

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	Inquest into the death of Tabatha Knees
Citation:	[2026] ACTCD 15
Decision Date:	10 September 2026
Before:	Coroner K J Archer
Findings:	See [28] - [34]
Catchwords:	CORONIAL LAW – manner and cause of death – multiple drug toxicity – protonitazene – contribution to cause of death – first established case in the ACT – where novel psychoactive substance contributed to cause of death
Legislation Cited:	<i>Coroners Act 1997</i> (ACT) s13, 52
Cases Cited:	Findings into death without inquest, Coroners Court of Victoria, COR 2023 002632
File Number:	CD 197 of 2022

CORONER ARCHER:

Introduction

1. On 16 July 2022, Tabatha Knees was found deceased at her residence in Ainslie, in the Australian Capital Territory (ACT). She was found by her housemate. With respect, I will refer to Ms Knees as Tabatha in these findings.
2. Testing conducted in the context of a post-mortem examination found quantities of a range of drugs in her blood. This included lethal concentrations of methadone, morphine, and codeine. Upon further toxicological analysis, protonitazene, a highly potent synthetic opioid, was also detected. Protonitazene belongs to the nitazene class of non-fentanyl novel synthetic opioids. These substances are generically referred to as novel psychoactive substances (NPS) in these findings. It is estimated to be at least 100 times more potent than heroin.
3. Tabatha's death is the first case emerging from the coronial system in the ACT where protonitazene toxicity was identified as a factor possibly contributing to a death.
4. It is in the public interest to highlight the significant risks to users of illicit drugs, including heroin, who may be unaware of the presence of NPS in the substances they consume. I address these public safety concerns in the findings at [30-34].

Jurisdiction

5. Tabatha's death was reported to the ACT Coroner's Court on 17 July 2022, as it fell within the terms of section 13(1)(a) of the *Coroners Act 1997* (the Act), being the death of a person who died 'unnaturally'.
6. I was required to hold an inquest into the manner and cause of Tabatha's death and make findings that are required by section 52 of the Act. That section of the Act relevantly provides:

52 Coroner's findings

- (1) A coroner holding an inquest must find, if possible—
 - (a) the identity of the deceased; and
 - (b) when and where the death happened; and
 - (c) the manner and cause of death; and
 - (d) in the case of the suspected death of a person—that the person has died.

(4) The coroner, in the coroner's findings—

(a) must—

(i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

(ii) if a matter of public safety is found to arise—comment on the matter.

Tabatha Knees

7. Tabatha was born on 12 August 1979 in the ACT. She was 42 years old at the time of her death.
8. Tabatha's life was marked by challenges arising from drug use and serious underlying mental health concerns. Together, those factors forced her into a lifestyle that brought her into contact with police and the courts in both New South Wales and the ACT. She was never sentenced to terms of full-time imprisonment. During her life Tabatha was subjected to repeated domestic violence, which not only jeopardised her physical safety but also exacerbated her mental health conditions, including depression and anxiety. In her later years, Tabatha also experienced serious medical issues, including a spinal injury from a biking accident. Her continued use of opioids was, at least in part, an attempt to cope with the chronic pain she suffered as a result of this injury.
9. Tabatha had been using illicit drugs, predominantly heroin, for several years prior to her death. While she sought opportunities for drug counselling, the complexity of her dual diagnosis of deteriorating mental health and ongoing addiction issues required a holistic response to her health needs. Tabatha was not able to engage with support services at a level and for a period that enabled such a response to be developed. Her response was to withdraw from support and her engagement with treatment services was limited.
10. Tabatha's brother died from a drug overdose approximately two years before her death.

THE INVESTIGATION

The Police Investigation of Events leading to Tabatha's Death

11. Tabatha's housemate provided an account of the events leading up to her death. He indicated Tabatha was consuming heroin daily. Tabatha would take prescription medications in the morning and would source heroin or methadone later in the day.
12. On 12 July 2022, Tabatha overdosed on heroin whilst riding a bus in the ACT. The ACT Ambulance Service (ACTAS) attended the scene and treated her; she declined to go to

the hospital. Tabatha later stated to attending police that she had purchased the drugs “in the city”.

13. On 16 July 2022, Tabatha was found by her housemate slumped on the floor of the lounge room. He could not find any signs of life and called triple zero. ACTAS attended and observed Tabatha to be deceased. Police and the Forensic Medical Officer (FMO) attended the scene to investigate.
14. The FMO observed injection scarring on Tabatha’s inner right elbow and a fresh injection mark on the back of her right hand. There was blood visible on her right hand which had likely come from the injection point. A band-aid was located on the deceased’s right hand but had become dislodged during the examination.
15. Her housemate said he had last seen Tabatha alive at about 2130 hours on the previous evening. Tabatha seemed to have stirred from the couch as her housemate entered the room and indicated to him that she “was not having a good day”.

Items located in a police search

16. Police searched the house for any information or evidence concerning Tabatha’s death. In various rooms, items were found consistent with drug usage including uncapped syringes, an empty clip seal bag with presumed drug residue, cannabis seeds, naloxone hydrochloride dihydrate (a single dose nasal spray for opioid overdose), fentanyl test strips and a sharps container. A large number of prescription medications were found in the bedside table drawer in Tabatha’s bedroom. The medication included:
 - (a) Pregabalin 150mg (used to treat nerve pain);
 - (b) Tramadol 200mg (an opioid pain medication);
 - (c) Mirtazipine 30mg (an anti-depressant);
 - (d) Methadone in the name of Carla Trevathan (dispensed on 20 December 2021);
 - (e) Metoclopramide 10mg (possibly to treat nausea or vomiting); and
 - (f) Unboxed empty blister packs of Valium (used to treat anxiety).
17. In the bedroom her housemate was occupying, a box of pregabalin in Tabatha’s name was located.
18. Three bottles of methadone were found in the kitchen. The methadone was prescribed in Tabatha’s name.

19. In the driveway within the backyard was a small metal bucket containing partially burnt paperwork. The top of the paperwork in the bucket was able to be retrieved, examined, and found to contain various old prescriptions in the name of the deceased, medication boxes, empty blister packs, and numerous passport photos of unknown females. The bucket was half filled with water. The remaining paperwork was too fire damaged for examination.

Post-Mortem Examination

20. On 19 July 2022 a post-mortem examination of Tabatha's body was conducted by forensic pathologist Professor Johan Duflou. On internal examination, a large amount of regurgitated gastric contents was identified which at least partially blocked the upper airway. Multiple anterior rib fractures without associated bleeding were observed. However, Professor Duflou found that these injuries occurred during an earlier event unrelated to her death and the injuries themselves did not contribute to the cause of her death. There were no obvious significant pre-existing natural disease processes. Professor Duflou found multiple needle track marks in sites suggesting self-administration of intravenous drugs.

21. Blood samples were subject to toxicological analysis with the following results:

Methadone	0.50 mg/L
Morphine	0.01 mg/L
Codeine	0.10 mg/L
Pregabalin	9 mg/L (approx.)
Tetrahydrocannabinol	15 ng/mL
Diazepam	0.57 mg/L
Nordiazepam	0.59 mg/L
Mirtazapine	0.08 mg/L
Paracetamol	Detected
Nicotine	Detected
Naproxen	Indicated but not confirmed

22. The ACT Government Analytical Laboratory (ACTGAL) is the agency generally responsible for undertaking toxicological analysis in the ACT coronial setting. ACTGAL provided some generic commentary in respect of these results:

Methadone	In respect of methadone there is a broad range of concentrations in blood/plasma that have been reported as therapeutic, toxic and lethal. The result here fell across all three ranges. Reported symptoms of methadone toxicity include respiratory depression.
Morphine	Morphine can be a metabolite of both heroin and codeine. Experienced heroin/codeine users may have a greater tolerance for morphine. The amount found here (0.01) falls within the toxic and lethal ranges. However, that level would not normally be associated with the lethal outcomes on its own. The reported toxic effects include respiratory depression.
Codeine	Codeine is an opium derivative. The level here is both within the therapeutic range and around the bottom of the toxic and lethal ranges. Respiratory depression is a known symptom of codeine toxicity.
Pregabalin	Pregabalin is used to treat pain. The level here is at the top of therapeutic range and around the bottom of the toxic range. Toxic effects have been reported in therapeutic doses in some people. Reported side effects of pregabalin include tiredness and sleepiness.
Diazepam	Diazepam is used to treat anxiety. The level here is within the therapeutic range.

	The drug is considered a sedative.
Nordiazepam	Nordiazepam is also prescribed to treat anxiety. It is also considered a sedative.
Mirtazapine	Mirtazapine is an anti-depressant. The level here is within the therapeutic range. Reported side effects of the drug include drowsiness.

23. Professor Duflou's opinion was that the toxicological outcomes and the death scene indicated that Tabatha had died from the effects of multiple drug toxicity. In his opinion, it was likely that the combination of the drugs caused respiratory depression sufficient to cause death. It is also likely that, when unconscious, Tabatha was unable to respond when vomitus entered her airways. This is likely to have contributed to her death.

Evidence from an Unrelated Criminal Investigation

24. During an unrelated investigation into a Canberra-based drug syndicate, AFP investigators identified that Tabatha's housemate had been purchasing illicit substances from two people, one of whom was known to police in the context of an ongoing drug distribution investigation. During a search warrant conducted at that person's residence, police located the deceased's name in a notebook that appeared to contain a 'tick list' of customers. A large amount of synthetic opioids (protonitazene) was also located during that search.
25. ACTGAL confirmed at the time of Tabatha's death, that routine toxicology conducted at the Court's request as part of the post-mortem process did not involve testing for NPS.
26. I therefore caused the Victorian Institute of Forensic Medicine (VIFM) to undertake a further analysis of a sample of blood that had been taken from Tabatha in the postmortem process. Analysis of the sample confirmed the presence of protonitazene. VIFM's processes did not permit the quantity of the protonitazenes in the sample to be determined.

27. A report was received from VIFM in March 2024 as to its analysis. The VIFM report contained this description of this drug (with references omitted):

1. Protonitazene or Pronitazene (IUPAC name: N,N-Diethyl-5-nitro-2-[(4-propoxyphenyl)methyl]-1H benzimidazole-1-ethanamine) is a novel synthetic opioid and isomer of isotonitazene and homologue of etonitazene and metonitazene from the 2-benzylbenzimidazole group of synthetic opioids (WHO, 2022).
2. Protonitazene is a highly effectual mu-opioid receptor (MOR) activator. Like typical opioid agonists such as fentanyl, the use of novel synthetic opioids induces sensations such as sedation, analgesia, and euphoria, and have significant potential for recreational abuse (WHO, 2022; Papsun et al., 2022).
3. This is new synthetic opioid and has no legitimate therapeutic use nor is this drug legally available in Australia.
4. Like other 2-benzylbenzimidazole opioids, the chemical structure of Protonitazene is unlike other previous groups of novel synthetic opioids detected in forensic toxicology (such as fentanyl and non-fentanyl derived NSOs) (Walton et al., 2022; Krotulski et al., 2021).
5. The pharmacology and toxicology of Protonitazene is not well-known and makes the interpretation of any measured concentration difficult.
6. Given its availability as a water-soluble powder, it is expected Protonitazene is recreationally administered by intranasal and intravenous administration (WHO, 2022).
7. It was first detected during forensic sampling in the United States and Canada in 2020 (WHO, 2022).
8. In 6 post-mortem cases Protonitazene was detected at an average concentration of 239 ng/mL, ranging between 1.3-1400 ng/mL (Papsun et al., 2022).
9. In vitro studies indicate Protonitazene is a selective and high affinity MOR agonist, with potency over 3 times that of fentanyl and with slightly higher efficacy when activating the MOR (Vandeputte et al., 2022).
10. Specific adverse effects of Protonitazene have not been routinely documented, however intravenous administration of 2-benzylbenzimidazole opioids is noted to cause respiratory depression, with a narrow therapeutic ratio between analgesia and the former (De Stevens, 1965; WHO, 2022). Autopsy findings from

93 fatalities involving various 2-benzylbenzimidazole opioids reported pulmonary congestion/high lung weight, cardiomegaly/high cardiac weight, cerebral oedema, gastric contents in the airways, and organ congestion (Montanari et al., 2022).

FORMAL FINDINGS – CAUSE OF DEATH

28. Professor Duflou was asked to consider his opinions in light of the VIFM report as to the presence of protonitazene. He indicated that the further information did not change his opinion as to the cause of death (being multiple drug toxicity). He indicated that protonitazenes present at even low levels can be highly potent. The presence may have added to the degree of respiratory depression that is likely to have occurred in this case. However, it is not possible to say that protonitazene on its own caused Tabatha's death. I accept his opinion.
29. For the purposes of section 52(1) of the Act, I find that Tabatha Knees died on 16 July 2022, in Ainslie in the ACT, of multiple drug toxicity, with aspiration of vomit also contributing to the cause of death.

FORMAL FINDINGS – MATTERS OF PUBLIC SAFETY

30. Recent decisions of the Victorian Coroner's Court have provided some analysis of NPS and their dangers. Ryan Andrew Robinson died on 17 May 2023. Coronial findings were published on 21 August 2025¹. Coroner Giles made general observations about this class of drug:
 - 40 Ryan's fatal overdose involved a combination of 'classic' illicit drugs (heroin, methamphetamine), pharmaceutical drugs (oxycodone, methorphan, clonazepam, nitrazepam) and new or novel illicit drugs (bromazolam, metonitazene, protonitazene).
 41. From a prevention perspective, this last group of drugs - which are referred to broadly as new or novel psychoactive substances (NPS) - were of particular interest in my investigation. NPS are a highly diverse family of drugs that have become established in unregulated drug markets around the world over the past 20 years.
 42. NPS first appeared as contributing drugs in Victorian overdose deaths in 2013, and in recent years the number of overdose deaths in which they were involved has grown steadily, from 17 deaths in 2019 to 48 deaths in 2024. The number of

¹ Findings into death without inquest, Coroners Court of Victoria, COR 2023 002632

NPS-involved overdose deaths appears to have plateaued in recent years, after steadily increasing between 2017 and 2022.

43. Despite this apparent plateau, NPS remain a closely monitored concern for at least two reasons. First, because they include particularly risky drugs such as nitazenes, which are a group of (mostly) very potent opioids that can be up to 1000 times stronger than morphine. Second, because NPS evolve so rapidly: in the decade between 2015 and 2024, 59 different individual NPS were identified as contributors to overdose deaths in Victoria, but most NPS only contributed to one or two deaths before not being seen again.
 44. We are still only at an early stage of understanding how NPS enter and circulate through unregulated drug markets in Victoria and Australia. This information will be critical so that effective interventions can be designed to reduce the risk of harm to people who use drugs.
 45. One important way that understanding of these drugs can be improved is through documenting whatever we can establish about substances containing NPS: where and how they were obtained, what they were believed to be (often substances containing NPS are sold as other drugs, for example novel benzodiazepines being sold as alprazolam), what form they came in (be it a pill, tablet, powder, capsule or otherwise), how they were used, and what effects were observed after the person took the substance.
31. In the ACT there is an existing capability of analysing for NPS in drug samples. CanTEST Health & Drug Checking Service is a pill and drug testing service funded by ACT Health and delivered in partnership with Directions Health Services, Pill Testing Australia and CAHMA. It has been present in the ACT since 2022. CanTEST posts alert about potentially dangerous drugs or additives to drugs that have been identified during its testing processes. This includes NPS. The service provided by CanTEST increases the potential for users to identify the presence of NPS in drugs that might be presently circulating within the community.
 32. The capacity of the coronial system to quickly identify cases where NPS might have contributed to the cause of death is subject to some constraints. The taking of blood samples from deceased persons are delayed by the scheduling of post-mortem examination. ACTGAL is presently working on establishing a capability to detect NPS in blood samples including a 'fast toxicology' capability. The timing of the establishment of that capability is not known. In the meantime, cases involving suspected drug overdoses are sent to the VIFM. That service does not offer a rapid NPS reporting capability. Since

Tabatha's case 36 cases have been sent to VIFM with a request for NPS testing. Nine (25%) of those cases were positive to NPS. A request for NPS testing is now included as standard in blood samples sent to VIFM where drug overdose is suspected. At present, because of the limitations on ACTGAL's testing capacity, suspected drug overdose cases are all sent to VIFM.

33. There is not an integrated public notification system that arises from known outcomes from toxicological testing for NPS in the coronial space. Warnings are issued on an ad hoc basis by the AFP where patterns of NPS detection in death cases suggest a greater prevalence of NPS in drugs apparently distributed within the ACT. It is noted that it is difficult to determine how long the drugs in which the NPS are found remain within the relevant distribution cycle for that drug that apply at the time of detection. This issue will affect the power of public messages to provide advice to users that is current. For example, batches of heroin brought to the ACT from Sydney or Melbourne that contain NPS might move through the supply chain at varying rates depending on batch size and the demand for the product of the particular supplier. A dangerous circumstance that arises is that heroin that is known to produce a greater 'high' can become popular in the market place. Heroin with higher purity levels or heroin with NPS added can produce that effect. Both circumstances created significant dangers for even experienced users.
34. It is anticipated that public safety issues arising from NPS will be examined in future coronial proceedings.

POSTSCRIPT AND CONDOLENCES

35. I extend my sincere condolences to Tabatha's family. I acknowledge the grief her family and loved ones have endured as a result of her passing.
36. I apologise to the family for the delay in finalising these findings.

I certify that the preceding thirty-six [36] numbered paragraphs are a true copy of the findings of Coroner Archer

Associate: Ella Mansfield

Date: 10 September 2026