IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004396

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Benjamin James Ralston
Date of birth:	29 January 1991
Date of death:	5 August 2022
Cause of death:	1a : Mixed alcohol and drug toxicity (heroin, promethazine, benzodiazepines, 3-fluoromethamphetamine)
Place of death:	8 Duggan Street, Brunswick West, Victoria, 3055

INTRODUCTION

1. On 5 August 2022, Benjamin ("Ben") James Ralston was 31 years old when he was found deceased. At the time of his death, Ben lived in Brunswick West with his partner Chloe.

2. Ben is remembered as a fun, social and intelligent young man.

Background

3. Ben grew up in Perth and Victoria. He was particularly close with his brother, Tom, and remained so throughout his life. Ben was bright, learned quickly and was a passionate reader. He also loved sport and played football, hockey and tennis.

4. In 2010, Ben moved to Melbourne to study a Bachelor of Archaeology at La Trobe University. After completing the course, he began a career in finance. He was an extremely hard worker, was well-regarded amongst his team and had received a promotion shortly before his death.

5. In January 2021, Benjamin began a relationship with Chloe, who he had known since 2016. They had a great relationship and moved in together in October 2021.

6. Ben was generally in good health. During year 12 he experienced disc degeneration and disc bulge in his lumbar spine, causing him to complete year 12 over two years. He was advised that he would never be able to engage in manual labour.

7. Ben drank heavily during social occasions and used recreational drugs, again in social settings.

THE CORONIAL INVESTIGATION

8. Ben'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 to be the Coronial Investigator for the investigation of Ben'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. This finding draws on the totality of the coronial investigation into the death of Benjamin James Ralston 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]

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

Circumstances in which the death occurred

13. After work on 4 August 2022, Ben went to the pub with Chloe's brother Joel. At around 7:45pm they stopped into Ben and Chloe's apartment, before heading out again to visit a few venues.

14. At around 1am on 5 August 2022 they returned to Ben and Chloe's apartment. Ben and Chloe had a short conversation where she told him that he had had enough to drink and to come to bed. So as not to disturb Chloe, Ben and Joel took some beers from the fridge and went to drink in the nearby Sheils Reserve. Joel passed out on a bench soon after.

15. At around 3:13am, a bystander called police to report a drunk male asleep on the nature strip of 9 Duggan Street, Brunswick West. The bystander could hear him snoring.

16. Police arrived at 3:44am and found the male, later identified to be Ben, unresponsive. They immediately commenced cardiopulmonary resuscitation (CPR) before paramedics arrived and took over.

17. Ben was unable to be revived and was declared deceased at 3:58am.

[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.

Identity of the deceased

18. On 11 August 2022, Benjamin James Ralston, born 29 January 1991, was visually identified by his partner, Chloe Simmons, who completed a Statement of Identification.

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

Medical cause of death

20. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Benjamin Ralston on 9 August 2022. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and VIFM contact log and provided a written report of her findings dated 7 March 2023.

21. The post mortem CT scan showed swelling about the brain. The external examination showed no evidence of any injuries that could have caused or contributed to death.

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

    a) Ethanol in blood (0.11 g/100mL)

    b) 6-Monoacetylmorphine in blood (~ 0.01 mg/L) and urine (~ 0.4 mg/L)[2]

    c) Morphine in blood (~ 0.2 mg/L) and urine (> 0.5 mg/L)

    d) Codeine in blood (~ 0.05 mg/L) and urine (> 1.0 mg/L)

    e) Promethazine in blood (~ 0.06 mg/L) and urine

    f) Diazepam in blood (~ 0.06 mg/L)

    g) Nordiazepam in urine (~ 0.06 mg/L)

    h) Temazepam in urine (~ 0.09 mg/L)

23. Dr Archer commented that the combination of drugs and alcohol detected would have led to fatal central nervous system and respiratory depression. Dr Archer initially ascribed the

[2] Indicates the recent use of heroin.

medical cause of death as 1(a) mixed alcohol and drug toxicity (heroin, promethazine, benzodiazepines).

24. At my request, further toxicological analysis was performed in December 2023. The novel psychoactive substance 3-fluoromethamphetamine was detected in blood. The original analysis was not able to positively identify this compound, but an expansion of the reference drug library allowed its identification in the reanalysis.

25. In a supplementary report dated 12 March 2024, Dr Archer provided an opinion that the medical cause of death was 1(a) MIXED ALCOHOL AND DRUG TOXICITY (HEROIN, PROMETHAZINE, BENZODIAZEPINES, 3-FLUOROMETHAMPHETAMINE).

COMMENTS

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

1. 3-fluoroamphetamine (often abbreviated as **3-FA**) is an amphetamine stimulant drug belonging to the wave of new psychoactive substances (**NPS**) that have spread through unregulated drug markets around the world over the past two decades. The term NPS refers to a diverse group of drugs that have similar psychoactive effects to illegal drugs traditionally used in recreational or non-clinical settings. 3-FA has effects similar to methamphetamine.

2. A defining feature of NPS as a group is their ever-changing composition; new NPS are being produced constantly, disseminated through unregulated drug markets and then dropping out of circulation.

3. The evolving nature of NPS creates significant intrinsic risk for people who use them, which is why they are a particular focus of current drug harm reduction efforts. They are developed and released without any rigorous clinical evaluation of their properties, meaning that a given NPS may have a stronger or weaker effect than the user anticipated, or unpredictable side effects when taken either alone or in combination with other drugs, which can increase the risk of harm.

4. This risk is exacerbated by the way that NPS are disseminated in unregulated drug markets. NPS are often passed off as other drugs, or included as adulterants, such that a person may use a substance without knowing exactly what it contains, heightening the risk of an adverse outcome from drug interactions and overdose.

5. The spread of NPS through Victoria's unregulated drug markets is reflected in the deaths investigated by Victorian coroners. Up to the end of 2017 there were only a small number of overdose deaths involving NPS, but this number grew steadily in subsequent years, from eight deaths in 2018 to 46 deaths in 2022. At the same time, the range of NPS contributing to Victorian deaths greatly expanded; early deaths primarily involved NPS stimulants and psychedelics, with benzodiazepines, empathogens, dissociatives and cannabinoids then progressively emerging as contributors over time.

6. In addition to NPS-involved overdose deaths, there are also several Victorian deaths each year where NPS are detected in post-mortem toxicology but the forensic medical investigation is unable to establish their role, if any, in the death. A challenge for toxicologists and forensic pathologists is that because the effects of many NPS are not known, they often do not have sufficient grounds to conclude the NPS contributed.

7. Ben's death is to date the only Victorian death where 3-FA has been identified as a contributing drug. This highlights an important prevention consideration: because NPS are always evolving, any harm reduction efforts need to address NPS as a group rather than focusing on individual NPS substances.

8. Over the past three years Victorian coroners have made recommendations regarding drug checking and a drug early warning network to reduce the risk of NPS-related harms.

9. A drug checking service enables a person who obtains a substance from an unregulated drug market to submit a sample, where it is analysed to establish what it contains. This information can then be provided back to the person who submitted the sample, as well as used to deliver harm reduction interventions such as education in risks of using the substance. Of particular relevance to these issues, a drug checking service would enable a person to learn whether a substance contains NPS and, if so, what these NPS are, thus empowering that person to make better informed decisions about using that substance.

10. I am extremely pleased to note that Victoria has committed to a Statewide Action Plan to reduce drug harms, which includes a pill testing (drug checking) trial to commence at the start of the summer 2024-2025 festival season. A mobile testing service will attend music festivals and events throughout the trial, and a fixed site is due to open in mid-2025, co-located with a health service in inner Melbourne. The government has advised that trained harm reduction peer workers and technical experts will be present during drug testing, to provide information about what is in the drug and give personalised and confidential harm reduction advice to help

people make informed decisions. The information gained by testing will also provide early public warning of emerging threats caused by NPS.

11. I cannot state that the availability of a drug checking service would have prevented Ben's untimely death, and in these specific circumstances it likely would not have. There is no guarantee that Ben would have used such a service had it been available, and the exact contribution of each of the identified drugs to his cause of death is unknown. However, drug checking would have at least provided an opportunity for him to find out more about the drugs he was taking, allowing him to make an informed decision.

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 Benjamin James Ralston, born 29 January 1991;

    b) the death occurred on 5 August 2022 at 8 Duggan Street, Brunswick West, Victoria, 3055;

    c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Benjamin James Ralston died from mixed alcohol and drug toxicity;

2. AND, having considered the available evidence, I find that Benjamin James Ralston's death was the unintended consequence of his intentional use and abuse of illicit and prescription drugs.

I convey my sincere condolences to Ben'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.

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

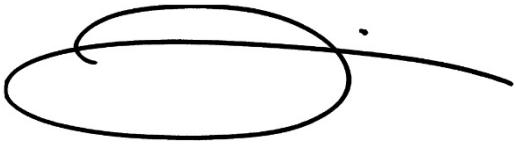
Chloe Simmons, Senior Next of Kin

Christina Bowker

Wayne Ralston and Debbie Eagles

Detective Senior Constable Patrick Cotterill, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 15 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.