IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002103

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	FT[1]
Date of birth:	8 May 2003
Date of death:	22 April 2023
Cause of death:	1(a) Injuries sustained in a motor vehicle collision (driver)
Place of death:	Ballan Road Service Road, Werribee, Victoria, 3030
Keywords:	Magic mushrooms, motor vehicle accident, hallucinogenic effects, psilocin, psilocybin

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

1. On 22 April 2023, FT was 19 years old when he died as a result of multiple injuries when his vehicle collided with a traffic light pole. At the time of his death, FT lived in an apartment in Werribee, which he rented with friends RA, HB and another.

2. FT was raised by his parents, Mr and Ms T, in the Traralgon area. FT is fondly remembered as a *'very popular young man*', who enjoyed spending time in the outdoors, fishing and exercising. At the time of his death, he worked as a trainee fumigation technician where he *'loved his job'* and *'worked hard'.*

3. FT held a Victorian driver's learners permit and was *'excited about getting his driver's licence'.* He owned a Ford Falcon XR6 which had previously belonged to his older brother.

4. Mr and Ms T both recall FT to be *'happy and healthy'*, and that he did not experience any known medical issues.

THE CORONIAL INVESTIGATION

5. FT'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of FT's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of this investigation until it came under my purview in October 2023 for the purposes of finalising the matter and handing down Findings.

10. This finding draws on the totality of the coronial investigation into the death of FT 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 21 April 2023, FT was at his Werribee apartment with his housemates, RA and HB. FT told HB he was *'feeling a little down'* because his girlfriend had to leave to attend a birthday party, however, HB noticed over the course of the evening he *'seemed to be happy and in a positive mood'.*

12. At approximately 10:00pm, FT was watching a film and told RA, *'I am just watching telly and I have had some mushrooms'*. RA had *'never seen someone on mushrooms before'* and so decided to sit nearby and monitor FT.

13. Three hours later, on 22 April 2023, at approximately 1:00am, RA assisted FT to bed and *'waited for him to fall asleep'.* Around 2:30am, RA also retired to bed.

14. At approximately 3:30am, HB was awoken by FT's footsteps. He recalls, *'I could hear [FT] grab a set of keys and then the front door opening'.* By the time HB rushed to the front door, he observed FT getting inside his vehicle and reversing down the driveway.

15. HB noticed that FT was struggling to manoeuvre the vehicle:

> *'I could see that his car wasn't straight and that he scraped some of the bushes along the driveway. [FT] backed his car out onto Mambourin Street until his back wheels mounted the grass on the centre median strip'.*

16. HB approached FT's vehicle, called his name in an attempt to get his attention, however, FT continued driving. He recalls:

[2] 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.

'I observed [FT] swing his vehicle wide, almost to the point where he was going to mount the footpath. [FT] was able to then straighten up his car where I observed him continue on the wrong side of Mambourin Street, heading towards Ballan Road'.

17. RA, having been awoken by the commotion, joined HB and the two of them ran to the end of Mambourin Street to locate FT, however, they could not see his vehicle. They returned to their apartment.

18. HB and RA then *'heard three separate loud bangs from [their] house'.* At the same time, a neighbour was awoken by a *'bang'*. She exited her house and observed the aftermath of motor vehicle collision in the nearby service lane of Ballan Road. She also noticed FT, who was unknown to her, lying prone, with obvious injuries, on the nature strip.

19. The neighbour contacted emergency services and attempted to stem the bleeding from FT's head. Victoria Police, Fire Rescue Victoria and Ambulance Victoria members arrived at the scene and commenced administering cardiopulmonary resuscitation (**CPR**). Resuscitation efforts were ultimately unsuccessful, and FT was declared deceased at 4:03am.

IDENTITY OF THE DECEASED

20. On 22 April 2023, FT, born 8 May 2003, was visually identified by his friend, RA, who completed a Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

22. Forensic Pathologist Dr Joanna Glengarry (**Dr Glengarry**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of FT on 24 April 2023. Dr Glengarry considered the Victoria Police Report of Death for the Coroner (**Form 83**), and post-mortem computed tomography (**CT**) and provided a written report of her findings dated 24 April 2023.

23. The post-mortem examination revealed multiple abrasions and lacerations about the body. A post-mortem computed tomography (**CT**) scan demonstrated multiple fractures including to the skull and spine.

24. Toxicological analysis of post-mortem samples identified the presence of psilocin at a concentration of ~ 25 ng/mL. Psilocin, a metabolite of psilocybin, is a psychoactive substance

commonly found in hallucinogenic or so-called 'magic' mushrooms. The intrinsic toxicity of psilocybin is generally very low, and deaths associated with psilocybin consumption are generally linked to the circumstances of misadventure or suicide rather than the toxicity of the hallucinogen itself.

25. Dr Glengarry provided an opinion that the medical cause of death was 1(a) *injuries sustained in a motor vehicle collision (driver)*.

26. I accept Dr Glengarry's opinion.

INVESTIGATION OF THE COLLISION SCENE

27. Victoria Police members investigated the scene and circumstances in which the collision occurred. The relevant stretch of Ballan Road has a posted speed limit of 70 kilometres per hour (**70 km/h**), was in good condition and free from hazards. At the time of the collision, the road was dry, and it was dark, though there was good visibility, and the traffic was light.

28. Evidence indicates that FT had been driving the Ford in a westerly direction on Ballan Road, approaching the intersection with Cambridge Drive. The vehicle veered off the road towards the left and collided with a traffic light pole. The vehicle continued travelling west and entered the service lane of Ballan Road before colliding with two stationary, unoccupied vehicles – a Toyota and a Subaru.

29. As a result of the impact, FT was ejected from the vehicle onto the nature strip.

30. At the scene, police members *'did not locate any pre-impact skid marks that indicated any emergency braking from the Ford prior to colliding with the traffic light pole'.* They identified tyre marks from FT's vehicle which were made as the vehicle continued towards the service lane.

<u>Reconstruction of the Collision</u>

31. Detective Senior Constable Yuxing Zhao (**DSC Zhao**) of the Forensic Services Department of Victoria Police undertook a reconstruction of the collision and provided a written report dated 24 May 2023.

32. According to DSC Zhao, once the Ford had collided with the traffic light pole and entered the Ballan Road service lane, it impacted with two vehicles. Damage sustained by the stationary vehicles indicates the first vehicle, a Toyota, was impacted at the rear, driver's side corner,

causing it to move forwards into a Subaru parked immediately in front. The impact of the collision with the Ford caused the Toyota to flip and come to rest on its roof. There was further damage to the Subaru, with DSC Zhao identifying that its *'driver side panels were distorted by a swipe-impact from the Ford'.* Following the sideswipe, the Subaru travelled forwards and collided with a nearby power pole.

33. FT's Ford came to rest facing north, perpendicular to the service lane. DSC Zhao identified the most substantial damage was to the front of the vehicle, where all front panels were missing. There was an additional crush impact to the engine cavity, consistent with a collision with the traffic light pole.

34. The driver seatbelt of FT's vehicle was *'retracted and locked, suggesting it was not worn at the time of the collision'*. The speedometer was *'locked'* and displayed a speed of 140 km/h. On this point, DSC Zhao clarified that *'no validation method can be used to assess whether the locked reading reflect the true impact speed. However, an impact speed of such magnitude is consistent with the damage at the scene'.*

35. DSC Zhao reviewed closed circuit television (**CCTV**) footage captured from nearby residents and which supported the reconstruction of the collision he had undertaken.

Mechanical Inspection

36. Senior Constable David Giulieri (**SC Giulieri**) of the Collision Reconstruction and Mechanical Investigation Unit of Victoria Police conducted a mechanical inspect on the Ford, and provided a written report dated 13 July 2023.

37. SC Giulieri concluded:

> *'There were no faults with the brakes, steering or accelerator system. Some components of these systems could not be fully examined due to being damaged, however, the damage to these components was consistent with the damage caused in the collision. Of the remaining components, my examination did not reveal any faults, failures or conditions that could have caused or contributed to the collision'.*

38. Additionally, there *'was no evidence of vehicle tampering found'.*

FAMILY CONCERNS

39. In correspondence to the Court dated 19 November 2024, Mr and Ms T expressed their concerns relating to the nature of FT's death, and queried whether there were any suspicious circumstances that led to his passing. In response to the family's concerns, I sought a supplementary statement from the Coroner's Investigator, Senior Constable Jarrad Portelli (**SC Portelli**).

40. SC Portelli acknowledges that there are minor inconsistencies between certain of the statements, including those provided by FT's housemates, HB and RA, however he *'found both statements to be fairly consistent and [holds] no concerns with both [HB and RA's] accounts from the nights'*. I note that human memory is fallible, especially in the wake of traumatic and distressing circumstances – indeed, RA provided his statement at 5:48am and HB some two weeks later.

41. SC Portelli reiterated his position that *'there were no suspicious circumstances'* involved in FT's death. I accept this assessment.

CORONERS PREVENTION UNIT

42. In the interests of a comprehensive investigation into FT's death, I sought the assistance of the Coroners Prevention Unit (**CPU**)[3] to better understand the factors present in the lead-up to the fatal collision and to assist in identifying any potential prevention opportunities.

43. The CPU provided me with information on 'magic mushrooms' in addition to that canvassed by Dr Glengarry in her post-mortem report. The CPU noted that the term 'magic mushrooms' refers to any mushroom containing the compounds psilocybin and psilocin. Psilocybin itself does not have a psychedelic effect; rather, when it is consumed it is converted quickly by the body into psilocin, which is a very potent psychedelic drug. For this reason, psilocybin is sometimes referred to as a "prodrug": a pharmacologically inactive compound that is metabolised into a pharmacologically active compound.

44. The CPU noted that the post-mortem concentration of psilocin is not a reliable measure of the hallucinogenic effect on the individual. Unlike alcohol, for which specific concentrations in

[3] 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.

blood can indicate the level of intoxication, psilocin concentrations cannot be used for such extrapolations. Therefore, it is not possible to gauge the degree of impairment which affected FT on the night of his death.

45. Deaths associated with magic mushroom ingestion occur through two main mechanisms, broadly described as the **toxic effects** and the **behavioural effects**. Regarding toxicity, higher doses of psilocin are believed to cause or contribute to adverse effects including cardiomyopathy, cardiac arrest and coma. These can lead to death, particularly when combined with other substances.

46. Regarding behavioural effects, psilocin's potent hallucinogenic and psychedelic effects can cause changes in the state of mind of those who consume it, leading them to perform actions they would not otherwise contemplate, including those that result in physical injury or death. Psilocin distorts vision and perception, increasing the risk to affected people when they interact with their environment.

47. I asked the CPU to provide me with information on previous motor vehicle accident deaths in which magic mushrooms had been identified as a factor. The CPU identified one prior death, which occurred in 2018, in which the individual, having consumed magic mushrooms, left their house and was fatally struck by a car (referred to further below as the death of 'Mr L').

48. At my request, the CPU also provided broader data regarding all deaths occurring in connection with magic mushrooms over the previous ten years. Between the years of 2014 and 2024, the CPU reviewed over 100 deaths where initial database searches suggested magic mushroom consumption may have occurred. The majority were not relevant and had only been identified by the CPU's searches because magic mushrooms and/or psilocin were mentioned incidentally in the coronial material. In most of the others, the evidence regarding magic mushroom use was inconclusive (for example, there was evidence of historical consumption but not proximal to the fatal incident; or magic mushrooms were located at the scene without evidence the deceased had consumed them, and so on).

49. There were 17 identified cases where psilocin was detected in post-mortem toxicology. Of these cases, the relationship between the magic mushrooms and the death varied. In two deaths, the toxic effects of the consumption were determined to have possibly or probably contributed to the death.

50. There were three deaths – in addition to FT's – where the **behavioural effects** of magic mushrooms were identified to be possibly or probably linked to the death. In two of these cases, the deceased individuals were around FT's age – between 19 and 21 years of age. In the first matter, the death of Mr N, the deceased consumed magic mushrooms and reportedly became introspective before he jumped out of an apartment window and died upon impact with the ground. The coroner concluded the death was *'accidental and occurred at a time he had consumed a quantity of the hallucinogenic drug psilocybin in the form of "magic mushrooms"'.*

51. In the second matter, the death of Mr L, the deceased consumed magic mushrooms and was watching television with friends before his demeanour rapidly changed, he became disturbed and abruptly left the house. He walked onto a nearby road and was fatally struck by a vehicle. The coroner concluded that Mr L's death was the result of *'impaired cognition as a consequence of ingestion of a hallucinogen that led directly to his irrational act of… stepping into the path of a car travelling at speed*'.

52. The CPU qualified that its data search was limited by multiple factors. These include that psilocin was not routinely tested by the VIFM until recent years, and therefore, prior deaths may have not been identified as belong to such a pattern. The CPU also stated that serious injuries sustained as a result of motor vehicle collisions and magic mushrooms may similarly be overlooked due to the limitations on the toxicological analysis that can be undertaken by Victoria Police following such events.

53. Accordingly, it is likely that there are further deaths and incidents of serious injury belonging to this pattern which have not been identified during the course of my investigation. Despite the limited yield, FT's death remains to be a tragic reminder of the catastrophic consequences that can flow from the consumption of magic mushrooms when combined with driving a motor vehicle.

COMMENTS

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

54. The circumstances of FT's death bring into sharp relief the frequency at which young people engage in risky and dangerous driving behaviours with fatal consequences.

55. Young drivers are highly likely to be involved in a motor vehicle incident and face a higher fatality rate than other age demographics. The Longitudinal Study of Australian Children

Annual Statistical Report of 2018 demonstrated that risky behaviour is far from uncommon in young drivers – with 80% of probationary drivers and 55% of learner drivers aged 16-17 having engaged in risky behaviours within their previous 10 journeys. These behaviours included driving while under the influence of alcohol or other common drugs, speeding and driving without a licence or seatbelt fastened.

56. The study also demonstrated that 4.5% of drivers between the ages of 16 and 17 years, and 9.1% of probationary license holders drove while under the influence of alcohol or other drugs during their previous 10 journeys. While the data was not stratified into specific substances, namely whether any individuals had been affected by magic mushrooms or other psychedelic substances, I consider these statistics to be striking.

57. Over recent years, statistics released by the Bureau of Infrastructure and Transport Research Economics have demonstrated an increase in the proportion of the yearly road toll attributed to young drivers on a national scale. In 2019, drivers aged between 17 to 25 years accounted for 18% of total driver deaths, this increased in 2022 to 20% and again in 2023 when they accounted for 22% of the total toll. Importantly, drivers below 25 years of age account for only 14% of total licence holders.[4]

58. In 2021, the Transport Accident Commission (**TAC**) launched a campaign to urge young drivers to buy the safest car that they can afford, having identified a high proportion of young persons' deaths occurring in older vehicles. This is a positive initiative and may reduce the severity and fatality of motor vehicle collisions, however, it remains that these efforts ought to be paired with public campaigns and education directed at young people, including in relation to using substances and driving a vehicle.

59. The Transport Accident Commission is currently undertaking research amongst drivers aged between 18 and 25 years to better understand their behaviours and attitudes towards driving.[5]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was FT, born 8 May 2003;

[4] Department of Infrastructure, Transport, Regional Development, Communications and the Arts, archived road deaths Australia. Accessible at: https://www.bitre.gov.au/publications/ongoing/rda/index.
[5] Transport Accident Commission, About TAC Surveys and Research. Accessible at: https://www.tac.vic.gov.au/road-safety/statistics/about-tac-surveys?drop=5.

b) the death occurred on 22 April 2023 at Ballan Road Service Road, Werribee, Victoria, 3030, from injuries sustained in a motor vehicle collision (driver); and

c) the death occurred in the circumstances described above.

61. Having considered the circumstances, I find that the fatal collision was caused by multiple compounding factors. I find that FT was an inexperienced driver who drove his car while under the influence of a hallucinogenic substance, at an excessive speed and without a seatbelt fastened. On the available evidence, the precise reason for which FT abruptly exited his Werribee house on the morning of 22 April 2023 remains unclear, but I am satisfied on the balance of probabilities that his judgment and functioning were impaired as a result of the substance he intentionally ingested.

62. Specifically, I find on the balance of probabilities that FT was affected by the hallucinogenic and psychedelic effects of so-called 'magic mushrooms'. He likely experienced distorted vision and perception, and impaired decision-making, which contributed to his decision to drive a car.

63. While there was no evidence of braking or other evasive action taken by FT prior to impact with the traffic light pole, I consider this to be likely due to his degree of impairment at the time of the collision, rather than reflective of any intentional conduct on his part.

I convey my sincere condolences to FT's family for their loss, and I acknowledge the distress caused by the sudden and traumatic circumstances in which he died.

ORDERS AND DIRECTIONS

I order that a de-identified version of 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:

Mr T

Ms T

Transport Accident Commission

Senior Constable Jarrad Portelli, Coroner's Investigator

Signature:

Coroner Ingrid Giles

Date: 06 January 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.