IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003988

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr RJ[1]
Date of birth:	[redacted] 1982
Date of death:	22 July 2023
Cause of death:	1a: COMPLICATIONS OF ACUTE ETHANOL TOXICITY
Place of death:	Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076
Keywords:	Alcohol toxicity, chronic alcoholism, ethanol, heavy alcohol consumption, alcohol harm reduction

[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 July 2023, Mr RJ was 41 years old when he died in hospital following a period of acute alcohol intoxication. At the time of his death, Mr RJ lived in Donnybrook with his partner, Ms BW.

Background

2. During his twenties, Mr RJ would *'drink socially'* with his friends. Eventually, Mr RJ's alcohol consumption increased. His mother, Ms AJ, recalled that he *'would drink alcohol alone in his bedroom on weekends (. . .) [she] would come home sometimes, and Mr RJ would be passed out on his bedroom floor'.*

3. From 2018, Mr RJ's friends observed instances of his intoxication. One friend recounted an occasion during which Mr RJ was observably intoxicated and *'slurring his words'* at lunch, leading them to believe that Mr RJ had commenced drinking alcohol earlier in the morning.

4. In 2020, Mr RJ met Ms BW, and in 2022, the couple moved in together. It was around this time that Mr RJ's alcohol consumption further increased, resulting in Mr RJ losing his driver licence due to driving while intoxicated. According to Ms BW, Mr RJ mostly drank alcohol on the weekends, and only occasionally during the week.

5. On 10 June 2022, Mr RJ was located by his sister *'passed out at the front door of his house'*. He was transported to Northern Hospital Emergency Department and found to have a blood alcohol content (**BAC**) of 0.414 g/100mL. Clinicians *'strongly advised'* Mr RJ to seek assistance and Mr RJ responded that he *'recognised his problem with alcohol misuse and the effect it had on himself, his family and his work but he stated that he finds it difficult to stop'.* Clinicians referred Mr RJ to ReGen (now Uniting) for support, however, there is no evidence that Mr RJ attended the service.

6. Ms BW similarly encouraged Mr RJ to seek professional support and to curb his alcohol consumption so they could *'start a family'.* In mid-2022, Mr RJ contacted Caraniche to organise Alcohol and Other Drug counselling. On 24 June 2022, Mr RJ attended an assessment appointment during which he described he drank *'1 bottle spirits [on] Friday and Saturday'* and that he often consumed the bottles within a *'two-hour period'*. Between July and August, five further appointments were scheduled however, Mr RJ either cancelled the appointments or did not attend.

7. Approximately one week prior to his death, Victoria Police members located Mr RJ being *'drunk and disorderly'* at a local train station. They transported him to Northern Hospital Emergency Department and Mr RJ was found to have a BAC of 0.405 g/100mL. Clinicians spoke with Mr RJ regarding the importance of therapy and seeking assistance. They suggested he stay another night in hospital *'to assist with detox'* but Mr RJ declined. Mr RJ told clinicians he *'wanted to follow up some of his issues with his [general medical practitioner]'.*

Medical History

8. Evidence indicates that Mr RJ experienced mental ill health since his adolescence and had diagnoses of anxiety and depression. Ms BW attributed Mr RJ's alcohol consumption to his mental ill health: *'Mr RJ would drink alcohol as a coping strategy for his depression'.*

9. Since May 2022, Mr RJ had approximately 11 or 12 consultations with a general medical practitioner (**GP**). Mr RJ was prescribed the anti-depressant, sertraline.

10. Mr RJ disclosed to his GP that he had previously attempted suicide via *'overdose'* however, it is unclear when this occurred. On 24 June 2022, during his intake assessment with Caraniche, Mr RJ denied experiencing any suicidal ideation.

11. Mr RJ's final consultation with his GP occurred on 17 July 2023. During this consultation, Mr RJ stated he was not experiencing any suicidal thoughts and appeared well-kempt.

THE CORONIAL INVESTIGATION

12. Mr RJ'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.

13. 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.

14. 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.

15. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr RJ's death. The Coronial 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.

16. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Mr RJ's death until it came under my purview in September 2023 for the purposes of finalising the investigation and handing down this finding.

17. This finding draws on the totality of the coronial investigation into the death of Mr RJ 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

18. On 21 July 2023, during the morning, Ms BW drove Mr RJ to their local VicRoads centre for the purposes of an appointment in relation to his driver licence, and continued on to her work. The couple exchanged text messages throughout the day. At approximately 2:40pm, Mr RJ told Ms BW that he was tired and going to go home.

19. At approximately 5pm, one of Mr RJ's neighbours exited his house and heard *'loud choking'*. The neighbour observed Mr RJ lying on a nearby driveway, he could smell alcohol and noticed there was vomit and blood nearby.

20. The neighbour contacted emergency services and at the call-taker's direction, placed Mr RJ in the recovery position. He recalled that *'it looked like he was having a seizure as his arm was jerking'*. Soon afterwards, Ms BW returned home from the supermarket and located the neighbour and Mr RJ.

21. Ms BW and the neighbour recalled that Mr RJ's *'colour changed'* and they commenced cardiopulmonary resuscitation (**CPR**) until emergency services arrived and took over. After approximately 55 minutes of CPR, Mr RJ demonstrated a return of spontaneous circulation.

[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.

22. Paramedics transported Mr RJ to Northern Hospital Emergency Department. Upon arrival Mr RJ had a BAC of 0.446 g/100mL, was admitted to the Intensive Care Unit (**ICU**) and intubated. Clinicians concluded he experienced a cardiac arrest due to respiratory failure caused by aspiration and/or alcohol intoxication. This was supported by lung markings present on a computed-tomography (**CT**) scan.

23. Mr RJ's condition declined, and clinicians believed he had a *'very poor chance of any neurological recovery given 55 minute downtime'*. Clinicians met with Mr RJ's family to discuss his condition, and it was decided to transition him to an end-of-life pathway.

24. On 22 July 2023 at 4:00pm, Mr RJ was declared deceased.

IDENTITY OF THE DECEASED

25. On 22 July 2023, Mr RJ (whose full name is known to the Court), born 10 July 1982, was visually identified by his mother, Ms AJ, who completed a formal Statement of Identification.

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

MEDICAL CAUSE OF DEATH

27. Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Mr RJ on 24 July 2023. Dr Lynch considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem CT scan and e-Medical Deposition Form completed by Northern Hospital and provided a written report of his findings dated 5 September 2023.

28. The post-mortem examination revealed findings consistent with the reported history and medical intervention.

29. Toxicological analysis of ante-mortem samples collected by Northern Hospital at 7:20pm on 21 July 2023 identified the presence of the following:

Ethanol (alcohol)	0.36 g/100mL
Acetone	~ 24 mg/L
Rocuronium	~ 1.9 mg/L
Diazepam	~ 0.06 mg/L

Nordiazepam	~ 0.04 mg/L
Sertraline	~ 0.02 mg/L

30. Dr Lynch provided an opinion that the medical cause of death was 1(a) *complications of acute ethanol toxicity*.

31. I accept Dr Lynch's opinion.

THE PREVALENCE OF ALCOHOL-RELATED HARM AND ASSOCIATED PREVENTION STRATEGIES IN VICTORIA

32. As I noted in the recently-published finding into the death of Kathleen Arnold,[3] in my role as a coroner, I regularly encounter the fatal consequences of alcohol use among the Victorian community. Each year more than 150 deaths involving the acute toxic effects of alcohol are reported to the Coroners Court of Victoria. At least another 100 deaths reported each year are caused by the chronic effects of alcohol use. However, these deaths represent only a proportion of all alcohol-related deaths, as most deaths resulting from chronic alcohol use are not reportable under the *Coroners Act 2008* (Vic), given they are largely classified as deaths that are due to 'natural causes' and therefore, unless they are also 'unexpected', will not usually be reported to the coroner.

33. More broadly, alcohol is a factor in a myriad of deaths in the absence of the complications of chronic consumption. Such circumstances include homicides where alcohol use was implicated; suicides of people who had a history of alcohol use and/or who were alcohol affected; fatal motor vehicle collisions where a driver or other involved person was affected by alcohol; drownings of people intoxicated by alcohol; and many others.

34. To explore what might be done to address the deadly toll of alcohol in the Victorian community, I commenced an analysis of certain of the deaths I am currently investigating in which the person, prior to death, had been engaged in alcohol use for an extended period, and the death was the direct result of alcohol consumption. My hope was that, through examining the circumstances of deaths falling into this broad category, I might be able to identify some commonalities pointing to potential areas for intervention to reduce alcohol-related harms.

[3] Finding into death without Inquest into the Death of Kathleen Arnold (COR 2023 005162), dated 11 February 2025, COR 2023 5162, Accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/2025-02/COR%202023%20005162%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest.pdf.

35. However, from review of the material I was unable to identify any meaningful commonalities. The alcohol-related deaths under my investigation were of people who had diverse socio-demographic profiles, patterns of alcohol use, mental health histories, and histories of engagement in treatment for alcohol related harms. They died in diverse circumstances linked to their alcohol use, reflecting the diverse ways tin which alcohol can cause harms across the Victorian community.

36. I then resolved to approach the investigation from a different direction, looking at what inquiries and reviews Victorian and Commonwealth governments had conducted over time to explore how to address alcohol-related harms, in the hope that I might identify any potential prevention opportunities among these. The Coroners Prevention Unit (**CPU**)[4] assisted me to identify relevant initiatives, which included the following:

i. The Parliament of Victoria Drugs and Crime Prevention Committee's Inquiry into Strategies to Reduce Harmful Alcohol Consumption (**Inquiry**), which delivered its final report in March 2006 after two years of consultation and work;[5]

ii. The Victorian Government's Alcohol Action Plan 2008-2013, which was published in May 2008 by the Victorian Department of Health and described specific actions to be taken as well as a broader framework for change to address alcohol misuse in Victoria;[6]

iii. The Victorian Auditor-General's Office report "Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm", published in June 2012, which examined the roles of Victoria Police, the Department of Justice and the Victorian Commission for Gambling and Liquor Regulation in preventing and reducing alcohol-related harm in Victoria;[7]

[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 including by providing data and statistics into the prevalence of certain deaths.

[5] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*. Volumes 1 and 2, and the Response to the Final Report, published on 23 March 2006. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria.

[6] Ministerial Taskforce on Alcohol and Public Safety, *Restoring the balance: Victoria's Alcohol Action Plan 2008-2013*, published May 2008. Accessible at: Victoria's Alcohol Action Plan 2008-2013 - May 2008.

[7] Victorian Auditor-General's Office, *Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm*, tabled on 20 June 2012. Accessible at: Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm | Victorian Auditor-General's Office.

iv. The VicHealth Alcohol Strategy 2019-2023, which was published in August 2019;[8] and

v. The Australian Government Department of Health and Aged Care's National Alcohol Strategy 2019-2028, published in December 2019, which was intended to guide state and territory governments as well as communities and health service providers in their responses to alcohol-related harms. This succeeded the National Alcohol Strategy 2006-2011 (there was no strategy in place during the intervening period 2012-2018).[9]

37. Additionally, noting that the Australian Parliament Standing Committee on Health, Aged Care and Sport is currently conducting an Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia (**the Inquiry**),[10] I considered the submissions received to date, in particular the submission of Alcohol Change Australia.[11] I acknowledge there are many excellent submissions to this Inquiry; I selected the Alcohol Change Australia submission for review because: (i) it specifically addresses alcohol-related harms; and (ii) the member organisations of Alcohol Change Australia include a number of highly respected public health bodies.

38. In reviewing the material, I was struck by the fact that despite these initiatives occurring over a 20-year time span, there was nonetheless a high degree of concordance between them regarding what needs to be done to reduce alcohol-related harms. The following broad areas were consistently identified as requiring action (though not every area was addressed in every document):

i. **Pricing:** Alcohol prices can influence risky alcohol use and associated harms, and changes to pricing may reduce harms.

ii. **Taxation:** Different types of alcohol products are taxed differently at present in Australia, and some taxation arrangements contribute to harmful alcohol use. Changes to how alcohol is taxed may reduce harms.[12]

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[8] VicHealth, *Alcohol Strategy 2019-2023*, published 5 August 2019. Accessible at: VicHealth Alcohol Strategy 2019–2023 | VicHealth.

[9] Australian Government Department of Health, *National Alcohol Strategy 2019-2028*, Canberra: Department of Health published December 2019. Accessible at: National Alcohol Strategy 2019–2028 | Australian Government Department of Health and Aged Care.

[10] *See in this regard* Inquiry into the health impacts of alcohol and other drugs in Australia – Parliament of Australia.

[11] Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions.

[12] For completeness, some alcohols (such as beer and spirits) are taxed proportionately to their alcohol content while other alcohols (such as wines) are taxed based on their price. As such, cheaper wine products are taxed less than premium wines, despite that their alcohol concentrations may be the same. Submissions of Alcohol Change Australia identify

iii. **Regulation:** The way that alcohol is made available (through sale and service) to the Victorian community is subject to regulatory controls. There are a number of areas (including but not limited to density of venues where alcohol is served or sold, times when alcohol is available, ways alcohol can be purchased, enforcement of regulations relating to alcohol service and sale, training requirements for those who serve or sell alcohol, and permitted types of alcohol promotions) where changes to regulation may reduce harms associated with alcohol use.

iv. **Healthcare:** It is critical to ensure that appropriate treatment is available in a timely manner to persons experiencing alcohol dependence or other alcohol-related health problems, and/or who are seeking assistance to reduce or cease alcohol use. This includes early intervention programs to support persons who may be at risk of harmful alcohol use.

v. **Advertising:** There are links between advertising and other alcohol promotion (for example via sponsorships) and harmful alcohol use. Advertising restrictions may be a potent harm reduction initiative, particularly if they result in a reduction in young people's exposure to alcohol product advertising. [13]

vi. **Product labelling:** Alcohol drink containers present opportunities to communicate information about alcohol use and its health impacts.[14]

vii. **Education for young Victorians:** There is a strong imperative to ensure that in schools and other contexts, young people are provided appropriate and effective education in responsible alcohol use and alcohol-related harms.[15]

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that *'high-volume, high-alcohol wine (such as cask wine) is often being sold at low prices'* (*see* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions at page 7).

[13] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 6.

[14] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 7-8.

[15] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 6. The need for education for young Victorians is also reflected in the recent finding of Coroner Catherine Fitzgerald in relation to the death of a 16-year-old boy from complications of acute alcohol intoxication – *see in this regard* the Finding into death without Inquest of LG, 12 December 2024. Accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/New_De-identified_COR%202022%20007423%20Form%2038%20-20Finding%20into%20Death%20without%20Inquest.pdf

viii. **Community education:** The negative impacts of alcohol use in the Victorian community may be addressed by taking action to increase general awareness about individual, family and community harms associated with alcohol consumption, and how to prevent or reduce them.[16]

ix. **Social attitudes towards alcohol:** Certain social attitudes support harmful alcohol consumption, such as the expectation that alcohol is consumed on social occasions and at celebratory events, and tolerance of high consumption levels. If these social attitudes can be changed, harmful alcohol use can be reduced.

39. Recognition of the need for action across these areas appears to extend back even further in time than the period I examined. I note that back in 2006, the Drugs and Crime Prevention Committee were already declaring that:

> *'There is now general agreement in both the national and international literature as to what is the most effective range of responses available to policymakers to address alcohol-related harms.'*[17]

40. This was echoed in the 2024 Alcohol Change Australia submissions to the Inquiry that:

> *'We know what works and it is time to implement a systematic, coordinated and evidence-based approach to reduce harm from alcohol in Australia.'*[18]

41. This 2024 call to action, nearly two decades on from the Drugs and Crime Prevention Committee's final report, led me to examine how the Victorian Government is currently coordinating its efforts to reduce alcohol related harms.

42. In particular, I noted that after the Victorian Government's Alcohol Action Plan 2008-2013 expired, there did not appear to be any follow-up action plan to build on what was trialled, implemented and achieved. This was to my mind unfortunate, given that effecting change in

[16] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 7-9.

[17] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*, Volume 1. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria, page xi.

[18] Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 2.

such diverse domains as social attitudes, community education and regulation requires sustained effort. The Drugs and Crime Prevention Committee observed in 2006 that:

> *'In an area as complex as alcohol and other drug policy it is neither possible nor desirable to achieve sustainable and long term change overnight. Incremental or gradual change is not only the most feasible way of moving forward but also the most desirable. As well, it is an approach that recognises community attitudes and the reality of the political and bureaucratic environments in which policy change occurs.'*[19]

43. Perhaps efforts to renew the Victorian Alcohol Action Plan were redirected towards the development of the National Alcohol Strategy 2019-2028, which was endorsed by State and Territory governments. However, if this is the case, it raises a further question about what Victoria has done under the auspices of the National Alcohol Strategy 2019-2028, noting the Strategy emphasises the central role of States and Territories in implementation:

> *'Jurisdictional implementation allows for governments to take action relevant to their jurisdiction with a national harm minimisation approach and strategies should reflect local circumstances and address emerging issues and drug types. It is expected that jurisdictions will prioritise actions that are evidence-informed and demonstrated to have the greatest impact on preventing and reducing alcohol-related harms.'*[20]

44. While the National Alcohol Strategy 2019-2028 describes a regular reporting framework to measure Strategy effectiveness and progress,[21] I have been unable to source any publicly-available reports describing Victoria's actions under the Strategy or progress towards goals. Further to this point, my attention was directed to an April 2024 report in which Alcohol Change Australia documented a *'lack of public monitoring or reporting'*[22] relating to the Strategy, and conducted their own analysis of the Strategy to establish that:

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[19] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*, Volume 1. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria, page xiii.

[20] Australian Government Department of Health and Aged Care, *National Alcohol Strategy 2019-2028*, published in December 2019. Accessible at: National Alcohol Strategy 2019–2028 | Australian Government Department of Health and Aged Care, page 13.

[21] Ibid at page 32.

[22] Alcohol Change Australia, *A Mid-Point Review of the National Alcohol Strategy 2019-2028: How is Australia tracking on reducing alcohol use and harms?* Published April 2024 and accessible at Alcohol-Change-Australia-report-A-mid-point-review-of-the-National-Alcohol-Strategy-April24.pdf page 2.

'There has been minimal or no change in alcohol use and harms across a range of indicators since the Strategy was introduced in 2019.'[23]

45. I draw no conclusions from this about what actions Victoria has, or has not, taken under the auspices of the National Alcohol Strategy 2019-2028, nor their merits or effectiveness. However, this situation clearly highlights the need for Victoria to lead its own program of work (whether described as a *'strategy'*, an *'action plan'* or otherwise) to address alcohol-related harms in the community.

46. This program of work should describe what specific actions are undertaken, the timeframes within which they should be implemented, who is responsible for them, and how they will be evaluated for effectiveness. It should also incorporate public reporting on implementation and evaluation of these actions to address alcohol-related harms. I expect that identifying and prioritising actions to be undertaken within the program of work will be straightforward; as already discussed, there is longstanding consensus on what needs to be done.

47. The Victorian Government announced in April 2024 that it would develop a new 10-year strategy to address alcohol and other drug harms. I understand that early work has already commenced, including stakeholder consultations to inform strategy development.[24] This could potentially be the vehicle for developing the program of work described above, however, as the scope and outcomes of the strategy have not yet been formalised, I cannot confirm whether this is the case. Therefore, a pertinent comment will be made in this respect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr RJ (whose full name is known to the Court), born [redacted] 1982;

    b) the death occurred on 22 July 2023 at Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076, from 1(a) *complications of acute ethanol toxicity*; and

    c) the death occurred in the circumstances described above.

[23] Ibid.
[24] Victorian Government Department of Health, *'Alcohol and Other Drug Strategy: What we heard overview'*, November 2024. Accessible at: https://www.vaada.org.au/wp-content/uploads/2024/12/AOD-Strategy-What-We-Heard-overview.pdf.

49. Having considered all of the circumstances, I find that Mr RJ's death occurred in the context of an extended history of alcohol consumption.

50. I note that Mr RJ indicated a desire to cease his alcohol consumption and had engaged with a service to assist him to do so, however, he faced difficulties with ongoing engagement with the service.

51. While there is evidence that Mr RJ experienced mental ill health including a prior suicide attempt, there is no evidence that he consumed alcohol in the lead-up to his death with the explicit intention to take his own life. However, on the background of previous hospitalisations and encouragement towards alcohol counselling, the circumstances of Mr RJ's death suggest a degree of recklessness regarding the potentially fatal consequences of excessive alcohol consumption.

52. Having made comments about the prevalence of alcohol-related harm in the Victorian community, I consider that the circumstances of Mr RJ's death bring into focus a range of prevention opportunities in this sector.

I convey my sincere condolences to Mr RJ's family for their loss and recognise the support provided to him by those who loved him.

COMMENT

Pursuant to section 67(3) of the Act, I make the following comment:

1. I note that I recently handed down three recommendations in my Finding without Inquest into the Death of Kathleen Arnold, who died in circumstances of alcohol toxicity.[25] The recommendation relevant to the present finding is '*that the **Victorian Government**, led by the **Victorian Department of Health**, develop: (i) a new Alcohol Action Plan; or (ii) a program of work (including specific actions, timeframes, accountabilities, and public reporting on implementation and evaluation) to address alcohol-related harms in Victoria*'.

2. I have noted this recommendation in Mr RJ's finding for the purposes of completeness and to reflect the range of circumstances in which people in this State die, very tragically, from the effects of alcohol, which underpins the need for a range of strategies to address alcohol-related

[25] Finding into death without Inquest into the Death of Kathleen Arnold (COR 2023 005162), dated 11 February 2025, COR 2023 5162, Accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/2025-02/COR%202023%20005162%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest.pdf.

harm in all its various forms. The Victorian Government and Department of Health may wish to consider and provide comment on Mr RJ's death in the context of their responses to this recommendation, which are due to be received on or around 12 May 2025.

ORDERS AND DIRECTIONS

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:

Ms BW, Senior Next of Kin

Victorian Department of Justice and Community Safety

Victorian Department of Health

Australian Government Department of Health and Aged Care

Victorian Alcohol and Drug Association

Alcohol Change Victoria

Alcohol Change Australia

FARE Australia

First Constable Liam Lewis, Coronial Investigator

Signature:

Coroner Ingrid Giles
Date: 18 March 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.