IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004464

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Zoha Khan
Date of birth:	11 September 2000
Date of death:	23 August 2021
Cause of death:	1(a) Mixed drug toxicity including tramadol and flualprazolam
Place of death:	24 Balmain Circuit, Taylors Hill, Victoria, 3037
Keywords:	Mixed drug toxicity; novel psychoactive substances; NPS; benzodiazepines; flualprazolam

INTRODUCTION

1. On 23 August 2021, Zoha Khan was 20 years old when she was found deceased at her friend's house. At the time of her death, Zoha lived in Caroline Springs with her parents and three siblings.

2. Zoha is remembered as a happy, funny, outgoing and very smart young woman who got along well with her family and friends.

3. When Zoha was 19 years old she travelled to Thailand for six months to teach English, gaining her Certificate III in teaching. When she returned, she began studying teaching at Victoria University.[1]

4. Zoha worked at KFC for three years, until she was 18 years old. She then spent a year at ANZ bank and a year at Westpac bank, before commencing a role at Allianz insurance. She resigned from Allianz around two days before her death, though did not disclose the reason for her resignation to friends or family.[2]

5. Zoha told her friends and family that she had sinus issues which required surgery but had no other significant health issues. She very occasionally drank alcohol, and smoke cannabis 'once or twice a week'.[3]

THE CORONIAL INVESTIGATION

6. Zoha'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.

7. 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.

8. 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

[1] CB, Statement of Amjad Khan, dated 22 May 2022.
[2] Ibid.
[3] CB, Statement of Amber Manuel, dated 22 May 2022.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

10. This finding draws on the totality of the coronial investigation into the death of Zoha Khan 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.[4]

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

Circumstances in which the death occurred

11. At around 8:30pm on 22 August 2022, Zoha drove to her friend Amber's house in Taylor's Hill and picked her up before visiting their friend Vladana's house. Zoha smoked some cannabis and drank one or two shots of tequila.[5]

12. At around 10pm, they returned to Amber's house. Zoha messaged her friend Billy, asking for tramadol. Zoha then drove to Billy's house in Epping, where she took two tramadol tablets. The pair then stopped at McDonald's to purchase food on the way back to Amber's house.[6]

13. Whilst driving, Zoha was intercepted at a Covid-19 road-block with Amber in the passenger seat. When questioned why she was breaching the curfew in place at the time, she told police she was picking up her friend who had a verbal argument with her boyfriend. Police then conducted a license check, establishing that Zoha was a learner driver, and issued her with an Infringement Notice for driving unaccompanied. She was also warned about not displaying L plates and breaching the Chief Health Officer's directions. Zoha appeared to be in good spirits during contact with police.[7]

---

[4] 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.

[5] CB, Statement of Amber Manuel, dated 22 May 2022.

[6] Ibid.

[7] Email from Sergeant Jason Davis, dated 5 November 2021.

14. At around 12:30am on 23 August 2023, Zoha and Amber returned to Amber's house. They ate their food and Amber went to bed, while Zoha stayed up speaking on the phone.[8]

15. At around 10:30am, Amber woke up and noticed Zoha lying in bed, not breathing and with froth coming from her mouth. She immediately called '000' who instructed her to commence chest compressions.[9]

16. Paramedics arrived shortly thereafter but Zoha was unable to be revived. When police officers arrived at the scene, Amber disclosed that Zoha had consumed a few sips of a Vodka Cruiser, two tablets of tramadol, one tablet of Xanax and some cannabis.[10]

Identity of the deceased

17. On 23 August 2021, Zoha Khan, born 11 September 2000, was visually identified by her mother, Amjad Khan, who completed a Statement of Identification.

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

Medical cause of death

19. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Zoha Khan on 24 August 2021. Dr Bedford reviewed the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 7 December 2021.

20. The post mortem examination revealed no findings of note.

21. Toxicological analysis of post mortem blood samples identified the presence of tramadol (~ 0.9mg/L) and flualprazolam. Analysis of post mortem urine samples identified the presence of tramadol and 11-nor-delta-9-carboxy-tetrahydrocannabinol (~ 13ng/mL).

22. Flualprazolam is a benzodiazepine derivative and has no established therapeutic use and is considered to be a novel psychoactive substance. The combination of tramadol and flualprazolam may have led to increased synergistic central nervous system sedation and respiratory depression.

[8] CB, Statement of Amber Manuel, dated 22 May 2022.
[9] Ibid.
[10] CB, Statement of First Constable Clayton Fox, dated 28 May 2022.

23. Dr Bedford provided an opinion that the medical cause of death was 1 (a) MIXED DRUG TOXICITY INCLUDING TRAMADOL AND FLUALPRAZOLAM.

FURTHER INVESTIGATION

24. Having noted the presence of the novel psychoactive substance (NPS) benzodiazepine flualprazolam at toxicology testing, I requested the Coroners Prevention Unit[11] (**CPU**) provide me with information on NPS benzodiazepines and their contribution to Victorian overdose deaths.

25. NPS are new or novel synthetic substances which produce psychoactive effects, often mimicking the effects of illicit drugs. They are generally not approved for therapeutic use and are known or suspected to pose similar health risks to other 'regular' illicit drugs.

26. There has been a proliferation of NPS in recent years. The European Monitoring Centre for Drugs and Drug Addiction[12] reported less than 20 NPS in 2008, over 100 in 2014, and over 700 individual NPS in 2018.

27. The rapid proliferation of NPS mean that when a new substance appears in an illicit market, by the time it is identified and described through toxicological analysis it has usually already been superseded by other NPS. With so many NPS circulating in drug markets, it is difficult to dedicate time and resources to study the metabolism of a particular NPS in the human body, meaning the effects are often largely unknown.

28. The CPU identified 40 NPS benzodiazepine-involved deaths between 2009 and 2020 in Victoria, seven of which involved flualprazolam. One NPS benzodiazepine-involved death occurred in 2015, one in 2018, 10 in 2019, rising to 28 in 2020.

COMMENTS

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

[11] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[12] The European Monitoring Centre for Drugs and Drug Addiction is an agency of the European Union and is the leading authority on illicit drugs in Europe.

1. My investigation into Zoha's tragic and unexpected death highlights the potential consequences of the use and abuse of illicit drugs, particularly those purchased from unregulated markets where the actual content and make up of the drug is unknown.

2. Although I am unable to determine with certainty where Zoha obtained the flualprazolam, it is possible that the 'Xanax' tablet she reportedly consumed the night before her death contained flualprazolam, rather than alprazolam, a pharmaceutical benzodiazepine.

3. Drugs obtained from unregulated markets may not be what the user expected: more potent, or adulterated, or even completely different to what was represented. Where this occurs, the potential for harm including overdose and death is increased. The appearance of NPS in unregulated markets has substantially increased this risk, because NPS are often substituted for other drugs and represented as being other drugs.

4. The rapid evolution of NPS means that suppliers may not even know what they are offering in the market, and the highly variable effects between NPS with respect to onset of action, potency, interactions with other drugs and other effects on the body mean that developing informed safe use practices is extremely difficult.

5. The number of Victorian overdose deaths involving NPS benzodiazepines has risen quite suddenly in recent years, a trend not unique to this jurisdiction. I am concerned that it may be indicative of an emerging trend, rather than a transitory feature of drug-related harms. In this regard, I have distributed this Finding for information to the Victorian Department of Health, with the aim that it assists the Department in understanding and responding to the risks presented by NPS benzodiazepines in Victoria.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Zoha Khan, born 11 September 2000;

   b) the death occurred on 23 August 2021 at Taylors Hill, Victoria, 3037;

   c) I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford and I find that Zoha Khan died from mixed drug toxicity, including tramadol and flualprazolam;

2. AND, having considered all of the circumstances, I am satisfied that Zoha Khan's death was the unintended consequence of her intentional use and abuse of illicit and prescription drugs.

I convey my sincere condolences to Zoha's family for their loss.

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.

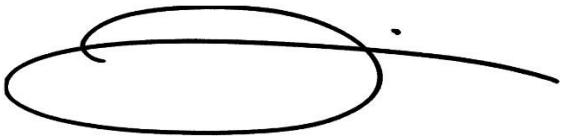
I direct that a copy of this finding be provided to the following:

Atia & Amjad Khan, Senior Next of Kin

Department of Health

First Constable Clayton Fox, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 12 February 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.