IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006443

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Shayn Nathan Darmanin
Date of birth:	12 December 1977
Date of death:	1 December 2021
Cause of death:	1(a) Mixed drug toxicity (methadone, synthetic cannabinoids (5f-cumyl-pinaca and cumyl-pegaclone), olanzapine, duloxetine) in a man with epilepsy
Place of death:	8/15 Clarendon Parade, West Footscray, Victoria, 3012

INTRODUCTION

1. On 1 December 2021, Shayn Nathan Darmanin was 43 years old when he was found deceased at his home. At the time of his death, Shayn lived alone in West Footscray.

Background

2. Shayn had a normal childhood and enjoyed playing football and skateboarding. Following secondary school he completed a certificate in building.

3. Shayn occasionally worked as a tattoo artist but his predominant source of income was the disability support pension.

4. Shayn had two children with a former partner, though there was an intervention order preventing him from having contact with them in place from 2013 to the time of his death.

5. Shayn spent considerable periods of time in custody, most recently between 3 May and 13 September 2021 relating to assaults against his housemate. Shayn was a recidivist family violence offender and had been listed as the perpetrator of family violence over 20 times on the Victoria Police LEAP database.

6. At the time of his death, Shayn was a participant in Sacred Heart Mission's Journey to Social Inclusion program, which assists with housing, social inclusion, economic participation and health and wellbeing. According to his case manager, Shayn was improving; he wanted to cease using drugs and wanted to make plans to sell his art in the future.

Medical history

7. Shayn began using cannabis at the age of 14, and as an adult regularly abused illicit and prescription drugs such as methylamphetamine, heroin, methadone and synthetic cannabinoids.

8. At the age of 20, Shayn was a passenger in a motor vehicle collision, sustaining a fractured vertebrae and an acquired brain injury. He also had anxiety and post traumatic stress disorder related to the collision, which deteriorated when he was homeless. He was prescribed medication for his mental health which helped his distress and agitation.

9. Shayn was epileptic but did not always prioritise taking his medication. He would send money to his sister Suzanne to hold until he needed to fill his prescriptions.

10. According to Shayn's general practitioner he was often demonstrative and distressed and would express hopelessness, but the impression was not one of suicidal risk.

THE CORONIAL INVESTIGATION

11. Shayn'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.

12. 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.

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Shayn's death. The Coroner's 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.

15. This finding draws on the totality of the coronial investigation into the death of Shayn Nathan Darmanin including evidence contained in the coronial brief. 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.[1]

[1] 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.

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

Circumstances in which the death occurred

16. On 29 November 2021, Shayn's case manager Anette Kirkeby spoke to him on the phone. He told her that he had had a seizure and was scared. She agreed to call the pharmacy to find out how much his medication would cost. Ms Kirkeby made enquiries with the pharmacy and attempted to call Shayn back, but he did not answer.[2]

17. On 1 December 2021, Ms Kirkeby looked for Shayn at Woolworths in Preston, where she often saw him. She then travelled to his home in West Footscray. His front door was open and the television was on, so she entered the home and found him lying on the floor with no signs of life. Ms Kirkeby contacted Emergency Services. Paramedics arrived shortly thereafter and declared Shayn to be deceased.

Identity of the deceased

18. On 10 December 2021, fingerprints of the deceased were compared with the Victoria Police LEAP database, confirming the deceased to be 'Shane Nathan Forde', whose legal name was Shayn Nathan Darmanin.

19. On the same day, my colleague Coroner Kate Despot reviewed the available material and determined that the cogency and consistency of all evidence relevant to identification of the deceased supported a finding that the deceased was Shayn Nathan Darmanin, born 12 December 1977. Accordingly, she signed a Determination by Coroner of Identity of Deceased (Form 8).

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

Medical cause of death

21. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Shayn Darmanin on 8 December 2021. Dr Fronczek considered the Victoria Police Report of Death (Form 83), VIFM contact log, medical records and post mortem computed tomography (**CT**) scan and provided a written report of her findings dated 17 March 2022.

[2] CB, Statement of Anette Kirkeby, dated 6 May 2022.

22. The autopsy revealed pulmonary emphysema, hepatic steatosis with mild fibrosis, cholestasis and mild inflammation, and cholelithiasis.

23. Toxicological analysis of post mortem samples identified the presence of the following:

    a) Methadone[3] in blood (~ 0.1mg/L) and urine

    b) EDDP (methadone metabolite) in urine

    c) 5F-Cumyl-PINACA (synthetic cannabinoid) in blood

    d) Cumyl-PEGACLONE (synthetic cannabinoid) in blood

    e) Olanzapine in blood (~ 0.02mg/L) and urine

    f) Duloxetine in blood (~ 0.01mg/L)

    g) Lamotrigine in blood (~ 1.9mg/L) and urine

24. Dr Fronczek commented that methadone, synthetic cannabinoids, olanzapine and duloxetine are capable of causing death. The pharmacology and toxicity of synthetic cannabinoids are not well known, which makes the interpretation of any measured concentration difficult. Overdose has been associated with acute kidney injury, metabolic disturbance, myocardial infarction, rhabdomyolysis, seizures and stroke.

25. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) MIXED DRUG TOXICITY (METHADONE, SYNTHETIC CANNABINOIDS (5F-CUMYL-PINACA AND CUMYL-PEGACLONE), OLANZAPINE, DULOXETINE) IN A MAN WITH EPILEPSY.

COMMENTS

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

1. Shayn had used the synthetic cannabinoids 5F-Cumyl-PINACA and Cumyl-PEGACLONE prior to his death. Synthetic cannabinoids are drugs that bind to and activate human cannabinoid receptors to produce subjective effects similar to cannabis, but which are chemically dissimilar to THC (the main psychoactive chemical in cannabis).

[3] The Department of Health advised that there was no permit to treat Shayn Darmanin with methadone.

2. The documented effects of synthetic cannabinoids include tachycardia, induction of acute psychotic symptoms and exacerbation of existing psychosis, agitation, panic and anxiety, nausea and vomiting, seizures, acute kidney injury and dependence and withdrawal following prolonged use.

3. In 2019 I investigated the death of Mr P[4], a middle-aged male who had consumed synthetic cannabinoids prior to his death. At the time of my investigation, synthetic cannabinoids were an emerging concern for Victorian coroners, both in their own right and as part of a broader growing trend in the involvement of new (or novel) psychoactive substances in Victorian deaths.

4. In my finding for that death I noted that there appeared to be a general lack of information and poor public understanding regarding the risks to health and life of using synthetic cannabinoids. I therefore recommended that the Victorian Department of Health and Human Services (as it was then known) consider how education regarding synthetic cannabinoids is disseminated to health services, and whether any training packages or similar are needed to equip clinicians to have conversations with patients about them.

5. Following up on these issues and noting another Victorian death on the same day as Shayn's also involving synthetic cannabinoids, I requested that the Coroners Prevention Unit (**CPU**)[5] establish whether synthetic cannabinoid involvement in Victorian deaths has continued to grow since I delivered my previous finding. The CPU advised that synthetic cannabinoid detections appeared to have peaked in 2019 (10 cases), before declining to only one case in 2022, none in 2023, and one case to date in 2024.

6. The CPU further advised that broader developments in drug markets may have contributed to this decline in synthetic cannabinoid detections. One such development was the expansion in patient eligibility for medical cannabis in Australia in recent years, coupled with streamlined prescribing requirements; these have been credited for a tremendous expansion in medical cannabis use, particularly from 2021 onwards.[6] A recent study found that exposure to synthetic

[4] COR 2019 005437.

[5] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist nonclinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

[6] See for example Graham M et al, "A provisional evaluation of Australia's medical cannabis program", International Journal of Drug Policy, vol 122, 2023, doi: 10.1016/j.drugpo.2023.104210; Australian Health Practitioners Regulation Agency, "Regulators come together as one million Australians turn to medicinal cannabis treatments", 20

cannabinoids dropped markedly in US states where permissive cannabis policies were introduced;[7] perhaps a similar effect is being observed in Victoria, with less demand for synthetic cannabinoids now that medical cannabis is more accessible.

7. The second possible explanation might be that synthetic cannabinoid supply to unregulated drug markets in Australia has fallen since 2021. While there is no useful data to illuminate this directly, the CPU noted that China has been identified as the major manufacturer and supplier of synthetic cannabinoids internationally, and Chinese regulation of certain synthetic cannabinoids have been linked with changes in detection of those substances in New Zealand border screening.[8] In 2021 the Chinese government announced that it had placed regulatory controls on all synthetic cannabinoids, effectively banning their manufacture; this may have reduced subsequent supply of synthetic cannabinoids to Australia.

8. Whatever the explanation, I consider that at present there is no strong rationale to make any further recommendations regarding synthetic cannabinoids. However, I will continue to monitor their involvement in Victorian deaths reported to the coroner.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Shayn Nathan Darmanin, born 12 December 1977;

   b) the death occurred on 01 December 2021 at 8/15 Clarendon Parade, West Footscray, Victoria, 3012;

   c) I accept and adopt the medical cause of death as ascribed by Dr Judith Fronczek and I find that Shayn Nathan Darmanin, a man with epilepsy, died from mixed drug toxicity including synthetic cannabinoids.

2. AND, having considered the evidence before me, I am satisfied that Shayn Nathan Darmanin's death was the unintended consequence of his intentional use and abuse of illicit and prescription drugs.

February 2024, < https://www.ahpra.gov.au/News/2024-02-20-medicalcannabis-treatment.aspx>, accessed 4 November 2024.

[7] Klein T et al, "Synthetic cannabinoid poisonings and access to the legal cannabis market: findings from US national poison centre data 2016–2019", Clinical Toxicology, vol 60(9), 2022, pp.1024-1028.

[8] Stansfield C et al, "Effects of external influences on synthetic cannabinoid trends in New Zealand, 2014 to 2020", Forensic Science International, vol 316, 2020, doi: 10.1016/j.forsciint.2020.110485.

I convey my sincere condolences to Shayn's family for their loss.

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

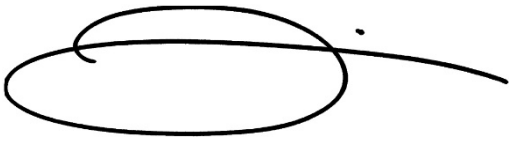
I direct that a copy of this finding be provided to the following:

Kya DeAngelou, Senior Next of Kin

Anita De Angelis

Detective Senior Constable James Lewis, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 27 February 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.