IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2023 005415**
**COR 2023 005416**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Catherine Fitzgerald |
| Deceased: | Laurence John Cox |
| Date of birth: | 27 May 1960 |
| Date of death: | Between 22 and 28 September 2023 |
| Cause of death: | 1(a) Sodium nitrite toxicity |
| Place of death: | 9 Florence Street<br>Niddrie Victoria 3042 |
| Deceased: | Ryley Ann Cox |
| Date of birth: | 12 January 1991 |
| Date of death: | Between 21 and 28 September 2023 |
| Cause of death: | 1(a) Sodium nitrite toxicity |

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|---|---|
| Place of death: | 9 Florence Street<br>Niddrie Victoria 3042 |

## INTRODUCTION

1. On 28 September 2023, Laurence John Cox, 63 years old, and his daughter, Ryley Ann Cox, 32 years old, were found deceased in their home. At the time of their deaths, Mr Cox and Ms Cox together lived at Niddrie, Victoria.

2. Mr Cox started using illicit drugs including heroin as an adolescent. He later commenced a methadone program. It is believed that he was abstinent from heroin use and methadone for a number of years prior to his death.

3. Mr Cox's medical history included anxiety, depression, emphysema, hepatitis C, invasive squamous cell carcinoma (treated with local excision), uveitis, and spondylitis. Mr Cox was legally blind, due to his uveitis. Mr Cox regularly complained of stomach and bowel issues to his family and to his friend, Russell Hall, and feared that he had stomach cancer, but refused to seek a medical diagnosis. Mr Cox was intermittently engaged with a clinical psychologist, although this appeared to cease in late-2017. He consulted with another psychologist on a limited number of occasions in 2019, however was not seeing this psychologist at the time of his death.

4. Mr Cox met Monique (Natalie) Nolisimo and commenced a relationship with her in the late 1980s. Ms Nolisimo fell pregnant with Ryley Cox in 1990. Mr Cox's sister, Cheryl Smith, noted that Ms Nolisimo did not have much involvement with Ms Cox over the course of her life.

5. Ms Cox's medical history included anorexia, secondary amenorrhoea, self-harm, alcohol dependence, depression, and substance abuse, namely cannabis since mid-adolescence and crystal methylamphetamine later in life. Ms Cox also had intermittent engagement with counselling, seeing a psychologist in 2015 but did not have any further sessions closer to the time of her death. Ms Smith noted that Ms Cox regularly spoke about "*grim*" topics such as death and methods to end one's life.

6. After leaving school, Ms Cox had two long-term relationships that were allegedly abusive, including physical and psychological abuse. Police and family violence support services were intermittently involved with Ms Cox and her former partners. Ms Cox left an allegedly abusive boyfriend in about 2015. Ms Smith reported that after the end of this relationship, Ms Cox became "*a hermit*" when she moved in with her father. She rarely left home, other than to attend her local supermarket.

## THE CORONIAL INVESTIGATION

7. The deaths of Mr Cox and Ms Cox were reported to the Coroner as they 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.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of the deaths of Mr Cox and Ms Cox. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the deaths of Laurence John Cox and Ryley Ann Cox, 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

12. About a year prior to his death, Mr Cox asked to meet up with his friend Mr Hall. When they met for coffee, Mr Cox informed Mr Hall that he intended to end his life. Mr Cox informed his friend that Ms Cox was "*going to go with [him]*" and that "*she doesn't want to live without [him] and can't survive without [him]*". The pair spoke about the issue for some time, and Mr

[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.

Cox stated, "*I don't want to suffer like my mum's suffered*", referring to his mother who died from cancer. According to Mr Hall, Mr Cox and Ms Cox believed cancer was hereditary, and they feared also developing stomach cancer. At the end of the meeting with Mr Cox, Mr Hall opined that his friend was "*still thinking about it but he wasn't sure how he was going to carry it out*". Mr Hall did not think Mr Cox had a plan in place but thought that Ms Cox was "*looking to do it with him as well*".

13. Following their meeting in about October 2022, Mr Hall remained in contact with Mr Cox. Mr Cox told him about contacting Dr Philip Nitschke, the founder and director of pro-euthanasia group, Exit International. Mr Cox also advised Mr Hall that he was surprised and shocked to learn that his mother had a new will, in which he only inherited half of the family home, which is where he lived with his daughter. He previously understood that he would inherit the entire house. Mr Hall observed Mr Cox seemed to lose the drive to "*chase up*" the will and his mood deteriorated.

14. From about March 2023 until mid-September 2023, Mr Cox started making large withdrawals from his Bendigo Bank account, up to $10,000 at a time, totalling $75,000. The bank became suspicious of his regular withdrawals and required him to present photo identification before he made any further withdrawals. Mr Cox and his daughter both obtained passports so that he could continue to make withdrawals.

15. Mr Hall encouraged his friend to see a solicitor and get advice about contesting the will. Mr Hall made an appointment for Mr Cox, where the solicitor advised they could represent him and could contest the will. However, Mr Cox was frustrated with the process and decided that he simply wanted to sell the house and move out.

16. In mid-2023, Mr Cox's solicitor informed the family that Mr Cox intended to sell the family home (previously owned by his mother), where he and Ms Cox were living. This came as a surprise to Ms Smith and the family, as they were unaware that this was his intention and he had not discussed it before. Mr Cox engaged a real estate agent to commence the sale process. Ms Smith and her daughter (the executor of the will) had little involvement in the process.

17. On 2 July 2023, a folder was created on Ms Cox's laptop which contained information about options for suicide, including Nembutal (pentobarbital), sodium azide, sodium nitrite and antiemetic drugs. On 17 July 2023, Ms Cox's Commonwealth bank card purchased two 25mg doses of pure sodium nitrite from a Polish website. This was delivered by DHL addressed to Ms Cox on 27 July 2023. Ms Cox's Commonwealth bank card purchased another two doses

of sodium nitrite from the same website that day, which were delivered addressed to her on 7 August 2023. Between the two deliveries, a document was downloaded to Ms Cox's mobile phone which contained instructions on preparing and ingesting sodium nitrite including how long it would take for death to occur.

18. On 26 August 2023, Mr Cox was collected from his home by his niece, Jessica Smith. Mr Cox requested the meeting to discuss his mother's will and estate. Mr Cox was unable to direct Ms J Smith to his usual café, the one he had been attending for about 20 years, and he acknowledged his surprise that he was unable to find the café. Once at the café, Mr Cox did not discuss the will, and said there was nothing specific that he wanted to discuss. He mentioned to Ms J Smith that he was proud of her and wanted her to take care of herself. Later that day, Mr Cox sent a message to Mr Hall explaining that he had met with his niece to move the estate process along.

19. Real estate agent, Paul Filippone, attended Mr Cox's home on 8 September 2023 to conduct a valuation. Mr Cox refused to provide Mr Filippone with a key to the property but agreed to vacate the home during any open house inspections.

20. The next day, a video was downloaded on Ms Cox's laptop depicting Dr Nitschke providing instructions for "*Potentiating Nitrite with Propranolol*". It explained that the combination of sodium nitrite and propranolol makes a "*stronger 'lethal drink'*".

21. On 16 September 2023, Mr Filippone attended Mr Cox's home for an inspection. Mr Cox left the home as previously agreed and took his dog. After no-one attended the inspection, Mr Filippone left and locked the doors behind him to secure the premises. He did not see Mr Cox or Ms Cox when he left.

22. On 19 September 2023, Mr Filippone called Mr Cox and left a message to organise another inspection for 23 September 2023. Mr Filippone did not receive a call or message in response.

23. The next day, Ms Cox attended her local Woolworths to purchase groceries. She was observed on CCTV at the Niddrie Shopping Centre that morning and returned home at about 11.54am. This is the last known sighting of Ms Cox. At about 1.30am on 21 September 2023, a 'notes' application was accessed on Ms Cox's phone. The note contained instructions on how to prepare sodium nitrite for ingestion.

24. On 21 September 2023, Mr Filippone was in the Niddrie area. As he had not heard from Mr Cox, he decided to pass by the home. He knocked on the door but was unable to raise anyone inside, so he left his business card in the door.

25. On 22 September 2023, Mr Hall received a phone call from Mr Cox, asking to meet for brunch on Monday 25 September 2023. Mr Hall advised he would collect Mr Cox at his home at about 10.30am, after he attended the gym. This was their usual routine.

26. On 22 September 2023, Mr Cox was recorded during daylight hours walking past a house in his neighbourhood, which was recording footage on a CCTV camera. He was taking his dog for a walk. His mobile phone's 'Health' application recorded increased activity during this time which correlates with this walk. This was the last known sighting of Mr Cox.

27. At about 7.30pm that day, the video about how to prepare sodium nitrite for ingestion was accessed on Ms Cox's laptop.

28. From 23 September there were no spikes in electricity usage recorded at the home of Ms Cox and Ms Cox, indicating there was no one using electrical items in the house.

29. On 24 September 2023, Mr Hall sent a text message to Mr Cox, to confirm he would attend at 10.30am on the following day as previously arranged. Mr Hall did not receive a response from Mr Cox.

30. Mr Hall attended Mr Cox's home on the morning of 25 September 2023 as previously agreed. He knocked on the door but was unable to raise anyone inside the house. Mr Hall called and left messages for Mr Cox, however, was unable to speak with him. Mr Hall returned the next day, 26 September 2023, and left a message on the front door, asking Mr Cox to call him.

31. By 27 September 2023, Mr Hall became increasingly concerned for his friend. His wife suggested calling Ms Smith, however Mr Hall did not have her phone number. Mr Hall attended the house again on 28 September 2023 and spoke to the neighbours. Mr Cox's neighbours stated they had not seen either Mr Cox or Ms Cox since about 22 or 23 September 2023. Mr Hall decided to call Mr Filippone, given that his contact details were located on the sales board at the front of the house. Mr Filippone noted that he had similarly not heard from Mr Cox and had been unable to conduct an open house on 23 September 2023, as previously planned. Mr Filippone agreed to contact Mr Cox's family.

32. Mr Filippone called Ms J Smith on 28 September 2023. Ms J Smith advised Mr Filippone that she would ask Ms Cox to get her father to return the real estate agent's calls. However, when Ms J Smith attempted to contact Ms Cox, she found her phone was switched off. She attempted to contact Mr Cox and encountered the same issue. Ms J Smith provided this information to Mr Filippone, who agreed to attend the house and knock on the door. Mr Filippone attended the house again, however, was still unable to raise anyone inside. He also told Ms J Smith that the card he had left the week before was still in the door and that the mail had not been collected from the mailbox.

33. Ms J Smith was concerned and decided to call the Avondale Heights Police Station to request a welfare check. Whilst waiting for police to attend, Ms J Smith and her two daughters decided to drive to the house. Upon their arrival, Ms J Smith spoke with Mr Cox's neighbour, Troy Shine. Mr Shine explained to the family that his daughter was a police officer, and offered to help.

34. Mr Shine and his daughter gained access to Mr Cox's house via an unlocked front window. Inside the home, they located Ms Cox in bed, completely covered by a doona and Mr Cox in his own bed. Both appeared to be deceased. Emergency Services were notified.

35. Police attended and investigated the scene. Police observed that Ms Cox's body was supine and completely covered by a doona, and there were two teddy bears positioned on either side of her head. Police did not observe any injuries to Ms Cox or evidence of violence in her bedroom. Police opined that the blanket and teddy bears appeared to have been arranged after her passing.

36. In the master bedroom, police located Mr Cox's body in bed. They similarly did not identify any signs of injury or violence. Two glasses were located next to the bed – one was empty, and the other was half-full with a clear liquid. There was also a small bucket beside the bin which contained a small amount of vomit. In the kitchen, police found four bottles of sodium nitrite, which appeared to have been shipped from Poland. Police also located a small amount of cannabis and drug paraphernalia in the home. Police did not locate any notes from either Mr Cox or Ms Cox, nor a will or other instructions left by either of them. Police identified $100,000 of cash in a brown duffel bag in the top of Mr Cox's wardrobe. There were no signs of violence, forced entry or other suspicious circumstances noted in the home. Mr Cox's dog was not found at the home, and has still not been located.

**Identity of the deceased**

37. On 9 October 2023, Coroner Sarah Gebert made a formal determination identifying the deceased as Laurence John Cox, born 27 May 1960, via fingerprint identification and the Police Report of Death.

38. On 9 October 2023, Coroner Sarah Gebert made a formal determination identifying the deceased as Ryley Ann Cox, born 12 January 1991, via DNA identification and the Police Report of Death.

39. I am satisfied that these identifications are correct. Identity is not in dispute and requires no further investigation.

**Medical cause of death – Laurence Cox**

40. Forensic Pathology Registrar, Dr Michael Duffy, supervised by Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 2 October 2023 and provided a written report of his findings dated 22 January 2024.

41. The post-mortem examination revealed no significant acute structural disease to account for death. The deceased had moderate coronary artery atherosclerosis without evidence of severe disease, coronary artery thrombosis or dissection, or features of an acute myocardial infarct to suggest a sudden cardiac death.

42. There was no evidence of any injuries which may have caused or contributed to death.

43. Vitreous humour biochemistry showed mild renal impairment.

44. Toxicological analysis of post-mortem samples identified the presence of morphine,[2] codeine,[3] alprazolam,[4] diazepam and its metabolites nordiazepam, temazepam and oxazepam,[5] metoclopramide,[6] cannabis metabolites delta-9-tetrahydrocannabinol, 11-OH-

[2] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[3] Codeine is an opiate found in opium isolated from the plant *Papaver soniferum* and is indicated as an effective antitussive and antidiarrheal agent.
[4] Alprazolam is a triazolobenzodiazepine derivative indicated for some depression symptoms, panic attacks, panic disorder, and agoraphobia.
[5] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[6] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

delta-9-tetrahydrocannabinol, and 11-nor-delta-9-carboxy-tetrahydrocannabinol (**THC-COOH**),[7] and sodium nitrate/nitrite.

45. Dr Duffy noted that sodium nitrate and sodium nitrite were detected at excessively elevated concentrations. He noted that sodium nitrate and sodium nitrite are inorganic salts that are used in preservation of meats, and often have a white crystalline appearance. Nitrates are relatively innocuous, but upon ingestion, may be converted to nitrites. Nitrites may cause death by formation of methaemoglobin leading to reduced oxygen transport in the blood, resulting in death by asphyxia. Co-consumption with antiemetics such as metoclopramide would have restricted the ability of the deceased to vomit and expel the sodium nitrate.

46. Dr Duffy provided an opinion that the medical cause of death was "*1(a) Sodium nitrite toxicity.*"

47. I accept Dr Duffy's opinion.

**Medical cause of death – Ryley Cox**

48. Forensic Pathology Registrar, Dr Michael Duffy, supervised by Dr Gregory Young, from the VIFM, conducted an autopsy on 2 October 2023 and provided a written report of his findings dated 22 January 2024.

49. The post-mortem examination revealed no significant structural natural disease to account for death. Vitreous humour biochemistry showed a mild degree of renal impairment. There was no evidence of any injuries which may have caused or contributed to the death. Self-harm marks on the forearms and thighs were also observed.

50. Toxicological analysis of post-mortem samples identified the presence of diazepam and its metabolite nordiazepam, metoclopramide, ibuprofen,[8] cannabis metabolites delta-9-tetrahydrocannabinol, 11-OH-delta-9-tetrahydrocannabinol and THC-COOH, and sodium nitrate/nitrite. Dr Duffy noted that sodium nitrate and sodium nitrite were detected at excessively elevated concentrations.

51. Dr Duffy provided an opinion that the medical cause of death was "*1(a) Sodium nitrite toxicity.*"

[7] Delta-9-tetrahydrocannabinol (**THC**) is the active form of cannabis (marijuana).
[8] Ibuprofen is a non-steroidal anti-inflammatory agent and analgesic.

52. I accept Dr Duffy's opinion.

## OPINION OF THE CORONER'S INVESTIGATOR

53. The Coroner's Investigator, Detective Senior Constable (**DSC**) Ricky Edge, interrogated the laptop and phones belonging to Ms Cox and Mr Cox. DSC Edge formed an opinion that Ms Cox was responsible for researching and purchasing the sodium nitrite online, as Mr Cox would not have known how to search this material online and was vision impaired.

54. DSC Edge opined that Ms Cox died prior to her father, as it appeared that her body was staged with the teddy bears and the doona covering her entire body. This appears to be corroborated by the last activity on her phone occurring in the early hours of 21 September 2023, whereas Mr Cox's phone activity continued until the evening of 22 September 2023, suggesting that he was likely alive longer than Ms Cox.

55. Notwithstanding the above, DSC Edge could not determine which of the following scenarios was more likely:

    a) If Ms Cox ingested the sodium nitrite of her own accord and was discovered by her father, already deceased.

    b) If Mr Cox assisted Ms Cox to take the sodium nitrite.

    c) If Mr Cox introduced the sodium nitrite to Ms Cox without her knowledge.

    d) If Mr Cox and Ms Cox had a pact to consume the sodium nitrite in a specific order.

## FINDINGS AND CONCLUSION

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

    a) the identities of the deceased were Laurence John Cox, born 27 May 1960 and Ryley Ann Cox, born 12 January 1991.

    b) the death of Laurence John Cox occurred between 22 and 28 September 2023 at 9 Florence Street, Niddrie Victoria 3042, from sodium nitrite toxicity.

    c) the death of Ryley Ann Cox occurred between 20 and 28 September 2023 at 9 Florence Street, Niddrie Victoria 3042, from sodium nitrite toxicity; and

    d) the deaths occurred in the circumstances described above.

57. Having considered all the circumstances, I am satisfied that Mr Cox intentionally took his own life. He mentioned suicide to his friend prior to his passing, had a history of mental health issues and had several severe and debilitating medical conditions.

58. Ms Cox also had a history of mental health issues and appeared to have become reclusive after moving back in with her father. There were indications by Mr Cox that he and Ms Cox were engaging in conversations about suicide, however I note that this did not occur in the presence of others. I am satisfied that Ms Cox conducted much of the internet research about sodium nitrite, downloaded instructional videos explaining how to use it, and was the one to purchase the sodium nitrite from Poland. Enough was purchased for two people to end their lives. On the balance of probabilities, I am satisfied that she was involved in the planning with her father and intentionally took her own life as part of an agreement by both of them to intentionally end their lives.

59. Ms Cox was last seen alive on 20 September and may have died at any time after that, as she did not have contact with anyone after that time. Mr Cox was last seen alive on 22 September and had phone contact with Mr Hall on that date. He did not have contact with anyone after that time and may have died any time after that. Whilst there is evidence Ms Cox's mobile phone was used on 21 September it is not possible to determine if this was due to use by her or Mr Cox, and the same can be said for phone data on Mr Cox's phone after 22 September, and the usage of Ms Cox's laptop. It is not possible, on the balance of probabilities, to determine when Mr Cox and Ms Cox died, or the order in which they died, with any greater precision.

**COMMENTS**

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

60. This Court has previously investigated a number of deaths involving Sodium Nitrite/Sodium Nitrate in circumstances where persons have intentionally ended their lives. I note that the use of this substance as a suicide method was recently investigated and commented upon by the State Coroner, Judge Cain, in the *Findings Into Death Without Inquest of Nathan Ruan Roy Greenwood* (COR 2021 004938).

61. In *Greenwood*, Judge Cain obtained information from the Coroner's Prevention Unit[9] regarding the frequency of occurrence of these deaths in Victoria and the associated issues, including any prevention opportunities. His Honour concluded that the Federal Government should investigate ways to further restrict the online sale and distribution of Sodium Nitrite in Australia, and made the following recommendation:

> That the Assistant Minister for Mental Health and Suicide Prevention; The Hon Emma McBride investigate in conjunction with other appropriate Ministers, Departments and Agencies of the Commonwealth ways to further restrict the online sale and distribution of Sodium Nitrite in Australia.

62. I note that the prevention issues associated with purchasing Sodium Nitrite online have been comprehensively explored in the *Greenwood* findings, and I have not identified any further prevention opportunities. As the issues regarding prevention have already been brought to the attention of the Assistant Minister for Mental Health and Suicide Prevention, The Hon Emma McBride MP, I make the following recommendation pursuant to section 72(2) of the Act:

> That the Assistant Minister for Mental Health and Suicide Prevention, The Hon Emma McBride MP, give consideration to the *Findings into the deaths Without Inquest of Laurence Cox and Ryley Cox* as part of any investigation regarding ways to further restrict the online sale and distribution of Sodium Nitrite in Australia.

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

I convey my condolences to the family of Mr Cox and Ms Cox for their loss.

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

> Cheryl Smith, Senior Next of Kin to Laurence Cox
>
> Monique Nolisimo, Senior Next of Kin to Ryley Cox

[9] 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 CPU 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.

Detective Senior Constable Ricky Edge, Victoria Police, Coroner's Investigator

The Assistant Minister for Mental Health and Suicide Prevention, The Hon Emma McBride MP

Signature:


Coroner Catherine Fitzgerald

Date : 28 August 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.