IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005181

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Trang Thi Thu Le
Date of birth:	17 September 1995
Date of death:	17 September 2023
Cause of death:	1a: 3,4-methylenedioxy-n-methylamphetamine (MDMA) and ketamine toxicity
Place of death:	The Alfred Hospital Emergency & Trauma Centre 55 Commercial Road Melbourne Victoria 3004
Keywords:	Drug overdose; MDMA toxicity; ketamine toxicity; serotonin toxicity; drug-induced hyperthermia; drug harm reduction; music festival; music event; drug checking; pill testing

INTRODUCTION

1. Trang Thi Thu Le (**Trang**)[1] was 28 years old when she died on 17 September 2023, after attending an electronic dance music (**EDM**) event at John Cain Arena the evening prior on 16 September 2023 **(the event**).

2. Trang grew up in Hai Phong, Vietnam, before moving to Australia with her mother and brother in 2017, when she was 22 years old, in order to live with her mother's new partner. At the time of her death, Trang lived with her family in Braybook and worked at a chicken company in West Footscray. Trang's father stayed in Vietnam.

3. At the time of her death, Trang was in a relationship with a man who she had met at a previous workplace (hereinafter referred to as her '**partner**'). Trang and her partner had been in a relationship for approximately 18 months and had planned to tell their families about the relationship and their intention to get married in April 2024.

4. Trang had no significant medical history, although she had been receiving medical treatment in relation to ongoing leg pain since March 2023. Trang also had no known history of mental health concerns.

5. Trang had a history of occasional recreational drug use.[2] Her partner described that he was aware that Trang would use ecstasy[3] approximately four times a year before attending a nightclub or electronic music event. Trang's partner noted that when she used drugs, this was "*usually only 1 pill*" and that she was presented as "*excited and happy, comfortable and dancing*," with the effects lasting for a period of approximately four hours. To her partner's knowledge, Trang had never become ill in response to using drugs previously.

6. Trang's partner stated that they would typically purchase drugs from a stranger at the event they were attending, noting, "W*hen you go to the festival, somebody would come up to you and ask if you wanted to buy some drugs. 1 pill would cost $100 Australian dollars*."

7. There is limited information available with regard to the details or circumstances of Trang's drug use on the night prior to her death.

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[1] Referred to throughout this finding as 'Trang', unless greater formality is required.
[2] The term 'recreational use' is deployed here in a neutral sense to distinguish it from clinical or therapeutic drug use.
[3] Ecstasy is a common street name for a tablet containing 3,4-methylenedioxy-n-methylamphetamine (**MDMA**).

THE CORONIAL INVESTIGATION

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

9. 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.

10. 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.

11. Victoria Police assigned an officer, Detective Senior Constable Bradley Cable, to be the Coronial Investigator for the investigation of Trang's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. Following a review of the coronial brief, I determined to seek advice from the Coroners Prevention Unit (**CPU**)[4] in order to contextualise Trang's death in relation to other fatal drug overdoses at music events and to assist in identifying potential prevention interventions. I also determined to seek further statements and materials, including from St John Ambulance, Ambulance Victoria (**AV**), Melbourne Park and Olympic Parks Trust (**Melbourne Park**), which manages John Cain Arena, and Harm Reduction Victoria.

13. This finding draws on the totality of the coronial investigation into the death of Trang Thi Thu Le, including evidence contained in the coronial brief, advice provided by the CPU, and additional materials obtained on my behalf by the Court.

[4] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

14. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

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

Circumstances in which the death occurred

Events leading to Trang's collapse

15. On 16 September 2023, Trang returned home from work and got ready to attend an electronic dance music (**EDM**) event featuring DJ MaRLo, a Dutch-born Australian trance DJ, at John Cain Arena. Trang had invited two friends to attend the event to celebrate her birthday the following day.

16. At approximately 8pm, Trang and her two friends met her partner at the stadium and they entered the event together, passing through security and a ticket scan. Security measures at the event included bag searches and use of a screening wand. There was also a secondary search area for individuals to be selected from the crowd and sent for searching. CCTV footage shows Trang and her group entering the venue at approximately 8.19pm.

17. After entering the stadium, the group met up with another friend of Trang who reportedly offered everyone in Trang's group a pill, which her partner understood to be ecstasy. Trang's partner observed that she took one of these pills, while he did not. Her partner stated that he suspected that Trang's friend must have bought the pills from inside the event, as he noted that security was checking everyone thoroughly.

18. Throughout the evening, Trang also reportedly consumed ketamine, although no further details are known as to how this drug was obtained or the quantity or form consumed.[6]

19. After entering the floor of the stadium, Trang and her partner danced together for a period, before her partner went outside to speak with a friend. Upon his return, Trang requested that her partner get her a drink of water. According to her partner, this took "*more than half an*

[5] 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.

[6] This is based on a subsequent disclosure by Trang's partner to treating clinicians that he was aware that Trang had consumed "*1 'Big' MDMA, and 1 x Ketamine.*" However, the St John Ambulance HERT crew noted that this information was elicited whilst the patient was in cardiac arrest, and the clinical workload, difficult environment, and the 'informant's' command of English impaired further exploration at the time.

hour because it was very busy". While Trang's partner was obtaining water, her friend called him and told him that Trang had lost consciousness and was receiving medical treatment.

Medical treatment at John Cain Arena

20. There is limited information available with regard to the events immediately prior to Trang's collapse, as Trang's partner was not present at this time, and no statements have been able to be obtained from any other witness. However, on the basis of the available evidence, it appears that Trang collapsed on the floor of the John Cain arena, some time shortly before 11pm. CCTV footage shows a security staff member carrying Trang into the bar area underneath the raisable seating (**Floor Bar**) at 10.58pm. At this time, Trang was noted as being conscious and breathing and was placed into the recovery position.

21. At 10.59pm, St John Ambulance communications was notified that a female patron located at the Floor Bar was experiencing a possible seizure. The St John Ambulance communications dispatched the closest response crew and a St John Area Commander (**Area Commander**).

22. At approximately 11.02pm, the Area Commander arrived at the location of Trang's collapse and requested a healthcare emergency response crew (**HERT**). The Area Commander reported that Trang was unconscious, fitting and may have suffered a 'drug overdose'. Shortly afterwards, Trang went into cardiac arrest, and responders commenced cardiopulmonary resuscitation (**CPR**). At 11.07pm, the St John HERT crew arrived at Trang's location, and Trang's partner disclosed to them that Trang had consumed "*1 'Big' MDMA, and 1 x Ketamine*."

23. Over the following hour, Trang received medical treatment from multiple teams of medical staff. This included:

    a) The St John Ambulance Medical Assistance Team (**MAT**), which was located on-site and stationed in a designated medical facility located in a cordoned off, low patron-density area on the internal concourse;[7]

[7] A statement provided on behalf of St John Ambulance notes that it is contracted to provide Event Health Services by event organisers within a specified physical area and regularly deploys Medical Assistance Teams to music festivals. St John Ambulance deploys a range of volunteers with diverse scopes of practice. These scopes are defined by nationally approved clinical practice guidelines and, to some extent, by legislation governing the practice of registered health professionals. The baseline skill set of St John Ambulance first responders includes first aid, as well as competency in the administration of limited medications, defibrillation, and oxygen delivery. St John Ambulance volunteers also include Advanced Responders, as well as AHPRA-registered nurses, paramedics, and doctors. Its highest-skilled health professionals comprise MICA paramedics, Critical Care Registered Nurses and Nurse Practitioners, and Consultant Intensive Care Physicians, Anaesthetists, and Emergency Physicians.

b) An Ambulance Victoria (**AV**) mobile intensive care ambulance (**MICA**) and Advanced Life Support (**ALS**) paramedic who were located on-site for the duration of the event, and were positioned within the St John Ambulance MAT;[8]

c) An external AV crew, who arrived approximately 10 minutes after Trang was found collapsed. An external AV crew is required where a patient is required to be transported to hospital.

24. I was greatly assisted in my investigation by a detailed statement from Dr Martin Dutch (**Dr Dutch**), outlining the course of treatment to Trang at John Cain Arena. In summary, the medical staff administered a range of measures over time to try to bring down Trang's core body temperature, which was abnormally elevated. They also repeatedly administered adrenaline to reverse cardiac arrest, and conducted mechanical CPR. They managed to restore Trang's spontaneous circulation at least twice, and in the process moved her from the floor of the stadium to the concourse level.

25. Finally, after a cardiac arrest at 11.43pm, the decision was made not to stop at MAT for further on-scene investigations, but to instead expedite Trang's transfer to hospital. Trang was loaded into an external Ambulance Victoria vehicle at 11.49pm, which subsequently departed John Cain Arena for the Alfred Hospital. Treatment continued during transport, including the administration of a further 2mg adrenaline.

Medical treatment at the Alfred Hospital

26. Trang arrived at the Alfred Emergency and Trauma Centre at 12.06am on 17 September 2023. On arrival, CPR was in progress with a Corpuls (mechanical CPR device) and a laryngeal mask airway (**LMA**) *in situ*. Trang remained in asystole.

27. During her medical reception in the Emergency and Trauma Centre, Trang received interventions and investigations as follows:

[8] State Medical Officer for St John Ambulance Victoria – Event Health Services, Dr Martin Dutch (**Dr Dutch**) explained that where St John Ambulance provide an onsite Medical Assistance Team (**MAT**), the role of Ambulance Victoria shifts from providing direct clinical care to organising external resources for patient transport to the hospital. Legislation prohibits St John Ambulance from transporting emergency patients directly to the hospital. In order for emergency patients to be lawfully transported, Ambulance Victoria must assume responsibility for the transport. Ambulance Victoria typically assigns a liaison officer within the MAT to facilitate early notification regarding the need for external ambulance resources. This process was followed at the MaRLo event. In disaster situations, the senior Ambulance Victoria paramedic assumes the role of Health Commander, an official position outlined in the state health response plan. Outside of disaster situations where an absolute command structure is in place, interactions between Ambulance Victoria and St John Ambulance should be collaborative.

a) Intubated with 7.5 endotracheal tube (**ETT**);

b) Two further 1mg doses of adrenaline intravenously;

c) Two 10ml doses of 8.4% Sodium Bicarbonate intravenously;

d) 1L cold 0.9% sodium chloride intravenously;

e) Chest X-ray confirming position of ETT and demonstrating consolidation of the left lung likely due to aspiration;

f) Bedside Ultrasound demonstrating no pericardial effusion and no organised cardiac activity; and

g) Arterial blood gas demonstrating severe mixed metabolic and respiratory acidosis with marked hyperkalaemia, lactataemia and profound hypoglycaemia.

28. Trang was also considered by Intensive Care Consultants for initiation of Extra-Corporeal Membrane Oxygenation, however it was determined that such an attempt would be futile.

29. Trang was declared deceased at 12.20am on 17 September 2024.

Identity of the deceased

30. On 17 September 2023, Trang Thi Thu Le, born 17 September 1995, was visually identified by her mother.

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

Medical cause of death

32. On 22 September 2023, Forensic Pathologist Dr Chong Zhou (**Dr Zhou**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and reviewed relevant materials, including results of toxicological testing, a post mortem computed tomography (**CT**) scan, the Victoria Police Report of Death (**Form 83**) and the e-Medical Deposition form. Dr Zhou provided a written report of her findings dated 28 March 2024.

33. Toxicological analysis of post mortem samples showed the presence of 3,4-Methylenedioxy-N-Methylamphetamine (**MDMA**), ketamine, and midazolam within blood.[9]

34. Dr Zhou commented that the detected level of MDMA was within the reportedly toxic or fatal range. In this respect, Dr Zhou explained that MDMA is a synthetic sympathomimetic compound with mixed stimulant, psychotropic, and hallucinogenic effects. The stimulatory effects of MDMA on the cardiovascular system include increased heart rate, force of contraction, and blood pressure. At high doses, during exertion, or in times stress, the heart may develop a cardiac arrhythmia (abnormal heart rhythm) which may be life-threatening. Seizures are also possible in the setting of overdose. In the brain, MDMA can lead to disruption of the thermo-regulatory centres responsible for the maintenance of body temperature. In some cases, usually associated with excessive physical exertion, this can lead to hyperthermia and death.

35. In relation to the identification of ketamine, Dr Zhou explained that ketamine is a dissociative anaesthetic that is normally used for short and medium duration operations as an induction agent. It has been known to be used illicitly for its hallucinogenic effects. Ketamine use and intoxication affects both the central nervous system and cardiovascular system and may cause altered mental status, sedation, impaired consciousness, hypertension, and tachycardia. More serious adverse effects include central nervous system depression, seizures, and cardiac arrhythmias (abnormal heart rhythms).

36. Dr Zhou noted that the autopsy did not identify any significant natural disease or any injuries which may have caused or contributed to death. Further, vitreous humour biochemistry showed no significant electrolyte abnormality within the limits of interpreting post-mortem samples.

37. In this context, and taking into account all available information, Dr Zhou provided an opinion that the medical cause of death was: *1(a) 3,4-Methylenedioxy-N-Methylamphetamine (MDMA) and ketamine toxicity.*

38. I accept Dr Zhou's opinion.

[9] Ambulance Victoria records and medical records from Alfred Health indicate that midazolam, but not ketamine, was administered by medical staff.

CPU REVIEW – FATAL OVERDOSES AT MUSIC EVENTS

39. Taking into account the circumstances of Trang's death, I determined to seek advice from the Coroners Prevention Unit (**CPU**) in order to contextualise Trang's death in relation to other fatal drug overdoses at music events and to assist in identifying any potential prevention opportunities.

40. The review was performed by the Research and Policy Team of the CPU and included a detailed analysis of available materials in light of relevant data and research. The review did not include any clinical review of the medical treatment provided.

41. Taking into account advice obtained by the CPU, I also determined to obtain additional materials including:

    a) Statement of State Medical Officer for St John Ambulance Victoria, Dr Martin Dutch (**Dr Dutch**) dated 19 May 2025;

    b) Statement of AV Director of Emergency Management Dale Armstrong (**Mr Armstrong**) dated 19 September 2025;

    c) Statement of Melbourne Park Chief Executive Officer, John Harnden (**Mr Harnden**) dated 3 June 2025; and

    d) Statement of Chief Executive Officer of Harm Reduction Victoria, Sione Crawford (**Mr Crawford**) dated 30 May 2025.

42. The CPU considered these statements and provided advice in relation to a number of possible prevention opportunities, as discussed further below.

Fatal overdoses at music events

43. In order to quantify the numbers of relevant fatal overdoses occurring at music events, the CPU performed a search of the Court surveillance database and the National Coronial Information System (**NCIS**) to identify relevant cases.[10]

[10] A death was considered relevant if it met the following inclusion criteria: (a) the death was reported to the CCOV between 1 January 2000 and 31 December 2024; (b) The Forensic Pathologist, Toxicologist, and/or Coroner established that the acute toxic effects of one or more drugs played a contributory role in the death (these deaths are colloquially referred to as 'overdose deaths'); (c) The deceased consumed the drugs that contributed to the fatal overdose at a music event in Victoria. In an effort to identify all relevant deaths, the CPU utilised multiple overlapping keyword searches

44. In total, the CPU identified 18 Victorian deaths (including that of Trang Thi Thu Le) between 1 January 2000 and 31 December 2024 where the death either definitely, or likely, resulted from drug consumption at a music event.[11]

45. Through review of these 18 cases, the CPU identified trends including that:

    a) The deceased were typically young adults, with an average age of 26 years;

    b) In 15 of the 18 deaths, MDMA was a contributing drug; and

    c) The cases could be categorised as falling into three main scenarios:

        i. People who attended multi-day festivals, used drugs, and were found by friends in their tents either deceased or experiencing an adverse drug reaction;

        ii. People who attended music events, experienced adverse events after using drugs, their friends took them home and they died after leaving the venue; and

        iii. People who attended music events, experienced adverse events after using drugs, collapsed with loss of consciousness, event staff were alerted, and first aid and ambulance responders were ultimately unable to revive them.

    d) Of the above three scenarios, the CPU noted that the third scenario – which describes Trang's death – was by far the most prevalent, accounting for 10 of the 18 deaths. In all 10 of these deaths the deceased had used MDMA, and in most deaths the forensic pathologists mentioned MDMA-induced hyperthermia and/or serotonin syndrome as being causal.

Drug harm reduction in music event settings

46. The CPU noted that Trang's night out at the MaRLo event should be understood within a broader cultural practice of members of the community using drugs while in attendance at EDM events, most commonly MDMA and/or other stimulants and psychedelics.

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across both the NCIS and surveillance databases but acknowledged it could not be certain that all relevant deaths were identified.

[11] The CPU defined a music event as an event at which one or more musical artists perform live, at a location that is temporarily set up for the performance. We excluded music performances at licensed venues such as bars and clubs and pubs from this definition, because these locations operate on a permanent or semi-permanent (rather than temporary) basis.

47. Australian and international research has explored extensively the nexus between EDM events and drug use, including the types of high-risk drug use that are particularly prevalent at these events. A common thread throughout research is that countermeasures designed exclusively to prevent people using drugs (for example police, security guards, bag searches, sniffer dogs, higher penalties for drug possession) have no positive impact on drug use or related harms, and in some cases can actually lead to riskier drug use and greater drug harms. Instead, the current approach draws upon harm reduction principles.

48. According to the Harm Reduction International definition:

> *Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws. […] It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support.*

49. Harm reduction is underpinned by a recognition that people use psychoactive drugs for a range of reasons and will commence and continue drug use despite any efforts (legal, medical or otherwise) to prevent them from doing so. Accepting this, harm reduction approaches focus on identifying the specific risks and harms that are associated with different types of drug use, and strategies that can be used to mitigate these harms when drug use occurs.

50. Harm reduction principles have informed Victorian coroners' examination of a range of public health issues relating to drug use, including their recommendations calling for supervised injecting and drug checking (also known as 'pill testing') – both of which are 'classic' drug harm reduction interventions.

51. The CPU opined that harm reduction is the most appropriate lens through which to approach the question of preventing future deaths in circumstances similar to that of Trang – posing the question: accepting that a group of people in our society will attend EDM events and use MDMA and other drugs, what can we do to mitigate harm to them when this occurs?

52. The CPU noted that a substantial number of studies have been published addressing drug harm reduction at music festivals. These studies were recently summarised in a 2024 systematic review that looked at the evidence for whether a range of interventions can reduce alcohol and other drug harms in licensed entertainment settings and outdoor music festivals (**the 2024**

systematic review).[12] Most of the evidence reviewed was relevant only to alcohol use in licensed entertainment settings, however some findings of relevance to music festivals were reported:

a) Drug checking or pill testing services at outdoor music festivals were found to be associated with people using reduced dose sizes of drugs and being more likely to dispose of potentially dangerous drugs; and

b) Drug detection dogs at outdoor music festivals were found to lead to increased risky consumption of drugs; and

c) Availability of medical services on-site at outdoor music festivals was found to be associated with a significant reduction in ambulance transfer rates from festivals to hospitals for alcohol and drug related reasons.

53. The most recent relevant Australia-specific study published in 2024 examined drug-related deaths at concerts and music festivals around the country between 2000 and 2019.[13] The researchers identified 64 such deaths, and similarly to the CPU's analysis of Victorian deaths, found that most deaths were of younger people and involved MDMA in combination with other drugs.

54. The researchers drew particular attention to drug checking as an important harm reduction intervention in festival settings, not only because it can identify potentially harmful substances before they are taken, but also because it provides opportunities to deliver education. The researchers also noted that other factors such as the festival environment (crowding, temperature, access to water) may have an impact on risk of drug-related harms at festivals.

Possible opportunities for prevention

55. Adopting a harm reduction lens, the CPU identified four areas for the investigation of Trang's death which presented potential death prevention opportunities, as follows:

a) Improved guidance for medical responses to drug-induced hyperthermia;

[12] Eassey C et al, "A systematic review of interventions that impact alcohol and other drug-related harms in licensed entertainment settings and outdoor music festivals", *Harm Reduction Journal*, 21, 2024, a.47.
[13] Santamarina R et al, "Drug-related deaths at Australian music festivals", *International Journal of Drug Policy*, 123, 2024, 104274.

b) Venue-specific features of John Cain Arena, including access to water and ease of access for treating clinicians;

c) Access to drug checking services; and

d) Improved guidance for drug harm reduction at music events.

56. The CPU's advice in relation to each issue is outlined below. In summary, the CPU concluded that there were few opportunities for prevention in relation to issues (a) and (b) above, but that drug checking and improved guidance for music event organisers both represented potential avenues for preventing further deaths in circumstances similar to that of Trang.

Medical responses to drug-induced hyperthermia

57. The CPU considered whether there may be any opportunities to improve responses to drug-induced hyperthermia through improved guidance for clinicians. In considering this issue, the CPU adopted a policy perspective, rather than a clinical lens.

58. In considering this issue, the CPU had regard to:

a) Existing clinical guidance materials;

b) The statement of Dr Dutch of St John Ambulance Victoria; and

c) The statement of Mr Armstrong of AV.

59. In surveying existing clinical guidance materials, the CPU identified only one publicly available guideline in relation to the treatment of hyperthermia in a festival setting where drugs may have been consumed,[14] being the NSW Health "*Pre-hospital guideline: Illicit substance-induced hyperthermia*" (**NSW Guideline**).[15] The NSW Guideline was first published in 2019 and most recently updated in August 2024.

[14] The CPU noted that hyperthermia is a well-documented symptom of serotonin toxicity. In particular, a 2021 study found that the majority of patrons at Victorian music festivals who experienced stimulant drug-induced serotonin toxicity and/or hyperthermia had consumed MDMA, noting MDMA use can lead to serotonin toxicity, and hyperthermia is a symptom of serotonin toxicity: Miles LF et al, "Characteristics, presentation and outcomes of music festival patrons with stimulant drug-induced serotonin toxicity", *Emergency Medicine Australasia*, 33(6), 2021, pp.992-1000.

[15] NSW Health, "Pre-hospital guideline: Illicit substance-induced hyperthermia", updated August 2024, accessed via <https://www.health.nsw.gov.au/aod/Pages/illicit-substance-induced-hyperthermia.aspx>, accessed 1 April 2025.

60. The CPU noted there did not appear to be any equivalent guidelines available in Victoria, and so queried whether there may be an opportunity for Victoria to adopt a similar model. This issue was addressed in the statements of Dr Dutch and Mr Armstrong.

61. Dr Dutch indicated that he did not consider that Victoria should adopt the NSW Guidelines.

62. In this respect, Dr Dutch explained that St John Ambulance staff already have access to relevant guidance regarding the treatment of substance-induced hyperthermia, noting in particular that St John Ambulance Victoria has internally developed an optimised Serotonergic Cardiac Arrest Protocol which has been reviewed and endorsed by an external toxicologist. St John Ambulance is also in the process of drafting two protocols to guide the clinical response to substance-inducted hyperthermia, including a non-cardiac arrest and cardiac arrest protocols. Dr Dutch noted that these have been based on a systematic literature review and will be subject to scientific publication and peer review.

63. Further, Dr Dutch noted that his personal perspective was that the NSW guidelines had "*significant limitations"*.[16] While a full analysis of the NSW guidelines is beyond the scope of my investigation, I note broadly that Dr Dutch highlighted concerns regarding use of outdated terminology, the omission of critical diagnostic criteria, the omission of guidelines in relation to key areas of treatment, and the inclusion of guidelines which Dr Dutch considered did not reflect best practice. While taking no position on this issue, I have determined to provide a copy of my finding to NSW Health for its consideration.

64. In considering the medical response provided to Trang, as informed by existing guidelines, Dr Dutch opined that clinicians had provided an appropriate response. Specifically, clinicians had appropriately identified that there was a high likelihood that Trang was suffering a cardiac arrest secondary to MDMA or amphetamine use,[17] and had tailored intra-arrest management to respond to this underlying etiology. This included through:

    a) An acknowledgement that return of circulation would likely be difficult to achieve (hence the pre-event planning of the mechanical chest compression device);

[16] Dr Dutch noted that St John Ambulance Victoria's Clinical Governance Committee is yet to determine its formal opinion on the 2024 NSW Guidelines

[17] In addition to Trang's partner having disclosed her drug use, Dr Dutch noted that Trang's presentation was likely sufficient to independently alert clinicians to the high likelihood that she was suffering a cardiac arrest secondary to MDMA or amphetamine use. Clinical signs suggestive of this diagnosis included the location being an Electronic Dance Music Event, the initial presentation of "seizure", abnormally elevated end-tidal CO2 measurements, intra-arrest hyperthermia and intra-arrest hypoglycaemia.

b) The early request for an advanced airway practitioner (anaesthetist) as the management of ventilation is especially challenging in serotonergic arrest;

c) The intra-arrest bolusing of cold intravenous fluid, designed to acutely lower core body temperature;

d) The placement of refrigerated drink bottles to axilla and groin to cool the patient; and

e) The pre-planned aim to 'push' for primary transfer to the MAT where additional time-critical interventions could be instituted.

65. Dr Dutch did not identify any opportunities for improvement or clinical guidance in regard to the medical response provided.

66. In considering these issues, Mr Armstrong of AV also expressed a view that the treatment provided to Trang would not have been improved through further clinical guidance.[18] In this regard, Mr Armstrong noted that AV's response was guided by a number of Clinical Practice Guidelines, including 'Drug Induced Hyperthermia – Clinical Practice Guideline A0719'. Mr Armstrong considered that this guideline is "*not dissimilar*" to the NSW Guideline, such that, "*had Trang been managed under the NSW guideline, the management would have been very similar to the care delivered by AV*."

67. In this context, whereby neither St John Ambulance nor AV were supportive of the implementation of new guidelines in Victoria as available in NSW, the CPU did not identify any relevant opportunities for improvement.

68. The CPU also noted the views of Dr Dutch that prevention opportunities are more usefully focused on earlier points of intervention. This is because, according to Dr Dutch, the evidence suggests that by the time a patient reaches hyperthermic serotonergic cardiac arrest, the prospects for preventing death are poor. Prevention opportunities are better focused, therefore, on intervening before a patient reaches that point. Dr Dutch reflected:

> *One important question to consider is whether hyperthermic serotonergic cardiac arrest is a survivable condition. I'm not sure that it is. Nevertheless, we try—very hard.*

[18] While these conclusions are evidently drawn by those whose organisations provided the emergency response in this case, I note for completeness that no issues were otherwise identified in relation to the medical response to Trang's collapse, and that there was no indication for an independent expert opinion to assess the same.

We have occasionally succeeded in restoring circulation in the prehospital setting. However, nearly all of those patients have subsequently died from multi-organ failure in intensive care.

...

In my 20 years of practice, I have only had one patient survive an out-of-hospital serotonergic cardiac arrest. Tragically, I later learned that he died after a subsequent drug overdose.

We appear to be more successful at preventing disaster if we can intervene before the patient arrests. Our mortality rates in these cases are significantly lower than those reported in the literature.

69. With such comments in mind, the CPU sought to explore a number of early points for intervention in Trang's journey, which may have prevented her from reaching cardiac arrest.

Venue-specific features of John Cain Arena

70. The CPU considered whether there were any features related to the venue of John Cain Arena which may have presented an opportunity for prevention, including improved access to water or access for clinicians in providing a medical response.

71. In considering this issue, the CPU had regard to materials included in the Coronial Brief as well as the following additional materials obtained:

    a) The statement of CEO of Harm Reduction Victoria, Mr Crawford; and

    b) The statement of Melbourne Park Chief Executive Officer, Mr Harnden.

72. As a preliminary issue, the CPU noted comments from Mr Harnden that Melbourne Park did not intend to host any further events of this nature, stating:

    The death of a patron is a tragic event for all who are involved, and this incident was distressing for patrons, Melbourne Park staff and first responders on the night. Despite the extensive risk mitigation measures put in place by Melbourne Park for the MaRLo event, the innate risks involved with this format of event are such that Melbourne Park has determined not to host these events in the future.

73. Despite this, Mr Harnden commented that learnings from the circumstances of Trang's death will inform future Melbourne Park event planning, in areas such as medical staff access points, protection of safety aisles and fire safety lanes, and the alignment of event briefing information with event plans.

74. The CPU also provided specific advice in relation to concerns raised regarding access to water and access for treating clinicians responding in responding to a medical emergency, as discussed below.

Access to water

75. The CPU considered whether there may have been any opportunity to reduce drug-related harms by improving access to water at the MaRLo event held at John Cain Arena.

76. Noting that dehydration presents particular risks to the health of people using MDMA, the CPU was concerned by the account of Trang's partner which stated that it had taken him more than half an hour in order to fetch water for Trang, immediately before her collapse. This is a concern reflected in the 2024 systematic review, which listed promotion of water hydration as a relevant intervention in licensed entertainment settings and outdoor music festivals.

77. In line with Trang's partner's reported experience, Harm Reduction Victoria stated that DanceWize volunteers[19] had observed issues with accessing water at the event, noting perceptions that:

    a) Water bottles were banned inside the venue;

    b) It was a 30-45min wait to get in and out of the arena to access the water stations (or use the toilet, get food, see first aid, etc); and

    c) There were access issues for DanceWize volunteers to enter the arena, and for patrons to access support services which were predominantly located outside the arena, as a result of significant bottle-neck issues at the entrance and exits.

[19] DanceWize is a peer-based alcohol and other drugs (**AOD**) harm reduction program operated by Harm Reduction Victoria since 1999 and is a Victorian Department of Health funded health promotion charity. Its purpose is to deliver peer care and support services for music events and festivals across Victoria. Mr Crawford noted that in this instance, DanceWize was contracted and attended the MaRLo event partly on a fee-for-service basis, which provided for 20 volunteers and no paid staff. Further information about DanceWize is available on the Harm Reduction Victoria website here.

78. However, Mr Harnden of Melbourne Park provided a contrasting account of the event. Mr Harnden stated that free water was available at a number of locations throughout the venue, including water bubblers on either side of the stage in the main arena and free water outlets in and around the main arena. An illustrating map was provided to the Court.

79. In addition, Mr Harnden outlined that Melbourne Park took extensive measures to ensure water accessibility for patrons, including:

    a) CCTV monitoring of queues at bar and food outlets, so staff balance at outlets could be changed and/or patrons could be redirected to less busy outlets;

    b) Regular checking and refilling of water bubblers;

    c) Dancewize staff circulating in the event and distributing water to patrons as required;

    d) Adequate water supply;

    e) Staff training that included staff awareness of the obligation to provide free water to patrons, and basic first aid training in addressing hydration-related concerns;

    f) Staff being present throughout the event to direct patrons to water and restrooms and first aid assistance;

    g) Public announcements at the event about staying hydrated and where water fountains were located;

    h) Large prominent signs directing patrons to water stations; and

    i) Pre-event information emailed to all patrons, which included specific information about the risk of high temperatures and strenuous dancing and the need to keep hydrated.

80. In response to specific concerns that there may have been substantial wait times for water, Mr Harnden stated that he did not observe or receive notification of any issues for patrons accessing water during the MaRLo event, noting that:

    a) No significant lines or queues were observed via live CCTV monitoring of food vendors, bars, water fountains or water bubblers throughout the event;

b) Melbourne Park's Venue Control Centre (**VCC**) staff received calls for water bubblers to be refilled and deployed floor staff to do so. VCC staff did not receive any notification that there was any delay in refilling bubblers, difficulty sourcing refills or water bubblers that were out of order; and

c) Apart from concerns raised by DanceWize in relation to the closure of the Floor Bar while Trang received treatment at this location, Melbourne Park was not otherwise made aware of any issues with the provision of water on the night, including from patrons, venue staff, or vendors, did not receive any reports or complaints that patrons would have needed to wait more than half an hour to access water.

81. In a further letter to the Court dated 13 January 2026, Mr Harnden rejected that there was a perception that water bottles were banned in the venue, emphasising that: (i) water bottles were not banned, but rather patrons were required to remove the lid of any personal water bottles upon entry and tip out the contents prior to entry; (ii) drinks sold in the venue were provided with lids removed, and free cups of water were provided in accordance with RSA requirements; (iii) there was a plumbed mobile water station at the event from which water bottles could be refilled; and (iv) the only receptacles that were banned were glass and aluminium bottles as well as plastic bottles over 600mL, due to safety issues (including the risk of injury if these were thrown around or broken). Mr Harnden also rejected that water or first aid accessibility was an issue at the venue.[20]

82. The CPU noted that it was difficult to reconcile these two, competing accounts.

83. Overall, while the CPU considered that the observations from DanceWize volunteers were concerning, it concluded that the measures identified by Melbourne Park were appropriate if implemented as described and so did not identify any further opportunities for prevention. I will address this further below.

<u>Ease of access for treating clinicians</u>

84. The CPU considered whether there may have been any opportunity to improve access for treating clinicians in responding to a patron experiencing a drug-related medical episode.

[20] In the letter of 13 January 2026, Mr Harnden noted further that patrons were able to access a water bubbler from each side of the stage, and under the raisable space, or obtain free water from the floor bar, without needing to leave the arena floor. Mr Harnden noted that water was regularly replenished throughout the course of the event. He further noted that first aid was available on the floor from the South Arena Floor first aid post, and from the roving Arena Floor Response Team. Mr Harnden emphasised that patrons did not have to leave the floor to access water or first aid.

85. This issue was raised on the basis of accounts from treating clinicians that they experienced difficulties both in accessing the location of Trang's initial collapse on the arena floor, and subsequently in transferring Trang from the floor of the stadium to the MAT:

a) In relation to accessing the location of Trang's collapse, one clinician recorded that "*access to the patient from the MAT [Medical Assistance Team] location to their position at the floor bar was incredibly challenging due to number of patrons present*" and "*the heavily crowded area*".

b) In a statement dated 3 June 2025, Mr Harnden noted that in the post-event debriefing, some staff noted challenges with access to the floor, stating that, "*The MaRLo event was sold out with 7,303 patrons attending on the night and moving between the arena floor, the raised seating areas and the venue concourse. Movement though this crowd while the event was in progress would have been challenging and as noted in the post-event debrief stage … MSS Security assisted Ambulance Victoria to access Trang in the quickest way possible*."

c) In relation to transferring Trang from the floor of the stadium to the MAT, Victorian Ambulance records recorded, "*Extrication difficult due to distance to travel through back of house area*".

d) The formal external debrief also noted, "*Significant challenges encountered in the moving of patient from floor to eastern side of venue to MAT. No clear path of travel that ensured complete privacy for patient and medical crews. Location of the MAT is important, particularly in a venue such as JCA [John Cain Arena] which is difficult to navigate – Requires significant review*."

86. Upon reviewing the statements of Dr Dutch and Mr Armstrong, the CPU noted that neither St John Ambulance Victoria nor AV had identified any significant concerns with regard to access that may have affected the medical treatment provided. Mr Armstrong stated, "*It appears that the location of the incident and the inherently chaotic nature of a festival environment contributed to the complexity of this event, however AV does not believe that additional or alternative steps would have altered the response to Trang's collapse*."

87. Mr Harnden of Melbourne Park also provided relevant context, explaining that, "*The route ultimately selected was longer in length than taking Trang through the crowded concourse. However, avoiding congested areas, providing space to the clinicians to properly treat Trang,*

maintaining Trang's privacy and dignity, and the confronting nature of shocks being administered to her in view of members of the public or event staff, were key considerations in choosing the route taken to the MAT."

88. In addition, the CPU noted that the formal external debrief recognised possible future risk mitigation strategies for moving patients from the floor to the MAT, including "*consideration of pre event walk throughs and scenario discussions to establish clear processes for patient movement from [General Admissions] floor to [medical] areas for all future events recommended*."

89. Overall, taking into account the views of St John Ambulance Victoria and AV that issues of access did not affect the care provided to Trang, the CPU did not identify any further opportunities for prevention in this regard.

Access to a drug checking service

90. The CPU identified that a key opportunity which may have prevented Trang's death was improved access to drug checking (also known as '*pill testing*') services, including the presence of a drug checking service on-site at the MaRLo music event. In considering this issue, the CPU had regard to past coronial findings and recent policy developments in this space.

91. The CPU noted that, although it is speculative whether the presence of a drug checking service at the MaRLo music event *would* have saved Trang's life, such a service would have at least created opportunities to reduce the risk of a fatal outcome. For example, if Trang (or a friend) had arranged to test their substances before use, and depending on the type of drug testing equipment at the event, they may have been able to learn the dose strength of those substances consumed, including ecstasy and ketamine, so as to make more informed decisions about how to minimise risks when taking them.

92. More generally, drug checking services provide an opportunity for a 'brief intervention' in the form of a discussion with a qualified drug harm reduction advisor, who can educate the person intending on using drugs on how to recognise potential adverse events, how to respond, as well as when and where to seek help. Equipped with this knowledge, Trang and/or her friends may have acted earlier when Trang began experiencing adverse effects from the substances that she had consumed.

93. In this context, I consider that the Victorian Pill Testing Service,[21] which is currently being trialled and recently commenced its fixed site phase, is a crucial drug harm reduction initiative.

94. The Victorian Pill Testing Service provides a free, confidential and anonymous drug checking service, which aims to detect life-threatening substances and reduce potential harms by giving people the information they need to make safer and informed decisions. It follows numerous coronial recommendations made in Victoria regarding the need for implementation of a drug-checking service in this state as a critical harm reduction measure, including in the face of dangerous, potent and potentially fatal substances such as nitazenes being 'passed off' as other drugs such as heroin, ketamine, oxycodone or similar.

95. Building on the recommendations made by my fellow Coroners, on 13 March 2024, I delivered the finding into the death of Mr SL (which involved the unknowing ingestion of a nitazene),[22] in which I recommended the trial of a drug checking service in the State of Victoria to gather evidence, experience and insights into how drug checking might reduce risks (including preventable deaths) associated with the use of drugs obtained from unregulated drug markets. My colleague Coroner Simon McGregor made similar recommendations in his finding into the death of Mr KM, which he delivered on the same day.[23]

96. In response to this body of coronial findings and recommendations, as well as sustained advocacy from drug harm reduction organisations, addiction medicine and public health experts among others, the Victorian Department of Health subsequently announced a drug checking trial was to be established in Victoria, with the *Drugs, Poisons and Controlled Substances Amendment (Pill Testing) Act 2024* (Vic) providing the legal framework.

97. The first stage of the trial has recently been completed, which involved a mobile service attending five music festivals and events across Victoria between 1 January 2025 and 25 April 2025. The next stage of the trial, a fixed-site service in Fitzroy called the Victorian Pill Testing Service, commenced in August 2025. The service is described on the Department's website as follows:

> *At the pill testing service, people are asked to provide a small sample of their drugs. This is usually a tiny scraping of a pill or a bit of powder that a chemist will analyse.*

[21] Previously known as Victoria's Drug Checking Service.
[22] Finding into the death without Inquest of Mr SL, 13 March 2024, COR 2022 006970, available here.
[23] Finding into death without Inquest of Mr KM, 13 March 2024, COR 2023 002206, available here.

The drug checking technology at services can test the make-up of most pills, capsules, powders, crystals, or liquids and identify substances such as dangerous synthetic opioids, like fentanyl and nitazenes. A harm reduction worker provides the test results and offers tailored advice. This includes information about potential risks and how the drug may interact with prescription medications and existing health conditions. For many, this will be the first time they've had a chance to talk openly with a health professional about drug use in a private, judgement-free space.[24]

98. As outlined on the website, there is data to support the effectiveness of drug checking as a method of reducing harms from illicit drugs. For example, a 2023 evaluation of the Australian Capital Territory drug checking service, CanTEST, revealed only 53% of substances tested matched the expected drug. For those where an additional drug, a different drug or an inconclusive result was found, one-third reported that they *'definitely will not'* use the drug.

99. I note that the initial experience of delivering the mobile drug checking trial across Victorian music events also appears to be very positive from a drug harm reduction perspective. In particular, for 65% of service users, it was the first time they had ever spoken to a health professional about drug and alcohol safety. More than 30% said they would take a smaller amount after having a conversation with the harm reduction worker. Two statewide drug advisories were also issued to the public following the detection of highly potent and unexpected substances with unpredictable effects.

100. In this context, I am optimistic that the Victorian Pill Testing Service will support Victorians to make more informed and safer choices about using drugs from the unregulated drug market – whether in pill form or otherwise – which may in turn to lead to a reduction in the number of preventable deaths.

101. Noting that initial evaluations indicate positive results as emerging from the mobile drug checking trial across music events, the CPU did not identify any further opportunities for prevention. However, I encourage the Victorian Department of Health to continue its efforts in ensuring such services are available to young people attending EDM events, who may be at a higher risk of experiencing drug-related harms.

[24] https://www.health.vic.gov.au/alcohol-and-drugs/pill-testing - accessed 15 August 2025.

Improved guidelines for drug harm reduction at music events

102. The final issue considered by the CPU was whether Victorian music event organisers might benefit from improved guidance as to how best to implement drug harm reduction principles effectively in the context of music events.

103. In considering this issue, the CPU had regard to:

    a) The statement of Mr Crawford of Harm Reduction Victoria; and

    b) Existing guidelines for music event organisers in NSW and Victoria.

104. The CPU noted that Harm Reduction Victoria provided helpful commentary by highlighting that government has a key responsibility in providing an overarching harm reduction framework in order to assist music event organisers to have greater clarity on steps required to implement harm reduction principles.

105. In emphasising the need for an improved framework in this space, Harm Reduction Victoria highlighted its perception of the disparity between the stated intentions of the MaRLo event organisers' during pre-event briefings which were reportedly to support a "*drug harm minimisation approach*," and the approach implemented on the day which was reportedly focused on police and security. According to Harm Reduction Victoria, this evidenced a "*poor understanding of harm reduction needs*" among music event organisers.

106. In particular, Harm Reduction Victoria outlined several perceived "*deficiencies*" in relation to the way that harm reduction principles had been implemented at the MaRLo event, while noting that this event was "*hardly an outlier*" – suggesting that such practices are common across similar music events. These included:

    a) Regular 'toilet checks' by event staff to look for signs of drug use in toilets (including by male staff inspecting female occupied toilets);

    b) Extensive list of prohibited items that included basic Harm Reduction supplies such as water, chewing gum and sunscreen. DanceWize was also restricted from providing certain items to patrons;

    c) Security staff performing 'random pat down' searches of attendees;

d) *Designated and signed 'strip search' areas, and event messaging that strongly suggested patrons would be strip searched despite VicPol indicating they would not be providing a dedicated presence onsite;*

e) *Reported instances of event staff and medical violently escalating and restraining intoxicated individuals who did not show any signs of aggression;*

f) *Event organisers directing security and staff that they needed to lock and secure prescriptions and that security should search people for prescriptions. Harm Reduction Victoria noted that both St Johns and Security refused multiple times on the basis that this is inconsistent with Victorian regulations & the Chief Health Officer's advice in regards to prescription medication at events.*[25]

107. Harm Reduction Victoria raised concerns that such practices may create "*a sense of mistrust & fear surrounding the event*" which "*may have led to patrons dangerously pre-loading MDMA before attending the event*."

108. In correspondence to the Court dated 13 January 2026, Mr Harnden, CEO of Melbourne Park, noted his appreciation of the assistance of DanceWize volunteers at the MaRLo event. However, he respectfully rejected the anecdotal perceptions of the night put forward by Harm Reduction Victoria. He noted that such comments were not raised with Melbourne Park during he event or at any subsequent time, including during stakeholder debriefs attended by Harm Reduction Victoria, and countered each of the assertions put forward.[26]

109. In the circumstances of Trang's death, I did not consider that it was possible to extend the scope of my investigations so as to make findings on those particular security measures adopted at the MaRLo event, including any "*deficiencies*" as alleged by Harm Reduction Victoria and summarised above, noting the limited information that was possible to source in relation to Trang's experience that night and the nature of the drugs sourced inside the event.

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[25] While Harm Reduction Victoria did not set out the specific regulations or advice it was referring to, I note that Safer Care Victoria has produced position paper titled, 'Medicines at public events', which includes advice from then-Chief Health Officer Dr Brett Sutton, available here: https://www.safercare.vic.gov.au/sites/default/files/2020-01/Position%20Paper%20Medicines%20at%20public%20events.PDF.

[26] In his letter of 13 January 2026, Mr Harnden emphasised, *inter alia*, that: (i) Melbourne Park policy stipulates that toilet checks of female toilets are to be undertaken by female staff; (ii) the only items that were restricted to be provided to patrons were those that were not permitted pursuant to the conditions of entry (such as chewing gum, which is a well-known conduit of prohibited substances); (iii) in the event that a secondary search was required to be conducted of a patron, this was done in a separate area under supervision; (iv) Melbourne Park received no reports of any staff violently restraining intoxicated individuals, noting further there is no record of any patron being evicted for intoxication; and (v) in accordance with conditions of entry, unsealed or prescription medication was not permitted, though sealed prescription medications were permitted in accordance with legislative requirements.

110. Further, as noted above, while swift access to water was reportedly an issue in Trang's case, I do not consider it appropriate to attempt to reconcile the two somewhat competing accounts of the broader availability of water at the event provided by Melbourne Park and Harm Reduction Victoria, given the advice of the CPU and the fact that ultimately, there is a possibility that tailored, safety-informed policies and procedures (such as banning aluminium or very large plastic bottles but allowing patrons to enter with smaller plastic bottles) may be perceived or experienced differently by a patron or volunteer on the ground (i.e. '*I can't take my water bottle in because water bottles are banned*'). Further, any deviations from policy might not be detected in a dynamic environment (e.g. with respect to security measures).[27]

111. Accordingly, I do not consider it to be necessary, possible or within the scope of my investigation to attempt to reconcile Melbourne Park's policies and procedures with their reported application to patrons on the night, and make no adverse findings in relation to Melbourne Park in this regard.

112. Nonetheless, I consider that the observations of Harm Reduction Victoria are relevant to the extent that the issues identified may be commonly experienced across EDM events in Victoria.

113. Similar issues were discussed in a finding handed down by Deputy State Coroner of the NSW Coroners Court, Magistrate Harriet Grahame, on 8 November 2019 following an inquest into the drug-related deaths of six patrons of NSW Music festivals between December 2017 and January 2019. Magistrate Grahame noted, in discussing the risks of using drug detection dogs and strip searches at music festivals, that:

> *There is also research which indicates purchasing from an unknown source is similarly risky. Increased presence of police may encourage users to buy their drugs within festivals, from random, unfamiliar sources, which is widely accepted to represent much greater risks to users.*[28]

114. In recognising the need for improved guidance for music event organisers, Harm Reduction Victoria highlighted the approach of NSW Health, which has produced specific guidelines

[27] In this connection, I consider there is a distinction to be drawn between the existence of plans, policies and procedures and their application on the ground, with the response of Melbourne Park focusing on the former. The evidence put forward by Harm Reduction Victoria may demonstrate a different experience of some patrons and volunteers of the event and I consider that such accounts ought to be seriously considered in any further reflections on lessons learned from the night.

[28] Deputy State Coroner, Magistrate Harriet Grahame, 'Inquest into the death of six patrons of NSW music festivals', State Coroner's Court of New South Wales, 8 November 2019, https://coroners.nsw.gov.au/documents/findings/2019/Music_Festival_Redacted_findings_in_the_joint_inquest_into_deaths_arising_at_music_festivals_.pdf.

intended to support the implementation of harm reduction in the context of music events, while noting that it did not support adopting the NSW model in full. This resource, titled 'Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction', has been produced to support event organisers to deliver safer music festivals, and to assist NSW Health to assess health and medical plans for music festivals that require an agreed health and medical plan under the *Music Festivals Act 2019* (NSW). The Guidelines include detailed advice in relation to topics such as harm reduction messaging, peer-based harm reduction programs, onsite medical service provision, onsite medical operations, and more.

115. In Victoria, guidance available for music event organisers is more limited. In this regard, the Victorian Department of Health has produced a general resource to guide safe practices at music events, titled, 'Code of practice for running safer music festivals and events (2013)' (**Code of Practice**), which includes a section on 'Harm reduction and education', although this section is far more brief than its NSW equivalent. In addition, while the Victorian Department of Health's website indicates that the Code of Practice was to be updated annually, it does not appear that any updates have been published since 2013.

116. I note that the Victorian Department of Health has recently issued a drug alert noting that high-dose MDMA capsules and pills are circulating in Victoria, including several steps to reduce the risk of harm and to seek urgent medical attention were required, which I consider to be very positive.[29]

117. However, over and above such periodic alerts, and noting the age of the Code of Practice referred to above, I consider there is considerable scope for improvement in the broader resources available to festival organisers and festival-goers. In this context, I consider that improved guidance developed in consultation with relevant harm reduction and clinical experts may offer a valuable opportunity to ensure that guidance for event organisers reflects current evidence-based drug harm reduction principles and that members of the public can make safer decisions in the course of their attendance at such events. I will make a recommendation to this effect.

[29] *See* https://www.health.vic.gov.au/drug-alerts/high-dose-mdma-capsules-and-pills-are-circulating-in-victoria, dated 5 December 2025.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Trang Thi Thu Le, born 17 September 1995;

    b) the death occurred on 17 September 2023 at The Alfred Hospital Emergency & Trauma Centre, 55 Commercial Road, Melbourne Victoria 3004, from *1(a) 3,4-Methylenedioxy-N-Methylamphetamine (MDMA) and ketamine toxicity*; and

    c) the death occurred in the circumstances described above.

119. Having considered all of the circumstances, I am satisfied that Trang's death occurred as a consequence of her deliberate ingestion of drugs, in the context of attending an electronic dance music (**EDM**) event, after accessing drugs from an unknown source within that event. The decision to access drugs from an unknown source, in a context where there was no access to drug-checking facilities within the event, meant that Trang would not (and could not) have been aware of the contents or potency of the drugs she was taking and was thus vulnerable to overdose or other drug-related harms.

120. Trang's death, on her 28th birthday, is a terrible loss for her loved ones and for the community as a whole. It must be understood within a broader context, in which the particular risks impacting young people engaging in drug use in the context of EDM events have been well-documented, with prevention opportunities well-recognised, and yet there remains significant room for improved implementation of harm reduction initiatives.

121. After careful consideration of the particular circumstances of Trang's death, and of evidence gathered in the course of my investigation, I have not at this stage identified any opportunities for prevention by way of improved guidance to assist in medical responses, though it is clear that those working in the field are dedicated to continuous improvement in this regard.

122. Similarly, while concerns were raised in relation to certain features of the venue – such as whether patrons had timely access to water, as well as whether treating clinicians had sufficient access to respond effectively to a medical emergency – I am satisfied that no adverse findings against Melbourne Park or any other entity are warranted in the circumstances. Further, I note that Melbourne Park has indicated that it has no intention to host similar events at John Cain Arena in future.

123. However, in considering the circumstances of Trang's death, I have identified significant broader opportunities for prevention with regard to the implementing of drug harm reduction principles. This includes working toward increased accessibility of drug checking (pill testing), including both fixed-site and mobile serves stationed within EDM events. In addition, I consider that drug harm reduction efforts could be supported through improved guidance from the Victorian Department of Health to assist music event organisers in understanding and implementing measures intended to reduce drug-related harms and to provide greater certainty for members of the public about the way in which such events will be run.

124. If such guidance were implemented, people going to EDM events and festivals will be clearer in advance of their attendance on what the approach of event organisers, security personnel and others controlling the event will be, and what their safety options are (e.g. the possibility of using a drug checking service at the event), and are therefore more likely to make safe choices. It ought to be emphasised that this is not about encouraging people to break the law. This is about recognising that some people in the community will use substances obtained from unregulated drug markets regardless of legal prohibition, and there is a requirement to protect their health and safety to the extent reasonably possible when this occurs.

125. I am hopeful that through continued efforts in this regard, we might prevent further deaths of young people attending music festivals and other similar events in Victoria.

RECOMMENDATIONS

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

i. That the **Victorian Department of Health** consult with relevant drug harm reduction and clinical experts to review and refresh the contents of the "Code of practice for running safer music festivals and events", to ensure its guidance on drug harm reduction at music festivals and electronic dance music events reflects current evidence and best practice.

ACKNOWLEDGMENTS

I convey my sincere condolences to Trang Thi Thu Le's family for their profound and tragic loss, and acknowledge the monumental efforts of first responders on the night of her tragic death.

I would also like to thank the Coroners Prevention Unit Research and Policy Team for its advice and assistance in obtaining statements from key organisations, including those involved in the emergency response, and those in the sector.

ORDERS AND DIRECTIONS

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

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

Senior Next of Kin

NSW Health

Victorian Department of Health

Melbourne Park and Olympic Parks Trust, C/- Minter Ellison

Dr Martin Dutch, St John Ambulance

Ambulance Victoria

Harm Reduction Victoria

Alfred Health (now Bayside Health)

Detective Senior Constable Bradley Cable, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 23 January 2026

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.