IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006447

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Christopher Patrick Dabadie
Date of birth:	26 December 1977
Date of death:	1 December 2021
Cause of death:	1(a) Unascertained
Place of death:	2/30 Falkiner Crescent, Dandenong, Victoria, 3175

INTRODUCTION

1. On 1 December 2021, Christopher Patrick Dabadie was 43 years old when he was found deceased on his couch. At the time of his death, Christopher lived in Dandenong.

2. According to medical records, Christopher's medical history included chronic right elbow wound following open reduction internal fixation for a fracture, left knee washout with patella tendon repair, pancreatitis, alcohol use disorder and possible alcohol withdrawal seizures.

THE CORONIAL INVESTIGATION

3. Christopher'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Christopher'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.

7. This finding draws on the totality of the coronial investigation into the death of Christopher Patrick Dabadie. 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

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

Circumstances in which the death occurred

8. On 29 November 2021, Christopher was found intoxicated by Protective Services Officers on a tram at Elsternwick Station. He was conveyed by ambulance to the Alfred Hospital, but self-discharged.

9. On 30 November 2021, Christopher was again found by Protective Services Officers at a tram stop at Federation Square. As he appeared unwell, the officers called an ambulance who conveyed him to the Alfred Hospital where he was found to be intoxicated. He again self-discharged against medical advice.

10. Overnight on 1 December 2021, a neighbour made a complaint about noise coming from Christopher's unit, including breaking of glass and banging on the fence.

11. Christopher's housing case manager Vivek Kumra attended at the unit and noticed a broken front window. After entering the unit, he found Christopher on the couch in the living room, non-responsive. He immediately called emergency services, who arrived shortly thereafter and declared Christopher deceased.

12. Police officers observed a bandage on Christopher's right forearm with blood visible. A small amount of blood was located on a pillow below the window, and on the floor near the dining table.

Identity of the deceased

13. On 1 December 2021, Christopher Patrick Dabadie, born 26 December 1977, was visually identified by his case manager, Vivek Kumra, who completed a Statement of Identification.

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

Medical cause of death

15. Forensic Pathologist Dr Gregory Ross Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Christopher Dabadie on 6 December 2021. Dr Young reviewed the Victoria Police Report of Death (Form 83), post mortem

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

computed tomography (**CT**) scan, scene photographs and medical records and provided a written report of his findings dated 6 June 2022.

16. The autopsy revealed moderate hepatic steatosis and mild double vessel coronary artery atherosclerosis, but no other significant natural disease. There were no significant neuropathological abnormalities seen in the brain.

17. The autopsy further showed an acute sharp force injury to the left upper arm, without associated injury to any significant blood vessels. This injury was consistent with a glass injury that may have been sustained by breaking a window. There was a non-healed fracture of the right elbow with inflammation but no evidence of deep or disseminated infection. There was no post mortem evidence of any injuries which may have caused or contributed to the death.

18. Dr Young commented that Christopher had a known history of epilepsy and alcohol withdrawal seizures, and that hypoventilation and/or cardiac changes occurring during or shortly after a seizure may cause death. He further identified the possibility of heritable cardiac arrhythmias.

19. Toxicological analysis of post mortem samples blood samples identified the presence of diazepam (~ 0.1mg/L) and its metabolite nordiazepam, and 5F-Cumyl-PINACA.

20. Dr Young commented that 5F-Cumyl-PINACA is a synthetic cannabinoid with no legitimate therapeutic use. Its pharmacology and toxicology are not well known, making interpretation of any measured concentration difficult. However, excessive consumption of some synthetic cannabinoids is known to be associated with seizure, cardiac anomalies or metabolic disturbances, which may lead to death.

21. Dr Young provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED.

COMMENTS

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

1. In 2019 I investigated the death of Mr P[2], 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.

2. In my finding for that death, delivered on 24 July 2020, 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. My colleague Coroner Leveasque Peterson made a similar recommendation (though focused more specifically on synthetic cannabinoid use among patients with cardiac conditions) in a subsequent finding delivered 15 May 2021.[3]

3. Following up on these issues, to contextualise my investigation into Christopher's death I requested that the Coroners Prevention Unit (**CPU**)[4] establish whether synthetic cannabinoid involvement in Victorian deaths has continued to grow since I delivered my 2020 finding. The CPU undertook a case identification and data collation exercise and advised that synthetic cannabinoid detections appeared to have peaked in 2019 (10 cases), before declining quite precipitously to only one case in 2022, none in 2023, and one case to date in 2024.

4. The CPU further advised that broader developments in drug markets may have contributed to this decline in synthetic cannabinoid detections.

5. 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.[5]

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[2] COR 2019 005437.
[3] COR 2018 004277.
[4] 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 non-clinical 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.
[5] 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 February 2024, < https://www.ahpra.gov.au/News/2024-02-20-medicalcannabis-treatment.aspx>, accessed 4 November 2024.

A recent study found that exposure to synthetic cannabinoids dropped markedly in US states where permissive cannabis policies were introduced;[6] perhaps a similar effect is being observed in Victoria, with less demand for synthetic cannabinoids now that medical cannabis is more accessible.

6. 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.[7] 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.

7. Whatever the explanation, I conclude 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 Christopher Patrick Dabadie, born 26 December 1977;

   b) the death occurred on 1 December 2021 at 2/30 Falkiner Crescent, Dandenong, Victoria, 3175;

   c) I accept and adopt the medical cause of death as ascribed by Dr Gregory Ross Young and find that Christopher Patrick Dabadie, a man using synthetic cannabinoids, died from unascertained causes.

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

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

[6] 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.
[7] 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.

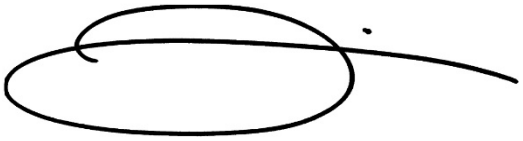
I direct that a copy of this finding be provided to the following:

Debra & Lesley Dabadie, Senior Next of Kin

Senior Constable Kimberley Donald

Senior Sergeant Ashley Sinfield

Signature:



AUDREY JAMIESON

CORONER

Date: 6 November 2024

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.
