjunct to other drugs: for example an adjunct to opioids for

analgesia; an adjunct to benzodiazepines for treating anxiety; or an adjunct to non-benzodiazepine hypnotics for treating insomnia. The pregabalin would interact with these other prescribed drugs to produce fatal central nervous system depression, which is why so many pregabalin-involved overdose deaths were from combined drug toxicity.

Where the pregabalin was not prescribed, it was often used for reasons such as to enhance the effects of heroin and other opioids, and to assist in managing negative effects (the 'comedown') associated with using drugs like methamphetamine, MDMA and cocaine. These uses again implicated other drugs, helping further to explain why pregabalin-involved overdose deaths so often were from combined drug toxicity.

The issue the Coroners Prevention Unit most often encounters when examining pregabalin-involved overdose deaths, is that doctors can be very careful when prescribing medications such as opioids and benzodiazepines, but may not apply the same level of caution when prescribing pregabalin. In some coronial investigations, doctors have been found to increase (double or triple) daily pregabalin doses without any rationale being recorded and without any post-increase monitoring; provide pregabalin scripts upon the patient's request rather than in line with how long each script should last; and provide scripts for 56 pregabalin tablets with five repeats at a time (336 tablets), giving patients effectively unrestricted access to the drug. Doctors prescribing pregabalin without any documented reason is also common; and once a doctor has commenced prescribing pregabalin they very rarely if ever taper and cease the drug.

While adding pregabalin as a monitored (target) drug on SafeScript is an essential step in addressing its harms, there will likely still need to be a substantial education effort directed at doctors to assist them in prescribing pregabalin safely and responsibly.

Attachment A

The following definitions and explanatory notes are included to assist in understanding and interpreting the contents of this report.

Definition of overdose

For purposes of VODR coding, an ‘overdose’ is a death where the expert death investigators (the coroner, forensic pathologist and forensic toxicologist) determined the acute toxic effects of a drug or drugs played a contributory role. This usage is consistent with the definition of a 'drug poisoning death' recommended by the United States Substance Abuse and Mental Health Services Administration (SAMHSA).[5]

Deaths associated with the behavioural effects of drug taking (for example, a fatal motor vehicle collision while affected by drugs and alcohol) or its chronic effects (for example, alcoholic liver disease) are excluded from the VODR. Likewise, deaths resulting from allergic reactions to drugs are excluded, along with deaths caused by injuries during drug administration, and deaths due to medical treatment errors (such as administering the wrong drug to a patient in hospital).

The definition of the term ‘drug’ largely reflects the SAMHSA definition:

> *Any chemical compound that may be used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury; for the relief of pain or suffering; to control or improve any physiologic or pathologic condition; or for the feeling it causes.*

Please note that alcohol is included as a drug in the VODR, whereas it is explicitly excluded under the SAMHSA definition. Cannabis is not included in the VODR, though, because there is debate as to whether cannabis use can lead to fatal toxicity.

Death surveillance

In Victoria, all deaths from suspected non-natural causes, including suspected overdoses, are required to be reported to the Coroners Court of Victoria. When a death is reported, the Court's trained staff review the Police Report of Death for the Coroner and any other available material (for example notes on the electronic case record) and code basic information about the deceased into the Court's Surveillance database. The information includes:

- Name.
- Sex.
- Age.
- Date of birth.
- Address where the deceased usually resided.

---

5 Goldberger BA, Maxwell JC, Campbell A, Wilford BB, "Uniform Standards and Case Definitions for Classifying Opioid-Related Deaths: Recommendations by a SAMHSA Consensus Panel", *Journal of Addictive Diseases*, 2013;32(3): 231-243.

- Address where the fatal incident occurred.
- Evidence of Aboriginal and Torres Strait Islander identity.
- Summary of circumstances as set out in the police report to the coroner.

Additionally, at this initial stage Court staff code information about the deceased's likely intent and the mechanism of death, using a slightly modified version of the ICD-10 Chapter 20 external causes of morbidity and mortality classification system. For example, if a death upon initial report appeared to be an unintentional drug overdose, the intent would be coded as "Unintentional" and the mechanism would be "Poisoning".

The coding of intent and mechanism is reviewed as the coroner's investigation progresses and more is known about what happened in each case (particularly when the cause of death is confirmed and again when the coroner makes their finding). Sometimes the intent and/or mechanism will be changed because of what is learned during the course of the investigation.

Victorian Overdose Deaths Register

While possible and probable overdose deaths may be identified during initial death surveillance, no case is added to the VODR until the forensic medical cause of death has been established. This is because SAMHSA recommends that the formal cause of death must be established before a death can be classified as an overdose.

Trained coders conduct regular searches across the Surveillance database, scanning cases with newly confirmed causes of death and reviewing autopsy reports to establish whether each case meets the definition of an overdose death. Any such death is added to the VODR and further information is recorded about the context in which it occurred. At this stage, the coders record the specific drug or drugs that the expert death investigators identified as playing a contributory role in the death. (Only contributing drugs are coded; any detected drugs that were not found to contribute to the death are set aside.)

Delay between death report and data collation

The requirement for a confirmed forensic medical cause of death means that Victorian overdose deaths data cannot be produced as quickly as some other types of coronial data. In some cases, the forensic pathologist and forensic toxicologist may be able to arrive at a forensic medical cause of death very quickly (within one to two weeks after the death is reported); but in other cases where there are complex circumstances and competing possibilities to assess, they may require several months to formulate the cause of death.

As a rule of thumb, the Court usually releases overdose deaths data with at least a six-month delay or time lag from date of death report, to ensure that most forensic medical causes of death are confirmed and therefore the data is as accurate as possible.

Drug type classification

To aid analysis of the overdose deaths data, the contributing drugs across all Victorian overdose deaths are classified into three main types, being:

- **Pharmaceutical drugs**, defined as drugs that have approved clinical uses and can be accessed through the health system in Australia.

- **Illegal drugs**, defined as drugs that are prohibited from manufacture, sale or possession in Australia.
- **Alcohol.**

While most contributing drugs fit within this classification system, a small number could be both pharmaceutical and illegal. These include:

- **Ketamine**, which is approved for anaesthesia and (less commonly) to manage symptoms of opioid withdrawal and is also imported and sold in illegal drug markets. Ketamine is classified as a pharmaceutical drug because it can be obtained legally in Australia, while recognising that in some cases it was probably not sourced via the health system.
- **Amphetamines**, which are approved for treatment of conditions such as narcolepsy and attention deficit disorders but are also imported and sold in illegal drug markets. These present a substantial classification challenge, and the following approach has been adopted:
    a. An amphetamine that contributed in the absence of methamphetamine detection is classified as a pharmaceutical drug. The reason is, in most cases where the amphetamine source is identified in Victorian overdose deaths, it is a pharmaceutical preparation such as dexamphetamine or lisdexamfetamine.
    b. Methamphetamine is classified as an illegal drug.
    c. Amphetamine detected in the presence of methamphetamine is assumed to be a metabolite of methamphetamine (rather than present in its own right) unless there is positive evidence of separate pharmaceutical amphetamine consumption.
- **Pentobarbitone**, which is approved for sedation and euthanasia of animals in Australia, and is also distributed for assisted dying in Victoria, but is very often found to have been imported illegally in Victorian deaths. Pentobarbitone is classified as a pharmaceutical drug because it can be obtained legally in Australia, while recognising that (like ketamine) the health system is probably not the source in most Victorian overdose deaths.
- **Etizolam**, which is a legal benzodiazepine in some countries but has no approved clinical use (and therefore is illegal) in Australia. Etizolam is classified as an illegal drug for this reason.
- **Cocaine**, which has clinical uses as well as being a major illegal drug imported into Australia. Cocaine is classified as an illegal drug because there are no clear instances in the Victorian overdose deaths data of clinical-sourced cocaine being used.

Changes in reported frequencies over time

The VODR's contents are regularly revised and updated as coronial investigations progress. Through the coroner's investigation, an overdose death initially characterised as unintentional may be reclassified as a suicide; or a death initially thought to be unrelated to drug consumption might be found to be a fatal overdose. The data reported out of the VODR represents the Court's best understanding of the deaths at the time when it was extracted, but data extracted at another time may be different.

Attachment B

Annual number of overdose deaths by local government area of fatal incident, Victoria 2015–2024.

Local government area	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Alpine	1	-	-	1	-	-	-	1	-	-
Ararat	1	-	3	2	2	2	-	1	2	3
Ballarat	1	6	12	7	14	10	10	14	14	6
Banyule	8	12	10	6	15	9	10	10	9	9
Bass Coast	3	6	5	4	7	4	-	4	6	3
Baw Baw	3	4	5	3	3	4	4	4	4	3
Bayside	3	8	6	12	8	14	15	7	7	8
Benalla	1	1	1	-	-	1	-	3	2	-
Boroondara	15	8	8	6	10	11	5	10	4	14
Brimbank	19	15	24	16	22	28	16	29	27	18
Buloke	-	1	1	1	-	-	-	1	1	-
Campaspe	2	4	3	2	3	6	1	4	2	1
Cardinia	3	8	5	5	7	7	13	4	6	6
Casey	15	9	19	10	18	20	14	20	15	16
Central Goldfields	1	2	2	2	1	2	-	1	2	1
Colac Otway	1	2	-	-	-	1	-	3	2	3
Corangamite	1	-	1	2	2	-	1	1	-	1
Darebin	16	18	18	13	14	14	10	18	14	19
East Gippsland	2	4	3	2	6	6	4	2	2	7
Frankston	24	20	17	26	21	17	12	16	16	19
Gannawarra	1	-	-	-	-	-	-	1	1	-
Glen Eira	7	5	12	7	8	9	13	7	13	10
Glenelg	7	2	2	2	1	1	1	-	2	-
Golden Plains	3	1	-	2	-	-	1	-	-	-
Greater Bendigo	13	6	17	13	9	10	12	6	9	11
Greater Dandenong	16	16	19	17	24	19	21	13	25	26
Greater Geelong	13	20	23	25	23	22	23	22	27	35
Greater Shepparton	11	5	3	7	7	7	6	4	6	5
Hepburn	1	-	3	1	-	-	2	4	-	-
Hindmarsh	-	-	-	-	1	-	-	-	-	-
Hobsons Bay	3	5	7	7	6	8	11	13	5	6
Horsham	-	3	1	-	1	1	1	2	2	1
Hume	11	11	10	11	13	8	14	11	13	22
Indigo	1	2	1	1	3	-	-	-	1	-

(Continued over page)

(Continued from previous page)

Local government area	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Kingston	6	5	17	9	8	10	8	11	15	11
Knox	11	7	15	17	16	13	15	7	10	11
Latrobe	4	10	8	12	6	12	11	8	8	18
Loddon	2	1	1	1	-	-	-	2	1	1
Macedon Ranges	1	2	-	3	5	2	2	2	2	2
Manningham	8	4	4	8	4	4	5	2	7	4
Mansfield	-	-	1	1	2	2	-	1	1	2
Maribyrnong	15	6	14	12	10	13	14	22	17	20
Maroondah	10	13	8	7	15	4	14	8	6	13
Melbourne	24	23	25	25	19	26	28	32	27	42
Melton	5	12	9	10	14	13	9	16	7	7
Merri-bek	9	17	13	23	13	11	7	19	17	12
Mildura	4	4	5	7	4	10	1	7	3	6
Mitchell	2	3	3	2	3	4	1	3	4	3
Moira	3	2	4	1	4	1	1	4	2	2
Monash	6	20	9	10	11	16	13	13	8	13
Moonee Valley	3	12	8	8	7	12	9	6	6	9
Moorabool	1	3	2	5	1	2	3	4	1	1
Mornington Peninsula	14	16	12	11	9	13	13	15	10	6
Mount Alexander	-	1	-	3	3	2	2	-	4	1
Moyne	1	1	-	1	-	-	1	2	2	-
Murrindindi	3	1	1	2	2	3	-	2	2	1
Nillumbik	5	4	3	3	3	3	1	5	3	4
Northern Grampians	1	-	-	1	1	1	-	1	-	-
Port Phillip	23	21	23	32	15	24	18	23	20	22
Pyrenees	-	-	1	1	-	-	-	-	-	1
Queenscliffe	-	-	-	-	-	2	-	-	-	-
South Gippsland	2	2	2	1	3	1	1	1	1	1
Southern Grampians	-	1	2	2	1	1	2	1	-	3
Stonnington	7	7	12	10	4	13	14	9	17	12
Strathbogie	2	-	-	-	1	1	1	2	1	-
Surf Coast	-	2	1	3	4	3	-	1	3	-
Swan Hill	1	1	1	1	2	1	1	-	-	1
Towong	-	1	1	2	-	1	-	1	1	-
Wangaratta	1	5	3	4	3	6	-	4	-	2
Warrnambool	3	2	3	4	1	3	1	4	5	6
Wellington	6	2	5	4	2	5	5	6	4	7

(Continued over page)

(Continued from previous page)

Local government area	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
West Wimmera	1	2	-	-	1	1	-	1	2	1
Whitehorse	17	12	16	10	9	9	21	8	14	9
Whittlesea	7	10	8	3	12	12	17	12	8	11
Wodonga	3	4	3	9	1	-	2	-	3	7
Wyndham	10	12	11	11	13	12	15	16	20	20
Yarra	23	27	20	32	25	17	18	21	33	27
Yarra Ranges	9	11	11	17	12	7	7	13	10	9
Yarriambiack	-	-	-	1	-	-	-	1	1	-