

Victorian overdose deaths, 2016–2025

7 October 2026

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1. Purpose

This report presents the 2025 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, numbers 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 numbers (for example 20 or fewer deaths per year), because the influence of random factors is far greater at lower numbers and can create the illusion of a trend where there is none.

2. Overdose deaths, Victoria 2016–2025

There were 5452 overdose deaths in Victoria between 2016 and 2025. This section provides an overview of basic numbers and the socio-demographics of the deceased.

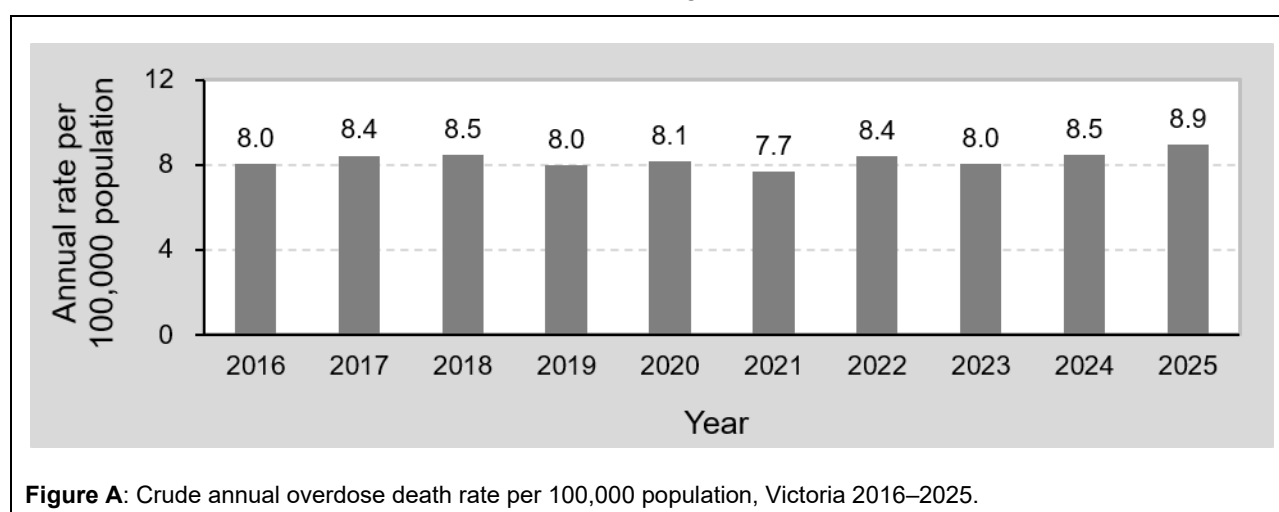
2.1. Annual number and rate by sex

Table 1 shows the annual number and proportion of Victorian overdose deaths by sex of the deceased person for the period 2016–2025. Between 2016 and 2022 the number was relatively steady, with an average of around 530 overdose deaths per year. In 2024 and 2025 the number was by comparison elevated, rising to 588 overdose deaths in 2024 then 632 overdose deaths in 2025. Males consistently accounted for around two-thirds of overdose deaths throughout the period, noting some variation from year to year.

Table 1: Annual number and proportion of overdose deaths by deceased sex, Victoria 2016–2025.

Sex	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number										
Male	332	342	347	332	351	354	353	344	399	433
Female	163	189	196	189	188	147	202	203	189	199
Total	495	531	543	521	539	501	555	547	588	632
Proportion										
Male	67.1	64.4	63.9	63.7	65.1	70.7	63.6	62.9	67.9	68.5
Female	32.9	35.6	36.1	36.3	34.9	29.3	36.4	37.1	32.1	31.5
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 2016–2025.¹ 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.



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 18 June 2026).

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, 2016–2025.

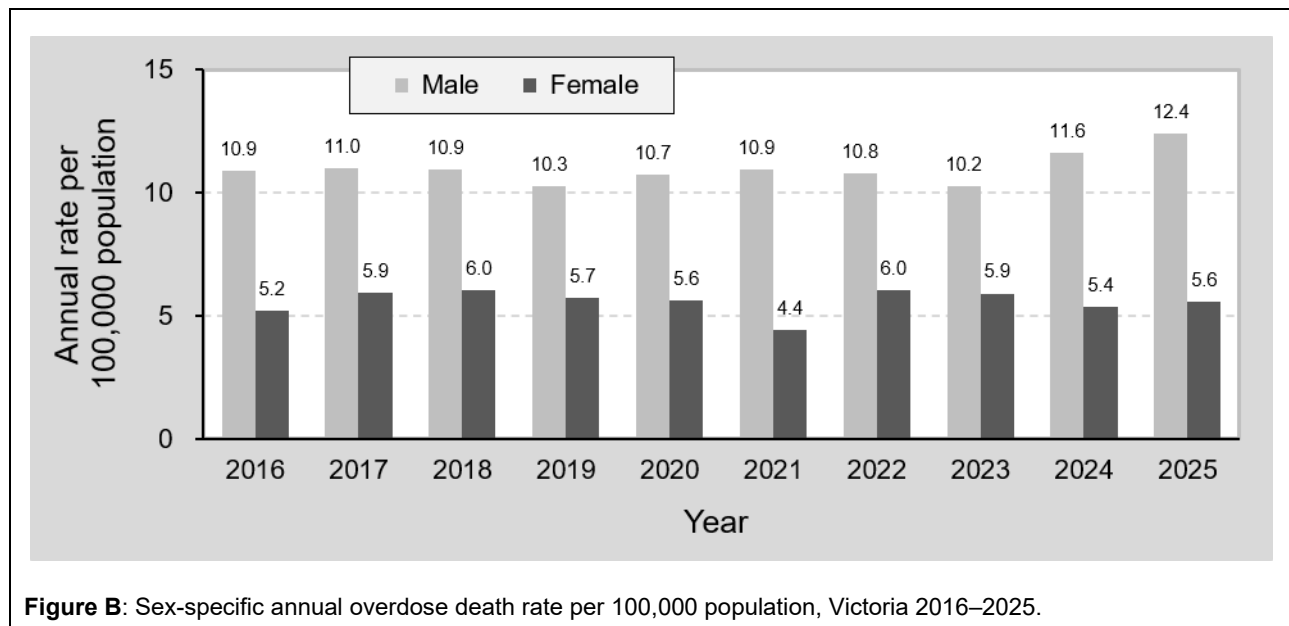
Table 2: Annual number of overdose deaths by deceased sex and age group, Victoria 2016–2025.

Age group by sex	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Males										
Under 18 years	3	1	-	4	-	-	2	4	1	-
18 to 24 years	20	11	16	16	27	17	24	22	23	21
25 to 34 years	52	69	68	47	60	76	59	46	69	58
35 to 44 years	112	113	106	93	93	93	87	90	105	97
45 to 54 years	83	82	98	92	100	97	94	96	106	156
55 to 64 years	40	36	43	47	44	47	61	57	62	69
65 years and over	22	30	16	33	27	24	26	29	33	32
Total	332	342	347	332	351	354	353	344	399	433
Females										
Under 18 years	1	3	1	1	-	-	-	3	1	-
18 to 24 years	6	8	13	8	5	7	6	6	10	13
25 to 34 years	25	23	28	22	36	23	23	37	26	29
35 to 44 years	47	44	48	39	52	36	43	48	49	36
45 to 54 years	39	46	36	54	47	42	61	49	41	48
55 to 64 years	29	36	41	33	24	22	41	30	33	47
65 years and over	16	29	29	32	24	17	28	30	29	26
Total	163	189	196	189	188	147	202	203	189	199
All people										
Under 18 years	4	4	1	5	-	-	2	7	2	-
18 to 24 years	26	19	29	24	32	24	30	28	33	34
25 to 34 years	77	92	96	69	96	99	82	83	95	87
35 to 44 years	159	157	154	132	145	129	130	138	154	133
45 to 54 years	122	128	134	146	147	139	155	145	147	204
55 to 64 years	69	72	84	80	68	69	102	87	95	116
65 years and over	38	59	45	65	51	41	54	59	62	58
Total	495	531	543	521	539	501	555	547	588	632

When annual numbers were broken down in this way, it was challenging to identify consistent trends across the 10-year period. For most age-sex groups there was a general increase in the annual number when comparing 2016 to 2025 (which mirrored the overall annual growth in overdose deaths), but fluctuations from year to year were quite marked and no underlying long-term 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.

A notable finding in recent years was the sharp rise in overdose deaths among males, from 344 in 2023 to 433 in 2025: an increase of 26% in two years. This was reflected in the male overdose death rate, which reached its highest level in a decade in 2025 (12.4 overdose deaths per 100,000 population of males – see Figure B). By comparison, the annual overdose death rate among

females in 2025 was within the range of previous years (5.6 deaths per 100,000 population of females, as shown in Figure B).



Looking further into the recent increase in overdose deaths among males, the clearest change was among males aged 45–54 years: the annual number of deaths in this group rose from 96 in 2023, to 106 in 2024, to 156 in 2025: a 63% increase. The reasons for this are not clear, but further analysis of this group is presented in Section 5.

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 2016–2025.

Fatal incident location	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number										
Metropolitan Melbourne	375	395	394	385	397	400	419	409	440	463
Regional Victoria	119	134	148	134	142	101	136	136	146	169
Unconfirmed	1	2	1	2	-	-	-	2	2	-
Total	495	531	543	521	539	501	555	547	588	632
Proportion										
Metropolitan Melbourne	75.8	74.4	72.6	73.9	73.7	79.8	75.5	74.8	74.8	73.3
Regional Victoria	24.0	25.2	27.3	25.7	26.3	20.2	24.5	24.9	24.8	26.7
Unconfirmed	0.2	0.4	0.2	0.4	-	-	-	0.4	0.3	-
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 5452 overdose deaths in Victoria between 2016 and 2025.

3.1. Single drug and multiple drug toxicity

Table 4 shows the annual number and proportion of overdose deaths in Victoria for the period 2016–2025 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 2016–2025.

Contributing drugs	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number										
Single	136	127	132	131	142	133	127	156	155	169
Multiple	359	404	411	390	397	368	428	391	433	463
Total	495	531	543	521	539	501	555	547	588	632
Proportion										
Single	27.5	23.9	24.3	25.1	26.3	26.5	22.9	28.5	26.4	26.7
Multiple	72.5	76.1	75.7	74.9	73.7	73.5	77.1	71.5	73.6	73.3
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 5a: Annual number of overdose deaths by contributing drug types, Victoria 2016–2025.

Contributing drugs	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number										
Pharmaceutical	385	421	428	410	405	378	408	379	408	424
Illegal	265	270	260	275	277	260	304	322	385	423
Alcohol	124	151	161	146	155	147	174	153	143	144
Total	495	531	543	521	539	501	555	547	588	632
Proportion										
Pharmaceutical	77.8	79.3	78.8	78.7	75.1	75.4	73.5	69.3	69.4	67.1
Illegal	53.5	50.8	47.9	52.8	51.4	51.9	54.8	58.9	65.5	66.9
Alcohol	25.1	28.4	29.7	28.0	28.8	29.3	31.4	28.0	24.3	22.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 5a 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 gradually over time, from 77.8% in 2016 to 67.1% in 2025. Across the same period the proportion of Victorian overdose deaths involving illegal drugs was initially stable (at around 52% annually on average between 2016 and 2021) but then rose notably from 2023 to reach 66.9% of deaths in 2025. Alcohol involvement fluctuated during the period without any clear trend and contributed to on average around 27% of overdose deaths per year.

To explore further how pharmaceutical drugs, illegal drugs and alcohol interacted to contribute to Victorian overdose deaths, each death was classified according to the combination of drug types that contributed. The seven mutually exclusive combinations were: (1) pharmaceutical drugs only; (2) illegal drugs only; (3) alcohol only; (4) pharmaceutical and illegal drugs; (5) pharmaceutical drugs and alcohol; (6) illegal drugs and alcohol; and (7) pharmaceutical drugs and illegal drugs and alcohol. Table 5b shows the annual number of Victorian overdose deaths for each combination of contributing drugs.

Table 5b: Annual number and proportion of overdose deaths by combination of contributing drug types, Victoria 2016–2025.

Drug combinations	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number										
Pharma only	154	173	178	155	158	138	141	133	112	124
Illegal only	71	69	71	60	82	63	93	98	124	154
Alcohol only	29	26	33	37	40	52	39	46	40	33
Pharma + illegal	146	138	133	160	144	153	147	163	209	210
Pharma + alcohol	47	62	72	54	64	51	71	46	51	52
Illegal + alcohol	10	15	11	14	12	8	15	24	16	21
Pharma + illegal + alc	38	48	45	41	39	36	49	37	36	38
Total	495	531	543	521	539	501	555	547	588	632
Proportion										
Pharma only	31.1	32.6	32.8	29.8	29.3	27.5	25.4	24.3	19.0	19.6
Illegal only	14.3	13.0	13.1	11.5	15.2	12.6	16.8	17.9	21.1	24.4
Alcohol only	5.9	4.9	6.1	7.1	7.4	10.4	7.0	8.4	6.8	5.2
Pharma + illegal	29.5	26.0	24.5	30.7	26.7	30.5	26.5	29.8	35.5	33.2
Pharma + alcohol	9.5	11.7	13.3	10.4	11.9	10.2	12.8	8.4	8.7	8.2
Illegal + alcohol	2.0	2.8	2.0	2.7	2.2	1.6	2.7	4.4	2.7	3.3
Pharma + illegal + alc	7.7	9.0	8.3	7.9	7.2	7.2	8.8	6.8	6.1	6.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Across the period 2016–2025, the annual number of overdose deaths involving pharmaceutical drugs only (i.e. no co-contribution from alcohol or illegal drugs) declined slightly, while the annual number of overdose deaths involving only illegal drugs more than doubled. The annual number of overdose deaths involving pharmaceutical drugs and illegal drugs in combination also rose, though most of this rise occurred in the most recent years 2024 and 2025.

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

3.3. Contributing pharmaceutical 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 of overdose deaths in which major pharmaceutical drug groups contributed, Victoria 2016–2025.

Drug group	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Pharmaceutical drugs	385	421	428	410	405	378	408	379	408	424
Benzodiazepines	263	308	304	285	286	266	268	265	270	286
Pharmaceutical opioids	183	202	207	209	194	182	184	180	182	183
Antidepressants	165	198	196	172	181	159	174	146	185	180
Antipsychotics	107	137	109	103	113	99	112	108	129	124
Anticonvulsants	54	78	87	87	93	86	101	93	108	102
Non-benzo anxiolytics	40	57	47	54	51	46	51	51	54	36

Table 6 shows the annual number of Victorian overdose deaths between 2016–2025 involving each of the major contributing pharmaceutical drug groups. Many overdose deaths were from combined drug toxicity involving multiple types of pharmaceutical drugs, which is why the annual numbers for each drug group in Table 6 sum to greater than the overall annual number of pharmaceutical-involved overdose deaths.

Across the 10-year period, benzodiazepines were overall the most frequent contributing pharmaceutical drug group, playing a role in on average 280 overdose deaths each year, with this number being reasonably consistent from year to year. Similarly, the annual number of pharmaceutical opioid-involved overdose deaths in Victoria remained steady, particularly after 2019. Antidepressants and antipsychotics were the other two most common contributors among pharmaceutical drug groups.

The recent stability in the annual number of Victorian overdose deaths involving pharmaceutical opioids and benzodiazepines appears to be a positive development, given that Victoria's population continued to grow during this time. While it is not possible to attribute the stable number to any specific initiative, we have previously noted that Royal Australian College of General Practitioners and the Victorian Department of Health efforts to improve safe access to these drugs may be impactful here.³

3.4. Individual contributing pharmaceutical drugs

Table 7 shows the annual most frequent contributing individual pharmaceutical drugs to Victorian overdose deaths. 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.

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.

3 See Coroners Court of Victoria, *Victorian overdose deaths, 2015–2024*, Southbank: Coroners Court of Victoria, 12 August 2025, p.10.

Table 7: Annual number of overdose deaths in which individual pharmaceutical drugs contributed, Victoria 2016–2025.

Contributing drug	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Benzodiazepines	263	308	304	285	286	266	268	265	270	286
Diazepam	204	245	235	232	220	217	213	213	219	232
Clonazepam	31	49	40	35	43	45	42	51	35	42
Alprazolam	23	27	31	28	31	26	18	22	22	16
Oxazepam	27	25	35	28	17	27	20	15	19	13
Temazepam	26	33	29	20	18	18	17	10	18	20
Nitrazepam	22	12	16	13	14	12	14	9	14	5
Lorazepam	7	8	6	9	12	10	5	8	10	11
Pharmaceutical opioids	183	202	207	209	194	182	184	180	182	183
Methadone	72	73	72	75	68	67	72	66	58	67
Oxycodone	54	67	62	60	60	47	58	41	60	46
Codeine	46	38	34	43	40	26	31	24	24	23
Tramadol	26	32	35	37	28	20	17	12	13	13
Tapentadol	-	1	9	13	20	19	18	38	26	31
Buprenorphine	2	8	20	11	17	10	17	23	26	28
Morphine	13	18	19	18	10	13	11	17	9	8
Fentanyl	14	14	18	5	5	13	2	6	7	4
Antidepressants	165	198	196	172	181	159	174	146	185	180
Mirtazapine	25	42	59	45	57	50	69	34	57	59
Amitriptyline	34	48	40	42	32	33	33	37	37	28
Citalopram	28	35	26	26	34	25	29	27	32	28
Venlafaxine	22	27	18	20	19	20	25	14	23	24
Duloxetine	15	12	19	20	17	18	12	8	12	21
Sertraline	11	18	19	20	14	12	15	11	16	13
Desvenlafaxine	19	16	18	12	15	8	14	10	10	15
Fluoxetine	16	10	12	12	10	13	8	13	19	15
Antipsychotics	107	137	109	103	113	99	112	108	129	124
Quetiapine	57	75	53	50	53	44	43	47	48	41
Olanzapine	36	41	42	33	44	34	45	45	59	64
Risperidone	14	9	13	10	4	6	18	7	17	16
Aripiprazole	3	6	6	4	5	6	8	10	13	12
Zuclopenthixol	4	14	4	7	8	3	5	3	9	7
Anticonvulsants	54	78	87	87	93	86	101	93	108	102
Pregabalin	34	55	69	68	70	66	66	78	92	78
Lamotrigine	3	6	10	7	8	8	12	5	8	14
Gabapentin	2	5	5	2	11	7	8	5	12	9
Valproic Acid	6	8	5	7	7	6	9	2	-	2

Table 7 continued over page

Table 7 continued from previous page

Contributing drug	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Non-benzo anxiolytics	40	57	47	54	51	46	51	51	54	36
Zopiclone	13	17	13	22	18	15	17	15	20	11
Doxylamine	13	18	18	16	10	9	13	16	15	17
Diphenhydramine	4	6	6	7	10	11	15	13	13	3
Zolpidem	6	8	6	8	8	9	9	5	7	5
Pentobarbitone	9	11	6	9	4	8	2	4	5	-
Other drugs of interest										
Paracetamol	30	33	32	47	33	18	19	16	25	16
Promethazine	11	16	27	18	18	16	21	30	19	19
Propranolol	8	17	13	12	11	14	9	10	11	13
Ketamine	3	3	11	6	11	12	10	18	16	18
Insulin	6	7	12	10	8	8	4	5	7	11
Amphetamine	1	3	5	3	4	6	5	11	6	8

Among the notable findings in the data presented in table 7:

- The steady rise over time in the annual number of Victorian overdose deaths involving anticonvulsants was primarily driven by pregabalin. After reaching a peak of 92 in 2024, the number of pregabalin-involved overdose deaths declined to 78 in 2025. While still high, this result may indicate that the July 2023 addition of pregabalin to the list of target drugs monitored under the SafeScript real-time prescription monitoring system in Victoria could be having a positive safety impact.
- The annual contribution of most individual opioids to Victorian overdose deaths remained steady or declined. The only exception was tapentadol, which contributed to rising numbers of overdose deaths across the period 2016–2023 before retreating slightly from the 2023 peak in 2024 and 2025. The reasons for the rise in tapentadol-involved overdose deaths are likely related to prescribing patterns; between 2015 and 2022 prescribed tapentadol use in Australia grew rapidly while prescribed use of most other opioids declined.⁴
- Diazepam remained the single biggest pharmaceutical contributor to Victorian overdose deaths. However, as with benzodiazepines generally, its contribution to overdose deaths was overwhelmingly in a setting of multiple drug toxicity, where it acts in combination with other drugs to cause enhanced central nervous system depression. Among the 2230 diazepam-involved overdose deaths that occurred in Victoria across the period, 2225 (99.8%) were the result of multiple drug toxicity.

3.5. Individual contributing illegal drugs

Table 8 shows the annual most frequent contributing individual illegal drugs to Victorian overdose deaths. The drugs are tabulated in descending order by total number of deaths to which they contributed during the period.

4 Chidwick K et al, “Trends in prescription opioid analgesic use in Australia from 2015 to 2022”, *International Journal of Drug Policy*, 135, 2025, article 104666.

Table 8: Annual number of overdose deaths in which individual illegal drugs contributed, Victoria 2016–2025. (*Noting new psychoactive substances are a family of drugs rather than an individual drug)

Contributing drug	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Illegal drugs	265	270	260	275	277	260	304	322	385	423
Heroin	190	221	203	212	187	173	230	204	248	261
Methamphetamine	120	95	96	111	117	138	143	164	217	249
New psychoactives*	8	4	8	17	33	36	48	41	49	35
Cocaine	11	10	17	21	28	23	19	32	48	35
GHB	5	6	5	7	18	10	22	24	32	38
MDMA	13	7	4	14	17	11	9	8	20	11

In 2025, overdose deaths involving each of heroin, methamphetamine and GHB reached a decade high; further commentary on heroin and GHB is found in Section 5.

Noting that new psychoactive substances (NPS) are not an individual drug but rather an umbrella term for a family of hundreds of diverse drugs,⁵ in Table 9 we further disaggregated the NPS-involved overdose deaths into main categories of contributing NPS.

Table 9: Annual number of NPS-involved overdose deaths by contributing categories, Victoria 2016–2025.

NPS category	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
New psychoactives	8	4	8	17	33	36	48	41	49	35
Benzodiazepine	-	-	1	10	28	26	40	33	36	27
Stimulant	7	2	-	-	4	3	4	8	6	4
Cannabinoid	-	2	7	6	2	2	-	-	1	1
Opioid	1	-	-	1	-	4	6	9	7	2
Psychedelic	3	2	-	-	1	3	-	-	1	1
Empathogen	-	-	-	-	5	1	-	-	-	-
Dissociative	-	-	-	-	2	-	1	1	7	3
Other and unknown	-	-	-	-	-	-	-	-	-	-

As with previous years, novel benzodiazepines were the most frequent contributing NPS category to Victorian overdose deaths in 2025, playing a role in 27 deaths. This was down from 2024, when 36 Victorian overdose deaths involved novel benzodiazepines. Bromazolam was the most frequent contributing novel benzodiazepine in 2025, followed by clonazepam. There were no stand-outs among other NPS drug categories contributing to Victorian overdose deaths in 2025. The very low number of novel opioids was a particularly welcome result given the potency of these drugs and the overdose risk they present.

It is unclear why NPS-involved overdose deaths declined by nearly 30% between 2024 and 2025, but one possible explanation is the impact of increased surveillance and analysis of substances circulating in unregulated drug markets. Relevant Victorian initiatives that have been established over the past few years include the Emerging Drugs Network of Australia Victoria (EDNAV) project, the Rapid and Precise Intelligence on Drugs (RAPID) project, the Victorian Potent Synthetic Opioid Advisory Group (PSOG) and Victoria’s drug checking (pill testing) services. Through these initiatives, a range of testing occurs (for example testing of blood samples taken in emergency

5 For a more detailed introduction to NPS please see Coroners Court of Victoria, *Victorian overdose deaths, 2015–2024*, Southbank: Coroners Court of Victoria, 12 August 2025, pp.19–21.

departments; testing of substances brought in for drug checking; testing of drug injecting equipment collected from sites around Victoria) to establish what types of substances are being used and identify substances of particular concern that may be circulating, such as those containing risky NPS. Testing results are used to inform drug harm reduction actions and may be disseminated in drug alerts to the public.

Illustrating the reach of these initiatives, in August 2026 the Victorian Government reported that in the 12 months since the state's first fixed-site drug checking service opened, more than 5,000 drug samples were tested and more than 2,500 conversations occurred between service users and harm reduction workers. The service also issued 28 drug notifications warning the community about dangerous substances, including two urgent alerts for nitazenes.⁶

The drug alerts are important because in addition to notifying the public about substances that might present particular risks, they also perform a more general role of educating the public and improving their knowledge and awareness of NPS and universal precautions to follow when using substances obtained from unregulated drug markets. Further to this point, while recognising the role of the Victorian drug surveillance effort in addressing NPS-related harms, it is important also to recognise the role of interstate services such as the groundbreaking CanTest drug checking service in Canberra, and Queensland's CheQpoint drug checking service. Alerts and information from these services have been disseminated in Victoria and therefore have contributed to harm reduction initiatives locally.

6 Victorian Department of Health, "Victorian Pill Testing Service marks one year at Fitzroy site", 27 August 2026, <<https://www.health.vic.gov.au/news/victorian-pill-testing-service-marks-one-year-at-fitzroy-site>>, accessed 17 September 2026.

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.⁷

4.1. Annual number

Table 10 shows the annual number of Victorian overdose deaths by deceased intent. While there was minor variation from year to year, the proportion of overdose deaths by intent was reasonably consistent across the period, 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 10: Annual number and proportion of overdose deaths by deceased intent, Victoria 2016–2025.

Intent	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total
Number											
Unintentional	348	396	396	403	417	386	434	399	426	467	4072
Undetermined	54	33	38	26	33	17	15	32	43	49	340
Intentional	93	102	109	92	89	98	106	116	119	116	1040
Total	495	531	543	521	539	501	555	547	588	632	5452
Proportion											
Unintentional	70.3	74.6	72.9	77.4	77.4	77.0	78.2	72.9	72.4	73.9	74.7
Undetermined	10.9	6.2	7.0	5.0	6.1	3.4	2.7	5.9	7.3	7.8	6.2
Intentional	18.8	19.2	20.1	17.7	16.5	19.6	19.1	21.2	20.2	18.4	19.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

⁷ 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 11 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 males (82.2%) than females (60.2%); and conversely the proportion of intentional overdose deaths was higher among females (31.6%) than males (12.5%).

Table 11: Overall number and proportion of overdose deaths by deceased sex and intent, Victoria 2016–2025.

Intent	Male	Female	Total
Number			
Unintentional	2950	1122	4072
Undetermined	187	153	340
Intentional	450	590	1040
Total	3587	1865	5452
Proportion			
Unintentional	82.2	60.2	74.7
Undetermined	5.2	8.2	6.2
Intentional	12.5	31.6	19.1
Total	100.0	100.0	100.0

4.3. Intent, sex and age group

In tables 12a and 12b, the data from table 11 is broken down further by age group. Table 12a shows the overall number and proportion of overdose deaths by deceased intent and age group among males; table 12b (over page) shows these figures for females.

Table 12a: Overall number and proportion of overdose deaths by intent and age group (years) among males, Victoria 2016–2025.

Intent	0-24	25-34	35-44	45-54	55-64	65+
Number						
Unintentional	177	535	849	849	407	133
Undetermined	12	28	59	52	24	12
Intentional	23	41	81	103	75	127
Total	212	604	989	1004	506	272
Proportion						
Unintentional	83.5	88.6	85.8	84.6	80.4	48.9
Undetermined	5.7	4.6	6.0	5.2	4.7	4.4
Intentional	10.8	6.8	8.2	10.3	14.8	46.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Among males, the proportions of overdose deaths that were unintentional, undetermined and intentional were relatively consistent across all younger age groups from 0–24 years through to 55–64 years. Across these age groups the proportion of overdose deaths that were unintentional ranged between 80.4% and 88.6%; and intentional overdose deaths accounted for between 6.8% and 14.8% of the cases. In males aged 65 and over, though, there was a substantial departure from this pattern, with the proportion of unintentional overdose deaths declining sharply to 48.9% and a concomitant increase in intentional overdose deaths to 46.7%.

Similar findings were evident also for females. Among younger age groups from 0–24 years through to 55–64 years the proportion of overdose deaths that were unintentional was consistently higher than the number of intentional overdose deaths; but in females aged 65 years and over the proportion of intentional overdose deaths (60.8%) was almost double the proportion of overdose deaths that were unintentional (32.3%).

Table 12b: Overall number and proportion of overdose deaths by intent and age group (years) among females, Victoria 2016–2025.

Intent	0-24	25-34	35-44	45-54	55-64	65+
Number						
Unintentional	55	173	297	332	181	84
Undetermined	3	24	44	34	30	18
Intentional	34	75	101	97	125	158
Total	92	272	442	463	336	260
Proportion						
Unintentional	59.8	63.6	67.2	71.7	53.9	32.3
Undetermined	3.3	8.8	10.0	7.3	8.9	6.9
Intentional	37.0	27.6	22.9	21.0	37.2	60.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

These findings have potential implications for overdose prevention among older Victorians, particularly relating to medicines safety and assessment of self-harm risk.

5. Themes and issues

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

5.1. Illegal drug involvement

Following the period 2009–2018 when the annual number of pharmaceutical drug-involved overdose deaths in Victoria was consistently around double the number of overdose deaths involving illegal drugs, from approximately 2019 onwards the gap between the two drug types narrowed steadily. Figure C shows the narrowing was due to two dynamics: (1) pharmaceutical drug involvement in overdose deaths plateaued after 2018, while (2) involvement of illegal drugs grew sharply from 2021 onwards, resulting in the numbers almost meeting by 2025.

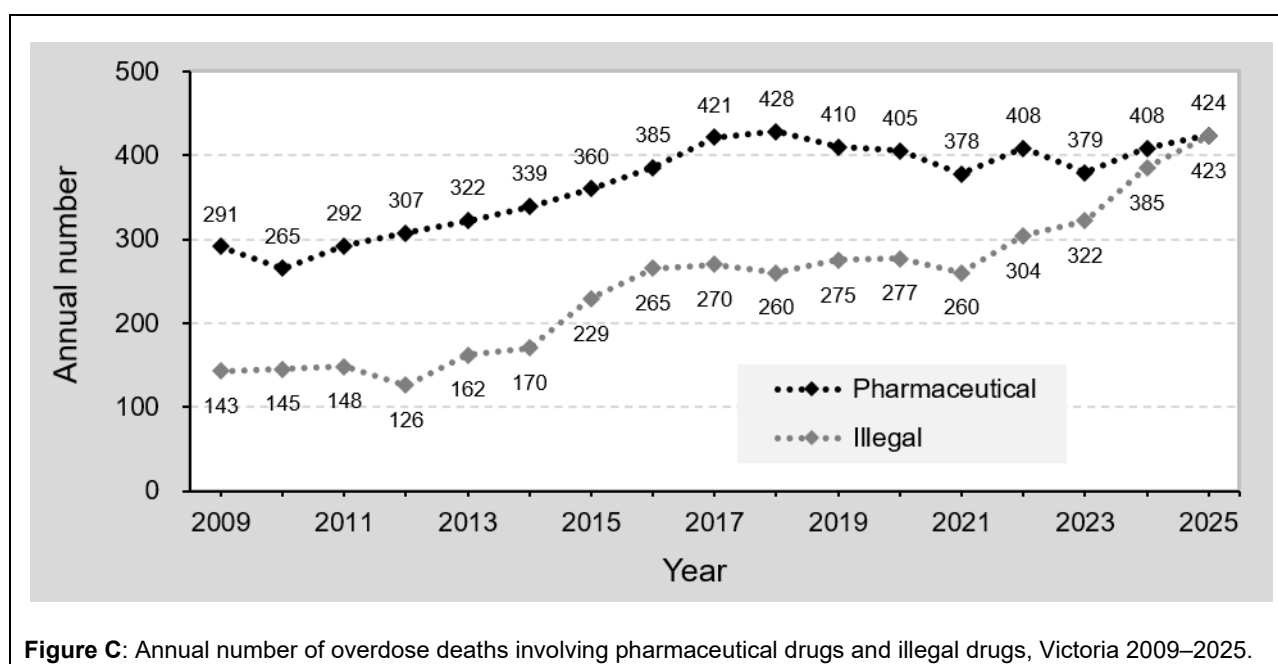


Figure C: Annual number of overdose deaths involving pharmaceutical drugs and illegal drugs, Victoria 2009–2025.

In interpreting the narrowing gap between pharmaceutical and illegal drug contribution in Victorian overdose deaths, one feature that Figure C does not clearly illustrate is the overlap between pharmaceutical and illegal drug contribution in the deaths. Figure D (over page, which draws from the data presented earlier in Tables 5a and 5b) was prepared to show this more clearly: it comprises a Venn diagram⁸ depicting the overlap between pharmaceutical and illegal drug contribution in Victorian overdose deaths for 2025, together with alcohol contribution. The main purpose of the Venn diagram is to represent visually how the majority of pharmaceutical-involved overdose deaths in Victoria in 2025 also involved illegal drugs, and conversely most illegal-drug involved deaths also involved pharmaceutical drugs.

8 The Venn diagram was prepared using the online tool built by Hulson T, “DeepVenn”, 2020, <<https://www.deepvenn.com/>>, accessed 28 July 2026.

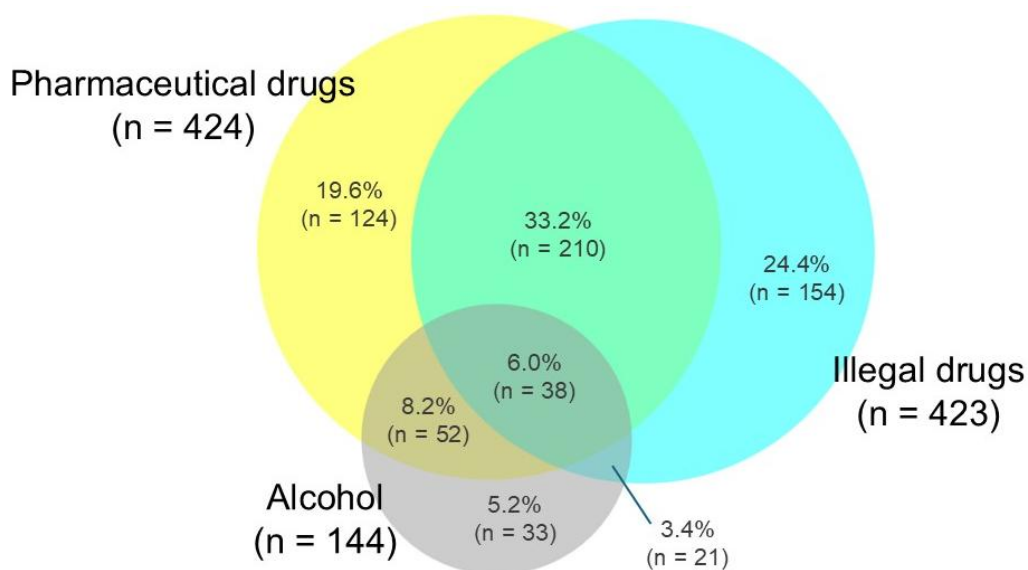


Figure D: Number and proportion of overdose deaths involving pharmaceutical drugs, illegal drugs and/or alcohol, Victoria 2025.

An important principle that Figure D reinforces is, harms associated with pharmaceutical drugs should not be conceptualised and approached as a separate phenomenon to harms associated with illegal drugs.

5.2. Heroin

The annual number of heroin-involved overdose deaths reached 261 in 2025, up from 248 and 2024 and 204 in 2023. Just over 80% of the deaths in 2025 occurred in Metropolitan Melbourne rather than Regional Victoria, which is consistent with other recent years.

Table 13: Annual number of heroin-involved overdose deaths in 12 LGAs that were most frequent locations for these deaths, Victoria 2016–2025.

LGA of fatal incident	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total
Yarra	20	16	26	17	10	11	14	19	21	24	178
Melbourne	7	15	13	10	14	9	24	7	23	24	146
Brimbank	13	19	10	15	17	8	19	14	13	11	139
Greater Dandenong	12	11	10	14	9	10	7	17	14	11	115
Port Phillip	11	9	18	9	8	11	15	12	14	7	114
Greater Geelong	12	6	10	12	5	10	7	10	14	14	100
Maribyrnong	5	9	7	5	6	5	14	9	13	11	84
Darebin	9	9	8	8	5	3	6	7	11	8	74
Merri-Bek	4	8	9	8	5	3	9	9	7	5	67
Frankston	4	6	8	9	3	4	1	11	10	9	65
Wyndham	5	6	5	2	3	4	7	7	13	8	60
Stonnington	2	5	7	2	5	10	5	10	3	9	58

Table 13 shows the 12 local government areas (LGAs) that were the most frequent locations for heroin-involved overdose deaths during the period 2016–2025, as well as the annual number of such deaths that occurred in each LGA.

Yarra was the location where the highest number of heroin-involved overdose deaths occurred across the 10-year period, followed by Melbourne and Brimbank. 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: 44.4% of heroin-involved overdose deaths in Yarra occurred in non-residential locations, followed by 43.2% in Melbourne, then 25.9% in Brimbank.

5.3. GHB

The annual number of Victorian overdose deaths involving the illegal drug gamma-hydroxybutyrate (GHB) reached a 10 year high in 2025 of 38 deaths.

GHB-involved overdose deaths in Victoria have certain distinctive features. One such feature is the unusually large overlap between GHB and methamphetamine involvement in the deaths. Table 14 shows that among the 167 GHB-involved overdose deaths occurring between 2016 and 2025, 23 (13.8%) were GHB-only overdoses and the remaining 144 (86.2%) resulted from combined drug toxicity; these included 124 deaths (74.3% of all GHB-involved overdose deaths) where methamphetamine played a co-contributory role.

Table 14: Overall number of GHB-involved overdose deaths by main co-contributing drugs, Victoria 2016–2025.

Type of overdose	N	%
GHB only	23	13.8
GHB in combination with other drugs	144	86.2
- Methamphetamine	124	74.3
- Diazepam	56	33.5
- Heroin	23	13.8
- Pregabalin	16	9.6
- Clonazepam	12	7.2
- Cocaine	12	7.2
- Olanzapine	11	6.6
- Citalopram	8	4.8
Total	167	100.0

Another distinctive feature is the basic socio-demographic profile of the deceased. While males accounted for approximately 66% of all Victorian overdose deaths between 2016 and 2025, in GHB-involved overdose deaths they comprised 50.3% (84 of 167) of the deceased. Further to this point, when examining the age of the deceased:

- The average age of all males who fatally overdosed in Victoria between 2016 and 2025 was 44.8 years, but was 39.2 years for those whose overdose deaths involved GHB.
- A more marked difference was observed among females: the average age of all females who fatally overdosed in Victoria between 2016 and 2025 was 48.2 years, but was 32.5 years for those whose overdose deaths involved GHB.

These findings have potential implications for harm reduction education targeting people who use methamphetamine or GHB, including particularly education in the risks of using both substances together and how these risks can be managed.

5.4. Males aged 45–54 years

As noted in the commentary accompanying Table 2 (section 2.2) above, the annual increase between 2024 and 2025 in the number of overdose deaths among males aged 45–54 years was very unusual; a one-year rise of 50 deaths has not been observed in any of the other sex-age groupings examined in this series of reports from the Court.

A further analysis of recent overdose deaths in the cohort of males aged 45–54 was undertaken, to establish what might have driven the rise. Initial findings were:

- Location of fatal incident did not appear to be a factor. In 2025, 77.6% of overdose deaths among the 45–54 male cohort occurred in Metropolitan Melbourne, which was consistent with proportions observed in previous years.
- Intent did not appear to be a factor. In 2025, 84.6% of overdose deaths in the cohort were unintentional and 10.3% were intentional; this was again consistent with proportions observed in previous years.

Table 15: Annual number of overdose deaths by contributing drug types in males aged 45–54 years, Victoria 2021–2025.

Contributing drugs	2021	2022	2023	2024	2025
Number					
Pharmaceutical	71	59	58	66	91
Illegal	50	68	66	84	131
Alcohol	40	27	32	28	37
Total	97	94	96	106	156
Proportion					
Pharmaceutical	73.2	62.8	60.4	62.3	58.3
Illegal	51.5	72.3	68.8	79.2	84.0
Alcohol	41.2	28.7	33.3	26.4	23.7
Total	100.0	100.0	100.0	100.0	100.0

Analysis of contributing drugs suggested that illegal drugs may be a potential driver of the rise. Table 15 shows the annual number and proportion of overdose deaths in the cohort by contributing drug types; between 2021 and 2025, the proportion of overdose deaths involving pharmaceutical drugs declined, as did the proportion involving alcohol, whereas the proportion involving illegal drugs reached a high of 84.0%.

A more detailed analysis of the individual drugs that contributed most frequently in the cohort during 2025, is shown in Table 16. Heroin and methamphetamine were clearly the most prominent contributors, playing a role in 87 and 80 overdose deaths respectively.

The data presented here does not necessarily in and of itself provide a coherent explanation for why there was such a sudden and large increase in overdose deaths among males aged 45–54 years in Victoria during 2025. For example, there does not appear to be any particular reason why males in this age group might have suddenly started using illegal drugs in greater numbers, or using them in riskier ways. It may be productive to review other sources of information on drug

harms in the Victorian population in 2025, to establish whether males aged 45–54 were over-represented also in these sources.

Table 16: Annual number of overdose deaths in males aged 45–54 years by most frequent individual drugs that contributed in 2025, Victoria 2021–2025.

Contributing drug	2021	2022	2023	2024	2025
Total	97	94	96	106	156
Heroin	34	56	45	63	87
Methamphetamine	22	30	35	50	80
Diazepam	41	32	34	36	51
Alcohol	40	27	32	28	37
Pregabalin	17	12	12	15	19
Olanzapine	6	5	11	9	18
Methadone	15	16	15	14	16
Mirtazapine	11	12	4	6	13
Cocaine	1	2	2	7	11
Clonazepam	3	4	3	2	11
Quetiapine	10	7	12	8	11

Attachment A

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

Definition of an 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).⁹

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, or heart disease resulting from prolonged amphetamine use) are excluded from the VODR. Likewise, deaths resulting from allergic reactions to drugs are excluded, along with deaths caused by injuries during drug administration, homicide by drug administration, and deaths due to medical treatment errors (such as administering the wrong drug to a patient in hospital).

Definition of a drug

The definition of a 'drug' informing VODR coding 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.

Alcohol is included as a drug in the VODR, whereas it is explicitly excluded under the SAMHSA definition. The reason for this inclusion is, alcohol is not only Australia's most harmful drug in its own right,¹⁰ but it also interacts with many other drugs to heighten overdose risk, so any fulsome understanding of drug overdose requires an understanding of alcohol's contribution. It is important to emphasise, though, that deaths where the acute toxic effects of alcohol played a causal or contributory role (i.e. alcohol-involved overdose deaths) comprise only a very small proportion of Victorian deaths each year in which alcohol plays a role.

Some other exclusions to note are:

- Cannabis is not included in the VODR, because there is debate as to whether cannabis has fatally toxic effects.
- Nitrous oxide is not included in the VODR, because most Victorian deaths involving nitrous oxide inhalation result from how the gas is inhaled, not the acute toxic effect of the gas itself.

9 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*, 32(3), 2013, pp.231–243.

10 Bonomo Y et al, "The Australian drug harms ranking study", *Journal of Psychopharmacology*, 33(7), 2019, pp.759–768.

- Volatile hydrocarbons are not included in the VODR.

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.
- 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 coding will be changed in the course of this review process.

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 complete 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 in the VODR 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 significant classification challenge, and the following approach has been adopted:
 - a. If amphetamine contributed in the absence of methamphetamine detection, it 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 present as a metabolite of the 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 in the VODR 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 numbers 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 2016–2025.

Local government area	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Alpine	-	-	1	-	-	-	1	-	-	-
Ararat	-	3	2	2	2	-	1	2	3	2
Ballarat	6	12	7	14	10	10	14	14	6	13
Banyule	12	10	6	14	9	10	10	9	9	9
Bass Coast	6	5	4	7	4	-	4	6	3	3
Baw Baw	4	5	3	3	4	4	4	4	3	1
Bayside	8	6	12	8	14	15	7	7	8	9
Benalla	1	1	-	-	1	-	3	2	-	-
Boroondara	8	8	6	10	11	5	10	4	14	10
Brimbank	15	24	16	22	28	16	30	27	18	26
Buloke	1	1	1	-	-	-	1	1	-	-
Campaspe	4	3	2	3	6	1	4	2	1	2
Cardinia	8	5	5	7	7	13	4	6	6	9
Casey	10	19	10	18	20	14	20	15	16	27
Central Goldfields	2	2	2	1	2	-	1	2	1	-
Colac Otway	2	-	-	-	1	-	3	2	3	4
Corangamite	-	1	2	2	-	1	1	-	1	-
Darebin	18	18	13	15	14	10	18	14	19	19
East Gippsland	4	3	2	6	6	4	2	2	7	10
Frankston	20	17	26	21	17	12	17	16	19	22
Gannawarra	-	-	-	-	-	-	1	1	-	-
Glen Eira	5	12	7	8	9	13	7	13	10	13
Glenelg	2	2	2	1	1	1	-	2	-	2
Golden Plains	1	-	2	-	-	1	-	-	-	2
Greater Bendigo	6	17	13	9	10	12	6	9	11	13
Greater Dandenong	17	19	17	24	19	21	13	25	26	16
Greater Geelong	20	24	25	24	23	23	22	27	35	45
Greater Shepparton	5	3	7	7	7	6	4	6	5	9
Hepburn	-	3	1	-	-	2	4	-	-	3
Hindmarsh	-	-	-	1	-	-	-	-	-	1
Hobsons Bay	5	7	7	6	8	11	13	5	6	6
Horsham	3	1	-	1	1	1	2	2	1	1
Hume	11	10	11	13	8	14	11	13	23	15
Indigo	2	1	1	3	-	-	-	1	-	-

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Local government area	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Kingston	5	17	9	8	10	8	12	15	12	17
Knox	7	15	17	16	13	15	7	10	11	15
Latrobe	10	9	12	6	12	11	8	8	18	7
Loddon	1	1	1	-	-	-	2	1	1	-
Macedon Ranges	2	-	3	5	2	2	2	2	2	2
Manningham	4	4	8	4	4	5	2	7	5	5
Mansfield	-	1	1	2	2	-	1	1	2	3
Maribyrnong	6	14	12	10	13	14	22	17	20	23
Maroondah	12	8	7	15	4	14	8	6	13	9
Melbourne	23	25	25	19	26	28	32	27	44	41
Melton	12	9	10	14	13	9	16	7	7	9
Merri-bek	17	13	23	13	11	7	19	17	12	16
Mildura	4	5	7	4	10	1	7	3	6	6
Mitchell	3	3	2	3	4	1	3	4	3	5
Moira	2	4	1	4	1	1	4	2	2	2
Monash	20	9	10	11	16	13	13	8	13	7
Moonee Valley	12	8	8	7	12	9	6	6	9	7
Moorabool	3	2	5	1	2	3	4	1	1	1
Mornington Peninsula	16	12	11	9	13	13	15	10	6	14
Mount Alexander	1	-	3	3	2	2	-	4	1	5
Moyne	1	-	1	-	-	1	2	2	-	-
Murrindindi	1	1	2	2	3	-	2	2	1	1
Nillumbik	4	3	3	3	3	1	5	3	4	3
Northern Grampians	-	-	1	1	1	-	1	-	-	2
Port Phillip	21	23	32	15	24	18	23	20	22	19
Pyrenees	-	1	1	-	-	-	-	-	1	-
Queenscliffe	-	-	-	-	2	-	-	-	-	-
South Gippsland	2	2	1	3	1	1	1	1	1	-
Southern Grampians	1	2	2	1	1	2	1	-	3	1
Stonnington	7	12	10	4	13	14	9	17	12	13
Strathbogie	-	-	-	1	1	1	2	1	-	2
Surf Coast	2	-	3	4	3	-	1	3	-	-
Swan Hill	1	1	1	2	1	1	-	-	1	1
Towong	1	1	2	-	1	-	1	1	-	-
Wangaratta	5	3	4	3	6	-	4	-	2	3
Warrnambool	2	3	4	1	3	1	4	5	6	4
Wellington	2	5	4	2	5	5	6	4	7	7

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Local government area	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
West Wimmera	2	-	-	1	1	-	1	2	1	1
Whitehorse	12	16	10	9	9	21	8	14	9	12
Whittlesea	10	8	3	12	12	17	12	8	11	9
Wodonga	4	3	9	1	-	2	-	3	7	5
Wyndham	12	11	11	13	13	15	16	20	20	15
Yarra	27	22	32	25	17	18	21	33	27	32
Yarra Ranges	11	11	17	12	7	7	13	10	9	16
Yarriambiack	-	-	1	-	-	-	1	1	-	-