



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2023 005102**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Ingrid Giles
Deceased:	Aisha Natasha Khan
Date of birth:	17 October 1978
Date of death:	12 September 2023
Cause of death:	1(a) Mixed alcohol and drug toxicity (tapentadol, diazepam, mirtazapine, amitriptyline, gabapentin)
	<u>Contributing factor(s)</u> Organizing pneumonia
Place of death:	29 Nicholson Parade Sunshine West Victoria 3020
Keywords:	Triple Zero call; multi-agency response; police and paramedic attendance; threat of suicide; presence of weapon

## INTRODUCTION

1. On 12 September 2023, Aisha Natasha Khan (**Ms Khan**) was 44 years old when she died at her home in Sunshine West. Ms Khan shared the home with one of her children, Murside Aytekin (**Murside**).
2. Not much is known about Ms Khan's childhood, however Murside reported that her mother grew up in Adelaide with two siblings. When she was in high school, Ms Khan met her future husband, and they married in 1997. They shared two children together and separated in 1999 or 2000.
3. Ms Khan reportedly experienced trauma from family violence perpetrated by her former husband. She had multiple physical and mental health conditions including peripheral neuropathy,<sup>1</sup> migraine, gastritis, undifferentiated chest pain, subjective cognitive concerns,<sup>2</sup> adjustment disorder (depressive type), alcohol use disorder and obsessive personality traits.
4. Ms Khan experienced two suicide attempts – one about 12 years prior to her passing, and one in July 2023. The July 2023 attempt occurred in the context of Ms Khan being terminated from her employment two months earlier. Her mental health deteriorated, and she took an overdose of prescription medication with alcohol. Her daughter found her unresponsive in her bedroom and called an ambulance. Ms Khan experienced a cardiac arrest and consequently was admitted to the Intensive Care Unit (**ICU**) at Sunshine Hospital.

### **Mental health treatment – July to September 2023**

5. On 2 July 2023, Ms Khan consumed an intentional overdose of medication (as noted above) and her daughter called Triple Zero. Paramedics attended the home and were required to resuscitate Ms Khan, before transporting her to the Sunshine Hospital Emergency Department (**SHED**). Following arrival at SHED, Ms Khan was transferred to the ICU for post-arrest care, which was complicated by delirium, sedation and the need for intubation.
6. On 10 July 2023, Sunshine Hospital's Consultation/Liaison Psychiatry team reviewed Ms Khan. They noted she was dysphoric, hopeless and was ambivalent about her overdose. Following medical clearance, Ms Khan was transferred to the Western Inpatient Psychiatric Unit (**WIPU**) where she was admitted as a voluntary patient. She presented as quite flat in affect and her engagement was superficial, however she denied immediate suicidal thoughts.

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<sup>1</sup> Thought to be secondary to chronic alcohol misuse.

<sup>2</sup> Ms Khan reported cognitive symptoms to complications from a cardiac arrest experienced in May 2023.

WIPU clinicians undertook safety planning with Ms Khan and involved her daughter. The plan included Murside keeping all of her mother's medication locked away, a pharmacy dispensation limit, removing sharp objects and providing emergency and triage numbers. WIPU also referred Ms Khan to alcohol and other drugs (**AOD**) support and the Acute Crisis Intervention Team (**ACIS**).

7. ACIS clinicians followed up with Ms Khan regularly from 13 to 31 July 2023. Ms Khan reported having no recollection of the events leading to the overdose, however admitted that she was experiencing ongoing cravings for alcohol, and chronic pain from her physical conditions. ACIS staff liaised with Ms Khan's general practitioner (**GP**).
8. ACIS clinicians regularly documented Ms Khan's impulsive risk of self-harm/suicide under the influence of alcohol. ACIS referred Ms Khan to CareinMind for psychological support, and to the Hospital Outreach Post-Suicidal Engagement (**HOPE**) team for support to address her multiple psychosocial stressors.
9. Ms Khan was assessed by a Mid-West AOD clinician on 20 July 2023. She appeared receptive to community support, received the contact details for DIRECTLINE, and was educated about how to manage urges/cravings.
10. From 13 to 30 July 2023, Ms Khan consistently denied suicidal thoughts.
11. On 27 July 2023, Ms Khan commenced working with HOPE as part of a 12-week program, due for discharge on 19 October 2023. The primary focus of HOPE was to consolidate Ms Khan's linkage with long-term AOD support, given Ms Khan's alcohol misuse was one of the primary drivers of her suicidality, in the context of significant psychosocial stress around finances.
12. Ms Khan presented to SHED again on 6 August 2023 following an intentional overdose of prescription medications in the context of alcohol consumption and was discharged the following day.
13. Three days later, on 9 August 2023, Ms Khan re-presented to SHED after making superficial cuts to her wrists in the context of alcohol intoxication. On this occasion, Ms Khan was initially placed on an Assessment Order, which was revoked upon review by a consultant psychiatrist the following day. Ms Khan denied suicidal thoughts or plans once she was no longer intoxicated and was discharged home. Ms Khan's HOPE clinician re-referred Ms Khan to ACIS, following her change in presentation.

14. A HOPE psychiatrist reviewed Ms Khan on 17 August 2023 given her increased risk profile. At that time, Ms Khan was documented as euthymic, denied active suicidal thoughts however had an ongoing sense of helplessness and uncertainty about her future. The psychiatrist documented an impression of situational crisis in the context of loss of job/structure and associated psychosocial stressors, with ongoing problematic alcohol use and subjective cognitive concerns. No medication changes were implemented, and the HOPE psychiatrist referred Ms Khan to the Yanna Yanna Prevention and Recovery Centre (YYPARC), for a voluntary admission.
15. Ms Khan was admitted to YYPARC on 27 August 2023. She was initially settled upon admission, with some affective dysregulation at times. A consultant psychiatrist reviewed Ms Khan on 28 August 2023 and noted that she was tearful and depressed but help-seeking. She denied active suicidal thoughts or plans.
16. Ms Khan was discharged from YYPARC early on 30 August 2023 due to breaching the YYPARC code of participant conduct. According to her medical records, Ms Khan reportedly “*participated in non-inclusive and discriminatory language toward staff and participants which threatened the psychological safety of the setting and was discharged*”. While Ms Khan received an explanation as to why she was being discharged, clinicians assessed that she did not have good insight into her how behaviour impacted the other participants. YYPARC provided a handover to HOPE and discussed Ms Khan’s safety plan, and what to do in the event of an emergency.
17. After being discharged from YYPARC, Ms Khan consumed at least two bottles of wine. A HOPE clinician spoke with Murside, who reported the alcohol consumption. Murside was also surprised that her mother was home. The HOPE clinician explained that Ms Khan had been discharged from YYPARC but did not provide further details and suggested that Murside discuss the issue directly with her mother. It was not clear whether YYPARC attempted to liaise with Murside prior to discharging Ms Khan.
18. HOPE staff reviewed Ms Khan via phone on 31 August 2023, where she disclosed her alcohol consumption. She reported an inability to keep herself safe, feeling “*like a failure*” with implied suicidal thoughts. The HOPE clinician advised Ms Khan to attend SHED to facilitate a voluntary crisis admission. Ms Khan was agreeable to the plan and attended SHED that evening.

19. Ms Khan was admitted to the WIPU on 1 September 2023 as a voluntary patient. The WIPU consultant psychiatrist reviewed her on the day of admission and documented “*depressive symptoms in the context of loss of job, financial stressors and chronic pain*”. The clinician increased Ms Khan’s mirtazapine dose from 15 to 22.5mg.
20. The WIPU psychiatry registrar reviewed Ms Khan on 5 September 2023. Ms Khan admitted to ongoing alcohol cravings, denied active suicidal ideation, plan or intent but expressed regret about surviving her suicide attempt and wished that she had died. The WIPU psychiatry registrar spoke to Murside on 6 September 2023 who reported that her mother had been well at home and was unaware that anything was wrong.
21. The WIPU consultant psychiatrist reviewed Ms Khan that same day. Ms Khan reported frustration in relation to the WIPU rules and said she was “*sort of ok and sort of not*”. Ms Khan reported ongoing anxiety and frustration due to her perception that the WIPU clinicians were slow to provide support. The team provided psychoeducation about the limitations and purpose of an acute admission, and the importance of long-term psychological treatment, which Ms Khan required to recover.
22. The WIPU psychologist also reviewed Ms Khan on 6 September 2023. The purpose of the review was to provide strategies for alcohol cravings and anxiety management. The psychologist assessed her as presenting with a primary substance use disorder with secondary depression, high impulsivity and high suicide risk when drinking. Ms Khan described intense cravings to drink alcohol and reported that she would drink as soon as possible. The psychologist discussed strategies to manage anxiety and urges, and AOD relapse prevention.
23. According to the nursing progress notes from the afternoon of 6 September 2023, Ms Khan was unwilling or unable to identify behavioural strategies to manage her alcohol use. she denied experiencing any efficacy from commencing anti-craving medication (acamprosate).
24. The final WIPU consultant psychiatrist review occurred on 8 September 2023. Ms Khan reported feeling distressed about being discharged home, she reported that she did not want to go home, and she did not feel safe. She also indicated that she had no support, that she was worried that she would start drinking alcohol again and that she would harm herself whilst intoxicated. Ms Khan noted her concerns that her daughter was only home on Saturdays, and she was worried about impacting her daughter.

25. Ms Khan was linked with the Western AOD team, and she was booked for an intake assessment at Odyssey House on 18 September 2023. The WIPU team offered other AOD supports, however she declined to attend same. WIPU provided information about an admission to Westside Lodge, a residential rehabilitation facility offering a three-month long therapeutic program for people experiencing problematic drug or alcohol use, as well as mental health issues. Ms Khan terminated the consultant psychiatrist review when the clinician discussed the role of an inpatient unit in providing containment. The WIPU consultant's impression was that there was no evidence of a syndromal depressive disorder, but rather an adjustment disorder with significant alcohol use on the background of a recent job loss, physical health conditions and significant rejection sensitivity. The WIPU team agreed that a prolonged inpatient admission would be counter-therapeutic, however thought that Ms Khan would benefit from long-term psychological support and AOD services, including residential rehabilitation, if appropriate.
26. The WIPU consultant psychiatrist contacted the HOPE consultant psychiatrist and the two discussed Ms Khan's presentation and agreed that she displayed a mix of "*cluster C and cluster B personality traits*",<sup>3</sup> for which a prolonged inpatient admission could be counter-therapeutic, fostering dependency, undermining autonomy and reinforcing external locus of control.
27. Ms Khan continued to deny thoughts of self-harm for the remainder of her admission at WIPU and reported feeling safe at the time of discharge. When she was discharged, the safety plan in place included ACIS and HOPE follow-up, CareinMind counselling, and an AOD intake appointment scheduled. Prior to discharge, the WIPU psychiatry registrar made two unsuccessful attempts to speak with Murside.
28. ACIS spoke to Ms Khan on 11 September 2023. She reported consistent low mood since discharge, however denied any acute risks or concerns and reported that she was feeling safe. She confirmed her safety plan was in place (her daughter holding onto her medications; no access to alcohol) and she agreed to ongoing engagement with ACIS.

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<sup>3</sup> The term 'traits' is typically used in psychiatry when a person does not satisfy the diagnostic criteria for a diagnosis of the related personality disorder.

## THE CORONIAL INVESTIGATION

29. Ms Khan'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.
30. 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.
31. 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.
32. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Khan's death. The Coronial 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.
33. This finding draws on the totality of the coronial investigation into the death of Aisha Natasha 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.<sup>4</sup>

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

### Circumstances in which the death occurred

34. On 12 September 2023, Ms Khan was reviewed by an ACIS clinician in person. The clinician assessed her as having ongoing risk of impulsive and high lethality behaviour in the context of alcohol intoxication. She continued to report a death wish and was unable to rate her level

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<sup>4</sup> 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.

of suicidal ideation, responding “*I don’t know*” or “*I try not to think about it*”. This was in keeping with her usual presentation. Ms Khan also noted that she was experiencing alcohol cravings. The clinician identified several protective factors, including Ms Khan’s increased willingness to reach out to clinicians for support.

35. Later that day, at about 4.15pm, Ms Khan enacted her safety plan by calling ACIS. She was transferred to occupational therapist, Julia Grieve (**Ms Grieve**). Ms Grieve recalled that Ms Khan was audibly distressed, expressed concerns for her safety, stated that she had consumed alcohol and was experiencing increased suicidal thoughts. Initially, she reported that she had no means to act on these thoughts.
36. Ms Grieve attempted to engage Ms Khan in safety planning, including contacting family/friends, distraction techniques and utilising her personal coping strategies. Ms Khan reported that she was alone, that her daughter was not expected home until about 6.30pm and that her regular coping strategies were not effective. While on the phone with Ms Grieve, Ms Khan reported that she found some medication and had taken nine tablets of her prescribed evening medication, although did not provide the name of same. Given her recent history of prescription medication overdose resulting in cardiac arrest, Ms Grieve advised Ms Khan of her duty of care and the need to call Triple Zero. Ms Grieve ended her call with Ms Khan and immediately called Triple Zero at 4.21pm.
37. Ms Grieve requested an ambulance be dispatched to Ms Khan’s home due to a disclosed overdose. During the call, Ms Grieve told the Ambulance Call-Taker (**ACT**) that:
  - a) She was not with Ms Khan but had just spoken to her over the phone.
  - b) Ms Khan disclosed that she had consumed nine of her evening tablets and was intoxicated from alcohol consumption.
  - c) When the ACT asked if Ms Khan was armed, Ms Grieve reported that Ms Khan told her that she had “*razorblades in the bathroom and cutlery downstairs in the kitchen*”.
  - d) Provided Ms Khan’s phone number.
38. Ms Grieve also answered the ACT’s key questions, presented to the ACT as part of the ‘Overdose/Poisoning’ protocol and the ACT recorded the following responses:
  - a) This was intentional.

- b) She is not violent.
  - c) She has a weapon.
  - d) She is armed with a razor.
  - e) It's not known if she is changing colour.
  - f) She is completely alert (responding appropriately).
  - g) She is breathing normally.
  - h) She has taken some medications: "*MERTAZAPINE [sic], TAPENTADOL*".
  - i) She took it now (less than 30 minutes ago).
39. The 'Overdose/Poisoning' protocol is automatically assigned a Priority 3 REFCOMM<sup>5</sup> response, as determined by Ambulance Victoria's (AV) Clinical Response Model (CRM). The job is held for a period of 60 minutes, to allow a Referral Service Triage Practitioner (RSTP) to triage the event. The event was presented to both REFCOMM and an ambulance dispatcher (AD1) for actioning. This event type also results in a notification to Victoria Police, so the event was presented to a police dispatcher (PD1) for actioning.
40. At 4.25pm, PD1 dispatched the Victoria Police unit Port 511 (POR511) to the event. The ACT was still on the phone with Ms Grieve and documented as follows:

*CALL FROM MENTAL HEALTH CLINICIAN, STATES SHE WAS ON THE PHONE TO THE PT AND SHE HAS TAKEN 9 OF HER EVENING MEDICATIONS EITHER MERTAZAPINE [SIC] OR TAPENTADOL, UNSURE EXACTLY WHICH ONE*

41. At 4.27pm, ACT documented "*AV STILL ASSESSING BY PHONE*" to indicate to PD1 that the event had been referred to REFCOMM for a phone assessment and that an ambulance had not yet been dispatched. The call ended at 4.27.08pm and the ACT advised Ms Grieve that an operator would call Ms Khan to assess and decided upon the most appropriate response. Following the end of the Triple Zero call, Ms Grieve notified the ACIS consultant psychiatrist and the relevant HOPE clinicians.

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<sup>5</sup> REFCOMM is an Ambulance Victoria service staffed by Referral Service Triage Practitioners (RSTPs). RSTPs consist of AV staff including paramedics, registered nurses and mental health triage nurses. Once an assessment has been completed by an RSTP, they can update an event priority or response. REFCOMM can also provide self-care advice to the caller or refer them to an alternative service provider.

42. At 4.35pm, a REFCOMM operator (**RSTP1**) became available and assigned themselves to the event. One minute later, PD1 noted in the event remarks that they would be referring the event to a Police Contact Liaison Officer (**PCLO1**) for review and direction regarding management of the response, due to a lack of available police units.
43. At 4.37pm, RSTP1 documented that they were calling Ms Khan. At 4.42pm, RSTP1 upgraded the event priority from Priority 3 to Priority 2 and recorded the following information:

*At 16.43.56 hours: INTENTIONAL POLYPHARMACY OD*

*At 16.47.52 hours: 10 X MIRTAZAPINE 10 X TAPENTADOL APPROX 10 X AMITRIPTYLINE APPROX 1620HRS*

44. RSTP1 upgraded the event from Priority 2 to Priority 1 at 4.48pm and documented “*DENIES OTHER SELF HARM*”. RSTP1 returned the event to the pending event list, and it became available to AD1 for dispatch. AD1 opened the recommended closest unit (**RCU**) function to identify a unit for dispatch and assigned Advanced Life Support (**ALS**) Paramedic Unit BF6531. BF6531 were 8.6km away from the event at the time and marked themselves enroute at 4.49pm.
45. At the same time, RSTP1 continued to update the event remarks with additional information obtained during their call with Ms Khan:

*HX [history] CARDIAC ARREST POST AMITRIPTYLINE OD EARLIER THIS YEAR*

*NIL AGGRESSION*

*AGGREEABLE TO TRANSPORT*

*HX MAJOR DEPRESSION*

46. At 4.52pm, PCLO1 updated the event remarks with a message to BF6531, seeking confirmation as to whether Victoria Police were still required. Two minutes later, AD1 updated the event remarks to include the rendezvous location that BF6531 were seeking.
47. RSTP1 ended the call with Ms Khan at about 4.59pm.
48. BF6531 updated their status to ‘arrived’ at 5.01pm, meaning they had arrived at the rendezvous location. Victoria Police had not yet arrived at the rendezvous location.

49. At 5.09pm, a second PCLO (**PCLO2**) recorded a message to PD1 in the event remarks “*AV HAVE REQUESTED A RV [rendezvous] AS ABOVE POLICE TO ATTEND*”.
50. At 5.11pm, an AV Communications Support Paramedic (**CSP1**) recorded in the event remarks that they had attempted to make contact with Ms Khan via phone at 5.10pm. At 5.13pm, Victoria Police attempted to dispatch a police unit to the event. The supervising sergeant was aware of the event.
51. At about 5.12pm, BF6531 advised CSP1 that they would attend the scene and perform a dynamic risk assessment from the front of Ms Khan’s home. At 5.14pm, PD1 updated the event remarks to advise BF6531 that there were no available Victoria Police units to attend and that the first available unit would attend. PD1 assigned Victoria Police unit NSS301 to attend the event (when available).
52. At 5.20pm, CSP1 documented that BF6531 asked for Fire Rescue Victoria (**FRV**) assistance to gain entry to the home. BF6531 knocked on the front door but there was no response and the home was locked. At 5.23pm, FRV unit T44 was dispatched to the scene, and arrived at 5.35pm.
53. From 5.35pm to 5.37pm, a Fire Radio Dispatcher (**FRD1**) received information from T44, who had spoken to BF6531, namely that the patient had “*overdosed and potentially armed with razor blade*”. T44 and BF6531 both requested attendance of police, due to the possibility that Ms Khan was armed.
54. At 5.38pm, a second FRD (**FRD2**) updated the event remarks with a request to Victoria Police, noting the patient was potentially armed and they wanted police to attend.
55. At 5.51pm, a second PD (**PD2**) dispatched Victoria Police units NKD302 and NSS303 to the event. At 5.59pm, BF6531 documented that they were delayed on scene waiting for Victoria Police to arrive.
56. At 6.00pm, PD2 marked NKD302 as enroute to the event, and NSS303 marked themselves as enroute to the event at the same time. NSS303 arrived at the property at 6.12pm, then gained access to Ms Khan home via the neighbouring property at 6.20pm.
57. Upon entry to Ms Khan’s home, police located Ms Khan in her bedroom, unresponsive. Paramedics and firefighters entered the home after police and immediately commenced

cardiopulmonary resuscitation (CPR). Paramedics and firefighters continued CPR for some time, however, were unable to revive Ms Khan and she was declared deceased at the scene.

58. Police investigated the circumstances of Ms Khan's death and observed empty boxes of tapentadol, gabapentin, diazepam, mirtazapine, and amitriptyline. Police also found unused esomeprazole, Campral (acamprosate), Betavit, thiamine, Mirtanza (mirtazapine), and Panamax (paracetamol), amongst others. No weapons were located on or near Ms Khan's body. Police did not identify any suspicious circumstances or third-party intervention in connection with Ms Khan's death.

### **Identity of the deceased**

59. On 12 September 2023, Aisha Natasha Khan, born 17 October 1978, was visually identified by her daughter, Murside Aytekin.
60. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

61. Forensic Pathology Registrar Dr Kaitian Yeo supervised by Dr Chong Zhou from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 15 September 2023 and provided a written report of her findings dated 18 December 2023.
62. Dr Yeo explained that the mechanism of death was likely from drug-induced depression of the central nervous system (CNS) leading to respiratory depression, apnoea (cessation of breathing), and death.
63. Toxicological analysis of post-mortem blood samples identified the presence of ethanol<sup>6</sup> (0.15 g/100mL), tapentadol,<sup>7</sup> diazepam and its metabolite nordiazepam,<sup>8</sup> mirtazapine,<sup>9</sup> amitriptyline and its metabolite nortriptyline,<sup>10</sup> gabapentin,<sup>11</sup> acamprosate<sup>12</sup> and paracetamol.<sup>13</sup>

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<sup>6</sup> Ethanol (ethyl alcohol, alcohol) is a social drug and product of yeast fermentation of sugars.

<sup>7</sup> Tapentadol is a centrally acting synthetic analgesic indicated for moderate to severe pain.

<sup>8</sup> Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

<sup>9</sup> Mirtazapine is indicated for the treatment of depression.

<sup>10</sup> Amitriptyline is a tricyclic antidepressant that inhibits the reuptake of noradrenaline and serotonin. It is indicated for major depression, panic disorder, neuropathic pain and enuresis.

<sup>11</sup> Gabapentin is clinically used for treatment of partial seizures and neuropathic pain.

<sup>12</sup> Acamprosate is clinically indicated for alcohol dependence.

<sup>13</sup> Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs.

64. Toxicological analysis of post-mortem urine samples identified the presence of diazepam and its metabolites nordiazepam, temazepam and oxazepam, mirtazapine, amitriptyline and its metabolite nortriptyline, gabapentin and paracetamol.
65. Toxicological analysis of post-mortem stomach samples identified the presence of tapentadol, mirtazapine, amitriptyline and gabapentin.
66. Dr Yeo explained that the level of tapentadol in post-mortem blood was consistent with excessive use. Upon a review of the deceased's medical records, her prescribed tapentadol dose was 50mg (slow release) at night and 25mg (immediate release) in the morning. Analysis of gastric contents found 120mg of tapentadol, which is higher than the prescribed dose.
67. The toxicological analysis above demonstrated the presence of multiple drugs with CNS depressant effects including diazepam, mirtazapine, amitriptyline and gabapentin. The combined use of alcohol and drugs with CNS depressant effects may have a synergistic depressant effect. CNS depression leads to stupor, coma, and eventual decreased respiratory drive leading to apnoea and death.
68. The post-mortem examination showed organising pneumonia within the bilateral lower lobes of the lungs with some features suggestive of being secondary to aspiration (inhaling foreign substances such as food or vomitus). Drug-induced CNS depression is a risk factor for the development of pneumonia. Pneumonia reduces the surface area in the lungs available for gas exchange which can predispose to relative hypoxaemia (reduced oxygenation of blood). This may reduce the level of hypoventilation secondary to drug-induced CNS depression required to cause hypoxic respiratory failure and cardiac arrest.
69. There was no post-mortem evidence of any injuries which may have caused or contributed to the death.
70. Dr Yeo provided an opinion that the medical cause of death was 1(a) Mixed alcohol and drug toxicity (tapentadol, diazepam, mirtazapine, amitriptyline, gabapentin), with a contributing factor of organizing pneumonia.
71. I accept Dr Yeo's opinion.

## **FURTHER INVESTIGATIONS**

72. Given the circumstances of Ms Khan's death, I directed further material be obtained from Triple Zero Victoria (TZV) and AV.

## Triple Zero Victoria

73. David Vassilopoulos (Manager, Emergency Communication Services) provided a statement to the Court to assist my investigation. Mr Vassilopoulos explained that when calls are made to the Triple Zero number, a Telstra E000 operator answers the call first. The Telstra operator asks which service (police, fire, ambulance) is required, and in which suburb or town the event is occurring. If the caller is reporting an event in Victoria, the Telstra operator transfers the call to a TZV police, fire or ambulance call-taker, depending on which service they request.
74. TZV ACTs are required to follow a structured question and answer methodology that is set by the International Academies of Emergency Dispatch (**IAED**), which is contained on software known as ProQA. The ACT is required to select the correct protocol of the 32 available protocols, based on the identified 'Chief Complaint' description provided. The Chief Complaint is the primary reason a person is seeking medical care, which is identified by the ACT as part of the structured call taking process.
75. Once the protocol is selected, the Computer Aided Dispatch (**CAD**) software will present a series of Key Questions for the ACT to ask the caller. The questions are specific to the protocol that has been selected. ProQA will generate subsequent questions for the ACT to ask the caller, based on the answers provided to other questions.
76. Once an ACT has assigned an event type to an event, the ACT will accept the event type into CAD and depending upon the response priority attached to the event type (pre-determined by AV), the event type will present to a TZV AD and/or REFCOMM. The priority levels are zero to three; zero being the most time critical and three being non-urgent events, most of which are sent through to REFCOMM. When a multi-agency ambulance and police attendance event type is generated, a notification is automatically provided to a PD to action (i.e., dispatch an available police unit to attend). The main method of PDs dispatching an event to a police unit is via radio broadcast.

### Whether relevant policies and procedures were followed

77. Mr Vassilopoulos explained that TZV's ambulance standard operating procedures (**SOPs**) require ACTs to process calls in accordance with ProQA. In this case, ACT1 selected the appropriate Protocol based on the Chief Complaint and entered the correct information in response to the Key Questions for the selected Protocol. Mr Vassilopoulos noted that ACT1 selected the appropriate Chief Complaint, which resulted in the appropriate event type and

priority being assigned to this event. The response of all dispatchers was also in accordance with the applicable TZV SOPs.

### Conclusion regarding weapons; requirement to seek further details

78. During the Triple Zero call, ACT1 asked Ms Grieve “*does she have a weapon*” in relation to Ms Khan. Ms Grieve responded that “*[Ms Khan] did say that she had, well she had razor blades in the bathroom and cutlery downstairs in the kitchen*”. ProQA presented ACT1 with three options to select from to record Ms Grieve’s response, being ‘yes’, ‘no’ or ‘unknown’. Based on the information provided by Ms Grieve, Mr Vassilopoulos stated that ACT1 appropriately selected ‘yes’ to this question.
79. Noting that Ms Grieve answered ‘yes’ to the Key Question regarding weapons, the next Key Question to ACT1 in ProQA was “*what is it*”. As Ms Grieve already provided this information, ACT1 selected ‘razor’ from the options in ProQA. Based on the responses to these questions, ProQA automatically recorded the following information in the event:

*She has a weapon*

*She is armed with a razor*

80. Mr Vassilopoulos explained that ACT1 was not required to seek further details from Ms Khan regarding her being ‘armed’, as ACT1 had asked the required Key Questions and recorded answers to same.

### Explanation of the SOP requirements

81. The Ambulance Call-Taking SOP in place at the time provided:

*All relevant information will be recorded in the ‘remarks’ field accurately, particularly pertaining to scene safety.*

*Note: Examples may include volunteered information, poisons, difficult egress/location information, descriptions of the patient or patient’s condition. For example, specific descriptions such as significant blood loss, colour changes, or descriptions pertaining to priority symptoms etc.*

82. Mr Vassilopoulos explained that where an ACT has entered scene safety information into ProQA in response to Key Questions, this information is automatically transposed into the

CAD event remarks. An ACT is only required to enter into the event remarks in CAD any scene safety information which has not already been captured in ProQA.

83. He noted that it was open to ACT1 to elaborate on the scene safety information already captured by ProQA in the event remarks. For example, to include that Ms Khan had razor blades in the bathroom and/or that there had also been mention of cutlery downstairs in the kitchen. However, he opined that it was also open to ACT1 to conclude that the key scene safety information provided by Ms Grieve – that Ms Khan had a razor – was already appropriately reflected in the event remarks.
84. In his experience, Mr Vassilopoulos opined that even if ACT1 had included the additional information referenced above in the event remarks, paramedics would have likely remained concerned about the potential involvement of a weapon, and of entering Ms Khan’s premises without police attendance.

#### ProQA changes

85. At the time of Ms Grieve’s call, ProQA required a ‘yes’, ‘no’ or ‘unknown’ answer to the question of ‘does s/he have a weapon’. On 4 December 2024, TZV implemented an upgrade to the ProQA software, which included a change to the relevant Protocol:
  - a) The Key Question ‘Does s/he have a weapon?’ was changed to ‘Are any weapons involved?’ A new ‘No (but caller reports)’ answer choice was added.
  - b) The Key Question ‘What is it?’ was changed to ‘What type of weapon is it?’
86. The reason this change was implemented by the IAED was provided as follows:

*This first change limits potential over-triage regarding the mention of weapons that are not involved, and the question’s answer option allow for the noting of weapons mentioned but not involved. The second change adds specificity and better relates to the new previous question.*

87. In my view, this is a sensible and common-sense change. Most people have cutlery in their homes, although they may not be near the cutlery or may not have it in their possession at the time of a call to Triple Zero. Requiring police to attend each of these incidents, particularly when there is no other evidence of aggression or other acute risks, would be a significant waste of resources.

## Updates to SOPs

88. Mr Vassilopoulos further noted that the ACT SOP instructions regarding scene safety have also been updated to state:

*All relevant information must be entered in the 'remarks' field accurately, particularly pertaining to scene safety (e.g. weapons, aggressive bystanders, threatening remarks etc).*

## **Ambulance Victoria**

89. AV's Operational Communications Advisor, Matthew Shields, provided a statement to the Court, and attached several of AV's 'Work Instructions' and SOPs. Mr Shields provided an extract of the conversations between BF6531, AD1 and the CSP.

90. At 4.53pm, BF6531 contacted AD1 regarding the rendezvous location to meet Victoria Police:

*BF6531: Brookfield – with an RV [rendezvous]*

*AD1: Brookfield, just stand by.*

*AD1: Brookfield, go ahead.*

*BF6531: Brookfield – just with the RV for 56 [Police], we're gonna meet them at the corner of The Avenue and I believe it was Link Road, let me double check.*

*BF6531: Brookfield – Correction, it's The Avenue and Nicholson.*

*AD1: Brookfield, 56 [Police] have just written a note there asking if you can advise from scene if they're required.*

*BF6531: Brookfield – says the patient's armed with a razor blade, I'm going to say that they're required.*

*AD1: Roger. Just head over to the DM on 109 [Duty Manager channel on the radio] for further [instructions], thank you, and MICA 13 received, thanks.*

91. BF6531 then contacted the CSP while enroute to the scene and had the following conversation:

*BF6531: Brookfield to the DM [Duty Manager]*

*CSP: Brookfield, go ahead*

*BF6531: Brookfield – Good afternoon, we have just been dispatched to 70707 in Sunshine West.*

*Seems like is a potential overdose. The note's saying that the patient is armed with a razor blade. We've been speaking with the dispatcher channel and they said that 56 [Police] want us to do an 'attend and assess'. I feel like they [Police] should probably come in with us to see if she is armed with a razor blade, if that note is correct. I was just told to come over and have a chat with you.*

*CSP: Let me just have a look at it for you guys.*

*BF6531: Much appreciated, thank you.*

92. At 4.55pm, the CSP contacted BF6531:

*CSP: Brookfield – are you on air?*

*BF6531: Brookfield.*

*CSP: Brookfield, it looks like the notes from REFCOM sounds like the patient does not have any aggression and they're agreeable to transport. I think that's why police aren't too keen on coming.*

*BF6531: Brookfield – Understand that. I guess our concern is the fact that she actually has a weapon. Whether or not she's aggressive or not still puts us at risk. I guess – that's why we're probably not too keen on going in without 56 [Police].*

*CSP: Roger. Would you be ok, maybe, to see if this patient's happy to meet you outside?*

*BF6531: I mean, that doesn't really mitigate the risk of her still having the razor blade on her. But, we can try if she can walk to the front door, and show us that she doesn't have anything maybe, but it's still on the risky side, I reckon.*

*CSP: Standby while I do a call back for you, Brookfield.*

*BF6531: Thanks, mate.*

93. BF6531 arrived at the rendezvous point at 5.01pm and contacted AD1:

*BF6531: Brookfield – arrived at RV, we are just chatting with DM on the other channel.*

*AD1: Roger. Thanks, Brookfield.*

94. The CSP contacted BF6531 at about 5.10pm, and the conversation concluded at about 5.13pm:

*BF6531: Brookfield to the DM.*

*CSP: Yeah, Brookfield, I'm having no luck contacting your patient, unfortunately.*

*BF6531: Yeah, righto. We did see a note on here that she has had cardiac arrest post some amitriptyline earlier this year, and it says she has taken the same dose, well, taken some amitriptyline today at least. Perhaps we should approach with caution and see if there's anything...do we know if anyone else is home, is that information you have?*

*CSP: It was handed over to me that there is another person there, yeah. I'm just...let me just have a read through.*

*CSP: Brookfield, yeah it's actually a fourth party caller so I suspect that that person is not on the scene at the moment.*

*BF6531: Yeah Brookfield – Thanks for that. I imagine that will be the mental health clinician that has called it through then. We can make our way down to the house and just have a look and suss anything out, but there is always a potential that we will probably need to section this patient as well who is a potential OD so we will probably still need police, possibly, as well.*

*CSP: Yeah, absolutely. I will type on their job that yeah it's getting fairly urgent. Just let us know what your 'spidey senses' say and, yeah, we'll update 56 [Police] with that info.*

*BF6531: Yeah, roger that. We'll head down and just have a look from the outside first.*

*CSP: No worries, understand. Thanks guys.*

95. BF6531 contacted the CSP again at 5.17pm, as follows:

*BF6531: Brookfield to DM*

*CSP: Brookfield*

*BF6531: Brookfield – we've just rang on the doorbell, knocked on the door. We've had no answer from the patient. I don't know if she is still in there or not, or maybe she is in arrest. We are probably going to need 56 [Police] to gain entry if there is a medical emergency going on.*

*CSP: Yeah 100% guys. Look, do you think you'll need the firies [FRV] to gain access too do you think you can gain access with 56 [Police] there just to make sure you're safe?*

*BF6531: Yeah, look...we don't feel comfortable going in, probably, without 56. We don't know if she's actually having a medical emergency or waiting around the corner for us when we do gain entry, so I think 56 would be more appropriate. But yeah, I guess I'll leave that to your call whether you send [FRV] or 56.*

*CSP: Yeah 100%, we'll keep, certainly keep 56 [the request for police] going. I'm just talking about for access – is the place locked up like Fort Knox and will we, do you think we'll need the big guns to get the door open?*

*BF6531: Yeah, so we got roller shutters on the front window and a security door with a wooden door behind from the looks of things, so yeah we will probably need some muscle to get through all of that, I reckon.*

*CSP: 100% No worries at all. You guys keep yourself safe and I'll get it CAS'ed to the calvary [Create Associated – a request to FRV to attend].*

*BF6531: Thank you.*

96. As noted above, FRV arrived on scene and BF6531 advised the CSP that FRV were not willing to enter the property without police attendance. Once police arrived, access was obtained and Ms Khan was found unresponsive.

*Process to be followed by paramedics attending at a scene where a patient is thought to be armed and whether that process was followed for Ms Khan*

97. Mr Shields drew my attention to AV's Work Instruction *WIN OPS 070 – Approach to a Scene*. Version 13 was in place at the time of Ms Khan's death. Of note:

- a) Section 5.1 states that *“if a RV location has been arranged with Dispatcher/Communications staff and police, AV crews should remain at the RV location until directed to proceed by police”*.
- b) Section 5.2 includes (amongst other directions) that *“AV supports operational staff to exercise discretion on whether to proceed or withdraw from a scene, based on risk assessment of safety concerns. Where safety is at risk, AV will support staff choice not to attend until risks have been adequately controlled.”*

98. Relevant to this guidance, Mr Shields explained:

- a) The BF6531 identified scene safety concerns, specifically that Ms Khan had a weapon (razor). While they were enroute, the crew sought a rendezvous with Victoria Police to ensure their safety when entering the scene. Police attendance was already anticipated by AV at that time, as this case was a multi-agency event.
- b) While attempting to arrange an RV, BF6531 were advised by AD1 that Victoria Police asked if BF6531 could advise from the scene whether police attendance was actually required. Mr Shields explained that it was reasonable and consistent with AD1’s instructions for BF6531 to escalate this to their CSP.
- c) BF6531 discussed the matter with their CSP, including with reference to the further information documented in the CAD by the RSTP. The CSP was unable to contact Ms Khan and following consideration of her prior overdose with cardiac arrest, BF6531 decided to proceed to the scene with caution.

99. Mr Shields stated that AV supports the exercise of BF6531’s discretion to attend a scene based upon a risk assessment of safety concerns.

100. Since Ms Khan’s passing, AV has updated *WIN OPS 070 – Approach to a scene* to include a new Section 6:

*6.2 Non-attendance at scene due to safety concerns.*

*Should attending crews deem the scene unsafe for them to attend they must contact DM/CSP for assistance. DM/CSP will take steps to clarify any potential safety issues. This may involve contacting the caller to further understand the risk.*

*After making contact with the caller, DM/CSP will relay any additional case information to the attending crew so that they can make an informed choice regarding entry to the scene. Where possible the crew members will reassess the situation and provide pertinent information to DM/CSP regarding their intentions.*

*If the event is still assessed as unsafe to enter, the crew must notify DM/CSP of their intentions and DM/CSP will request police attendance via the CAD system.*

*The Dispatcher/DM/CSP will advise the crew as to further actions that are to be taken prior to police arrival (e.g., stand down from the event until the scene is secured).*

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### *6.3 Police requested but delayed or not attending*

*In the event that police are delayed or elect not to attend, the dispatcher/DM/CSP will advise the crew. If the situation remains unchanged and the crew continue to deem the scene unsafe the DM/CSP should discuss the event to determine subsequent actions.*

101. While this updated guidance came into effect after Ms Khan's death, Mr Shields explained that BF6531 did contact the CSP who took steps to clarify any potential safety issues, and the paramedics decided to proceed to the scene with caution.
102. Following this incident, AV has also implemented a Scene Safety Flowchart for use by Secondary Triage Practitioners to clarify scene safety information during the Secondary Triage Process.

## **Analysis of TZV and AV response**

### *Applicable systems, policies and procedures*

103. At the time of Ms Khan's death, due to a static setting in the IAED protocol, the ProQA system automatically recorded that she was "armed" with a weapon, which automatically creates a request for police attendance. Once the weapon was mentioned and recorded, this automation could not be overridden.
104. Although Mr Vassilopoulos stated that the ACT was not required to ask for more information about the razor blades or cutlery, it was notable that they chose not to do so. In my view, it would have been prudent for ACT to ask more information about the location of these items,

i.e., were they usual household items in their usual location (razor blade in the bathroom, cutlery in the kitchen) or whether Ms Khan had disclosed that she had armed herself with these items, i.e. with the intent to harm herself. Most, if not all, households would have ordinary items like cutlery, razor blades or scissors, and there is a clear differentiation between those items being in their usual location, and those items being used or involved.

105. As opined by Mr Vassilopoulos, even if additional information were obtained by the ACT, it is unlikely that BF6531's approach would have differed, as they would have remained concerned. Of note, during BF6531's conversation with the CSP, they noted it was not clear to them whether Ms Khan was actually having a medical emergency or whether she was waiting for paramedics to arrive, to potentially assault them.
106. Unfortunately, the mandatory notification to Victoria Police triggered a chain of events that created a significant delay in the time taken for AV staff to reach Ms Khan.

#### Changes to the ProQA system

107. As noted above, ProQA has been updated so that ACTs ask if any weapons are *involved* and the ACT is able to add free-text information. If the same circumstances reoccurred today, the ACT could now respond 'no' to the weapons question but also include free text about the reference made to razor blades in the bathroom and cutlery in the kitchen, as well as the patient not being violent. This enables the ACT to exercise more discretion to input information in a way that would not automatically trigger police attendance.

#### Compliance with AV policies/procedures

108. As noted above, Mr Shields referred to two sections of *WIN OPS 070 – Approach to a scene* version 13:
  - a) Section 5.1 states that “*if a RV location has been arranged with Dispatcher/Communications staff and police, AV crews should remain at the RV location until directed to proceed by police*”.
  - b) Section 5.2 includes (amongst other directions) that “*AV supports operational staff to exercise discretion on whether to proceed or withdraw from a scene, based on risk assessment of safety concerns. Where safety is at risk, AV will support staff choice not to attend until risks have been adequately controlled.*”

109. In my view, there appears to be an inconsistency in the two paragraphs that could create confusion and risk for paramedics.

*CSP: Yeah, Brookfield, I'm having no luck contacting your patient, unfortunately...*

*BF6531: Yeah, Brookfield -- Thanks for that. I imagine that will be the mental health clinician that has called it through then. We can make our way down to the house and just have a look and suss anything out, but there is always a potential that we will probably need to section this patient as well who is a potential OD so we will probably still need police, possibly, as well.*

*CSP: Yeah, absolutely. I will type on their job that yeah it's getting fairly urgent. Just let us know what your 'spidey senses' say and, yeah, we'll update 56 [Police] with that info.*

110. The conversation and approach above appears to be inconsistent with section 5.1, which directs paramedics to await police instructions, however it is consistent with section 5.2 which allows paramedics to exercise discretion. However, the changes to *WIN OPS 070 – Approach to a scene* have rectified this issue, with the addition of section 6.3:

*In the event that police are delayed or elect not to attend, the dispatcher/DM/CSP will advise the crew. If the situation remains unchanged and the crew continue to deem the scene unsafe the DM/CSP should discuss the event to determine subsequent actions.*

111. The new Scene Safety flowchart also provides additional guidance to paramedics. Of note, the flowchart requires the secondary triage operator to assess the weapon identified more proactively, including finding out if a patient with suicidal ideation has the means to cause harm, what weapon they have, if they are a threat to other people, and, where it has been noted by the previous call-taker that they have a weapon, to clarify if they are indeed armed. In my view, this additional step creates an additional verification regarding the question of a patient's risk to other people by obliging the triage practitioner to both make their own assessment and to review previous assessments and then record this in CAD using red bold font to ensure it is not missed.

Natural justice response - TZV

112. As a matter of procedural fairness, the Court wrote to TZV to provide them with an opportunity to respond to my proposed findings. TZV responded in relation to two proposed paragraphs, firstly:

*In my view, it would have been prudent for ACT to ask more information about the location of these items, i.e., were they usual household items in their usual location (razor blade in the bathroom, cutlery in the kitchen) or whether Ms Khan had disclosed that she had armed herself with these items, i.e. with the intent to harm herself. Most, if not all, households would have ordinary items like cutlery, razor blades or scissors, and there is a clear differentiation between those items being in their usual location, and those items being used or involved.*

113. TZV acknowledged my perspective, however submitted (relying upon Mr Vassiliopoulos' statement) that ACT1 asked the relevant key questions, as required. The ACT SOPs at the time did not require ACT1 to ask clarifying questions about the location of these items.

114. I acknowledge that ACT1 was not *required* to ask further questions. However, as evidenced by the changes to the ProQA questions, eliciting further information about the items is clearly relevant, including to avoid so-called 'over-triangling'. I make no criticism of the ACT1, as they did what was asked of them by the processes at the time.

115. TZV further submitted that ensuring scene safety for paramedics is paramount. As such, when weapons are mentioned, a high degree of caution is required and important safety information must be passed onto the attending paramedics. In those circumstances, TZV submitted that it is not open to conclude that ACT1 asking additional questions would have resulted in a different risk profile and/or action by AV to attend Ms Khan's home sooner. While I consider this to be a distinct possibility (i.e. that further questions about the items may have led to a different risk profile and quicker response), I accept the TZV submission and cannot conclusively determine whether the additional information would have changed the outcome.

116. Secondly, TZV responded to my proposed comment:

*Sadly, the combination of the request for police attendance when it was potentially not required, miscommunications, missed information, the decision to have one unit attend to paperwork, and Victoria Police's constrained resources on the evening all contributed to a delay in police attendance of nearly two hours [one hour, 48 minutes].*

*As noted above, it is unclear the precise time when Ms Khan fell unconscious and when her condition became irreversible (i.e., no longer survivable even with medical treatment). In those circumstances, I am unable to determine that earlier police arrival (enabling earlier medical treatment) would have prevented the death. However, I am satisfied that earlier medical intervention would have optimised Ms Khan's chances of survival.*

117. TZV submitted that insofar as it is suggested that police attendance was potentially not required, the converse is also true (police potentially *were* required). Any statement that police were not required (as opposed to *potentially* not required) would, in their view, only be open to make with the benefit of hindsight and with the knowledge that Ms Khan did not have any weapons on her. I accept that at the time of the Triple Zero call, it was not known whether police were *actually* required. I considered it to be somewhat unclear what this submission set out to achieve; suffice to say that I consider that the risk presented by Ms Khan (and resultant mix of emergency personnel required to attend upon her) ought to have been informed by the best possible information as elicited from the call-taker at the time Ms Khan dialled '000'.
118. In relation to reference to a "*delay in police attendance of nearly two hours [one hour 48 minutes]*", TZV submitted that this wording implied the 'delay' was reasonably avoidable. TZV submitted that this timeframe instead reflects the time between the first Triple Zero call and the time of attendance between police, rather than "*an assessment of the extent of any period of 'delay' in Ms Khan being reached by police or paramedics*". I acknowledge the nuance that TZV is enunciating here, as there is obviously a period of time that elapses between a Triple Zero call and the arrival of paramedics/police.

#### *Procedural fairness response - AV*

119. As above, the Court wrote to AV to provide them with an opportunity to respond to my proposed comments. AV's solicitors responded by summarising and highlighting what it considers to be the most relevant improvements, as it pertains to the circumstances of this case:
- a) The ProQA system has been updated in relation to questions regarding weapons ('does s/he have a weapon' compared to are 'any weapons involved').

- b) TZV updated its ACT SOPs regarding scene safety. The change is aimed at encouraging call-takers to add narrative descriptions of scene safety information that is received.
- c) AV's WIN OPS 070 has been improved with additional clarity (as noted above).
- d) AV has implemented a Scene Safety Flowchart for use by Secondary Triage Practitioners to clarify scene safety.

120. AV submitted that when the above changes are applied to the circumstances of Ms Khan's case, there would be the following practical implications:

- a) It is less likely that cases will be unnecessarily assigned in the first instance as a multi-agency event requiring police response (where the circumstances may not warrant such a response);
- b) In those cases which are still assigned an event type involving a multi-agency response (police and ambulance):
  - i. The information available to responding agencies regarding scene safety is more likely to include detail which may assist in determining the need for a rendezvous with police prior to paramedics attending the scene.
  - ii. AV now provides clearer guidance to its staff on how to manage such situations where police have been requested but are delayed or not attending the scene.

121. AV concluded by submitting that I can be satisfied that relevant and appropriate systemic improvements have been implemented and that I need not make any further recommendations. I accept this submission.

### **Victoria Police response**

122. As noted above, just under two hours elapsed between when Victoria Police were first requested to attend the scene and when they arrived. This delay was largely related to a lack of available resources.

123. Detective Senior Sergeant Rhiannon Norton (**D/S/Sgt Norton**) was the senior sergeant in charge of the Brimbank and Melton Police Service Areas (**PSAs**) on the evening of Ms Khan's death. Her role was to oversee the two patrol sergeants who were on duty for those areas,

Acting Sergeant Mark Harwood (**A/Sgt Harwood**) and Sergeant Paul Dowling (**Sgt Dowling**).

124. In the Brinbank PSA on 12 September 2023, D/S/Sgt Norton explained that they commenced the shift with one less unit than they would usually have, and there were two other members that had urgent correspondence to address. D/S/Sgt Norton advised A/Sgt Harwood that NSS303 would initially be completing urgent correspondence at Sunshine Police Station, however if he needed them for any jobs, he could notify her immediately and they could be ready to assist. D/S/Sgt Norton was also informed of a potential fight planned in the Melton PSA between rival youth gangs that required additional resources. Melton-based detectives were assisting the local units in that area and D/S/Sgt Norton explained that she asked Sgt Dowling (who was supervising the area) to contact her if he required additional assistance.
125. At 3.47pm, D/S/Sgt Norton was advised via Police Communications that an armed robbery had occurred in Taylors Lakes and that there were five offenders in custody. Brimbank-based detectives were assisting uniform members at the scene, in addition to A/Sgt Harwood and his partner.
126. At 5.10pm, D/S/Sgt Norton requested assistance from Bacchus Marsh members, given the resourcing constraints. Before they were able to respond, several detective units offered to assist.
127. At about 5.13pm, D/S/Sgt Norton recalled hearing a job on the radio for a female who had taken prescription medication and had threatened suicide at an address in Sunshine West. There were no units available to attend, however A/Sgt Harwood explained general duties police unit NSS301 was about to clear a job and they would attend Ms Khan's home.
128. From 5.13pm to 5.40pm, there were multiple jobs occurring across the division. D/S/Sgt Norton explained that detectives from the family violence investigation unit (**FVIU**) were also deployed to assist with the planned fight in Melton. She recalled that she spent a considerable amount of time on the phone, liaising with various units throughout this time. She also requested assistance from Bacchus Marsh again.
129. At about 5.40pm, D/S/Sgt Norton spoke with A/Sgt Harwood to enquire about resourcing in his area. He reported that he was at the scene of the armed robbery in Taylors Lakes and did not need additional resources at that stage. After this call, D/S/Sgt Norton checked active jobs on her Electronic Patrol Duty Return (**ePDR**) and noted that no units had attended Ms Khan's

home in Sunshine West. She attempted to call the complainant (Ms Grieve) to obtain further information, however, was unable to reach her. D/S/Sgt Norton observed the note from AV that Ms Khan had previously experienced a cardiac arrest after an overdose and that forced entry would be required. D/S/Sgt Norton noted that she never heard this information over the radio, only on the ePDR.

130. D/S/Sgt Norton was not aware that a police vehicle had not been dispatched to Ms Khan's home, nor of the elevated risk of cardiac arrest and changed priority, as updated by REFCOM, until she stopped to check archived jobs on her ePDR (which she noted is her usual practice). She also noted that this information was not broadcast via police radio. The entry about prior cardiac arrest was made by TZV at 4.49pm. D/S/Sgt Norton did not provide the precise time when she stopped to review the ePDR, although it appears to have been after she spoke to A/Sgt Harwood at 5.40pm. This suggests that about an hour transpired before D/S/Sgt Norton was aware that both a police vehicle had not been dispatched and of the increased risk and urgency of the situation.
131. D/S/Sgt Norton requested an update in relation to why no police unit had attended the job, then noticed that NSS303 was at the police station, so she directed them to attend. D/S/Sgt Norton asked A/Sgt Harwood for an update regarding NSS301 and NKD302. A/Sgt Harwood explained that NSS301 was busy and that NKD302 would be sent to the event.
132. Later that evening, D/S/Sgt Norton asked A/Sgt Harwood why he had not dispatched NSS303 to Ms Khan's event. He stated that he wanted to let that unit complete their urgent paperwork first.
133. From a review of the notes and running sheets of the police officers involved, it is clear that there were various other priority jobs during the relevant time period, including a robbery, an armed robbery, an assembly of 30 people, a 'planned brawl', a burglary and that requests for urgent paperwork could not be completed due to other priorities.
134. It appears that police attendance at Ms Khan's home was delayed due to a combination of factors:
  - a) Unit POR511 initially accepted the job but did not acquit the job and it was not redeployed to another unit.
  - b) Some units were tied up and existing high priority jobs.

- c) A decision was made to allow one unit to finish paperwork at the station, rather than dispatch that unit to Ms Khan's event.
- d) Updates in respect to the increasing priority/urgency of the job do not appear to have been broadcast over police radio and/or relevant police did not become aware of these updates.

Procedural fairness response

135. As noted above, the Court also wrote to Victoria Police to provide them with an opportunity to respond to my proposed comments. Solicitors on behalf of Victoria Police identified some discrepancies in some of the times quoted in the proposed findings, and these have been duly amended. Otherwise, Victoria Police confirmed that they did not wish to file any formal written submissions.

**Legislative Council's Legal and Social Issues Committee inquiry**

136. In 2024 to 2025, the Legislative Council's Legal and Social Issues Committee (**'the Committee'**) undertook an inquiry into Ambulance Victoria and provided its report to Parliament on 14 October 2025. The Committee reviewed the triaging of Triple Zero calls and heard from relevant stakeholders.

137. The report discussed the TZV call-taking dispatch system, including the automated algorithms, the automatic generation of event types and the secondary triage system (which is discussed above). The Committee heard that these systems worked well to free up resources for time-critical events. However, the Committee also identified concerns regarding the call-taking systems, particularly:

- e) The system is calibrated to identify serious, time-critical cases but this can have the consequence of over-triaging Code 1 cases;
- f) The ProQA system uses set questions and answers to search for the worst case scenario;
- g) Call-takers can only select the event type but cannot select the priority of the response; and
- h) The software itself can only be altered via the IAED (as discussed above).

138. In response, the Committee made the following findings:

- a) Finding 37 – As a result of the risk averse triage systems, paramedics are sometimes dispatched to incidents with priority codes that overestimate the priority level, or do not require an ambulance response at all; and
- b) Finding 38 – AV staff and paramedics consistently report instances of over-triaging or misdiagnosis by call-takers due to the inflexibility of the call-taking software.

139. Relevantly, the Committee made the following recommendations:

- a) Recommendation 12 – That AV introduce performance indicators around the accuracy of the call-taking triage process, particularly in relation to Code 1 cases. AV should then publish data in its annual reports on the number of Code 1 cases where it was discovered that the event type assigned during the call-taking process did not match the actual problem.
- b) Recommendation 13 – That the Inspector General of Emergency Management (IGEM) undertake and publish a review of emergency ambulance call answer performance in order to improve the call-taking process and reduce cases of over-triaging.
- c) Recommendation 14 – That AV adopt critical oversight similar to other jurisdictions that are able to override the event types prescribed by ProQA.
- d) Recommendation 15 – That AV increase the number of clinical staff assigned to oversee the call-taking processes at state emergency communications centres. This may include communications clinicians or other clinical staff as AV sees fit. AV should also encourage TZV staff to be more confident in flagging what they believe to be incorrect event types.

140. Recommendations 12 to 15 do not directly reference over-triaging related to the unnecessary requirement of police attendance, nor is there reference to this issue in the Committee's report. However, it could be argued that this issue is within the scope of these recommendations.

### **Conclusion regarding emergency services response**

141. Sadly, the combination of the request for police attendance when it was potentially not required, miscommunications, missed information, the decision to have one unit attend to

paperwork, and Victoria Police's constrained resources on the evening all contributed to a delay in police attendance of nearly two hours (one hour, 48 minutes). As noted above, it is unclear the precise time when Ms Khan fell unconscious and when her condition became irreversible (i.e., no longer survivable even with medical treatment). In those circumstances, I am unable to determine that earlier police arrival (enabling earlier medical treatment) would have prevented the death. However, I am satisfied that earlier medical intervention would have optimised Ms Khan's chances of survival.

142. It is unfortunate that the ProQA system at the time did not permit ACTs with the discretion to document whether a reported weapon was actually involved in the incident, or rather, that it might simply be present elsewhere in the home. The changes to the ProQA system now permit discretion regarding how weapons are recorded to avoid unnecessary over-triangling. AV's *WIN OPS 070 – Approach to a scene* has been improved with additional clarity, and improvements have been made to AV's secondary triage procedures to permit dynamic risk assessments when police are delayed or elect not to attend.
143. Given these changes, I am satisfied that I do not need to make any recommendations about the issue of weapons that arose in Ms Khan's case. Nevertheless, Recommendation 13 of the Committee may still be relevant here, and I intend to re-state Recommendation 13.
144. With respect to Victoria Police's response, I acknowledge that the day of the fatal incident was a busy period within the Brimbank PSA and there were simply not enough police units to attend Ms Khan's home immediately. In hindsight, it is easy to question a decision to allow a unit to complete urgent paperwork at the police station in such a situation, although I note that A/Sgt Harwood and D/S/Sgt Norton may have been unaware of the increasing priority/urgency of the job, due to updates being broadcast over a very busy radio channel, and I make no adverse comment about such decision.
145. There also does not appear to be an automated reminder system to remind supervisors that a job has not yet been attended to, and it was up to D/S/Sgt Norton to determine this for herself. It also does not appear that new information obtained from AV (for example) is easily accessible to supervising police, as evidenced here. If the supervising member does not hear the broadcast via police radio, they need to manually search their ePDR for this information. This system leaves open the possibility that a supervisor might not remember all the outstanding jobs to attend, there is no automated way to prompt the supervisor about outstanding jobs, nor is there an automatic way to notify a supervisor of the changing priority

of the job (save the police radio). As it is not clear that the delay directly caused or contributed to the death, I am satisfied that this issue does not require further investigation in this forum.

## **CPU REVIEW**

146. Given Ms Khan's contact with public mental health services proximate to her death, I also referred this case to the Coroner's Prevention Unit (CPU)<sup>14</sup> for an independent review of the mental health treatment Ms Khan received prior to her passing.

### **First admission to WIPU – 10 to 12 July 2023**

147. The CPU opined that in this admission, Ms Khan was appropriately referred for AOD support and community mental health crisis intervention. The CPU did not identify any issues or prevention opportunities in this admission.

### **First ACIS episode of treatment – 13 to 31 July 2023**

148. The CPU opined that ACIS assertively monitored Ms Khan's mental state and risk and liaised with her GP to ensure a continuity of care in the community. The CPU opined that the treatment provided by ACIS was responsive and of a high standard, and did not identify any issues or prevention opportunities.

### **HOPE engagement – 27 July to 12 September 2023**

149. The CPU noted that Ms Khan's engagement with HOPE was responsive and was of a high standard. The CPU did not identify any issues or prevention opportunities.

### **YYPARC admission – 27 to 30 August 2023**

150. As noted above, Ms Khan was discharged early due to non-compliance with the YYPARC code of conduct. At the time of her discharge, Ms Khan did not appear to have any acute risk issues, suggesting that the discharge was reasonable in the circumstances, given the need to maintain a safe environment for staff and all participants.

151. While Murside was advised that her mother had been discharged, it does not appear that she was informed of the reason for same. The CPU noted that it was unclear whether YYPARC

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<sup>14</sup> The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

attempted to liaise with Murside prior to discharge and opined that best practice would have involved liaising with her prior to discharge, given the active role she had in her mother's mental health treatment. Nevertheless, the CPU did not find that this amounted to a prevention opportunity, due to the subsequent contact with other clinicians and her admission to WIPU. The CPU did not identify any other issues with Ms Khan's admission to YYPARC.

### **HOPE engagements post YYPARC**

152. The CPU opined that the treatment provided by HOPE was responsive and of a high standard. The CPU did not identify any issues or prevention opportunities in relation to this episode of treatment.

### **WIPU final admission – 31 August to 9 September 2023**

153. The CPU opined that Ms Khan was appropriately readmitted to WIPU when her risk increased to a level where she was unsafe to remain in the community. Her condition improved over the period of her admission and the CPU opined that the decision to discharge her from WIPU was reasonable, given the discharge and safety plans in place. The CPU opined that the discharge and safety plans were in line with best practice and the evidence base which supports people with these disorders to be best treated with a short crisis admission, rather than prolonged inpatient admissions.
154. The CPU noted that prior to discharge, the psychiatry registrar made two unsuccessful attempts to speak with Murside on 8 September 2023. There was no documentation that suggested any mental health clinician (from any team) spoke to Murside between discharge from WIPU and Ms Khan's final call with ACIS. However, the CPU did not believe that this presented a prevention opportunity, due to the prior frequent engagements (by all arms of the team) and contact with the registrar on 6 September 2023. Murside appeared to be aware of her mother's safety plan and demonstrated a willingness to contact services when required.

### **Analysis of mental health treatment and service contact**

155. While the CPU identified minor issues in some of the service contact (as outlined above), I am satisfied that these did not cause or contribute to Ms Khan's death and that there are no prevention opportunities arising from this treatment. To the contrary, the CPU considered the treatment Ms Khan received from Western Health was of a high standard. I agree with this opinion.

## Natural justice response

156. As above, the Court also wrote to Western Health to provide them with an opportunity to respond to the CPU's opinions on the minor issues identified in some of the service contact.
157. Western Health acknowledged the observations, namely, that there were instances where family contact was not undertaken or documented prior to discharge. In response, Western Health submitted that it is committed to reinforcing and strengthening staff education regarding the importance of engaging families and carers in communication and shared decision-making, wherever clinically appropriate. This will include regular education, supervision and reminders regarding proactive attempts to contact family members, appropriate documentation of those efforts and consideration of family involvement as part of routine discharge planning.
158. Western Health also recognised that there are situations in which family involvement may not be feasible or appropriate, including where patients do not consent to family engagement or where family members decline participation. Notwithstanding these circumstances, Western Health will continue to emphasise that, wherever appropriate and necessary, reasonable efforts should be made to involve families in care and decision-planning.
159. I commend Western Health for proactively looking for methods to improve communication and engagement with families of patients, as well as for the high level of care it provided to Ms Khan as a complex and chronically at-risk patient.

## FINDINGS AND CONCLUSION

160. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Aisha Natasha Khan, born 17 October 1978;
  - b) the death occurred on 12 September 2023 at 29 Nicholson Parade Sunshine West Victoria 3020, from mixed alcohol and drug toxicity (tapentadol, diazepam, mirtazapine, amitriptyline, gabapentin) with a contributing factor of organizing pneumonia; and
  - c) the death occurred in the circumstances described above.
161. Having considered all of the circumstances, I am satisfied that Ms Khan's death was the consequence of the deliberate ingestion of drugs. While Ms Khan deliberately ingested the medications that caused her death, I am not satisfied that she intended to end her own life.

Ms Khan acknowledged feeling suicidal and enacted her safety plan by contacting Ms Grieve (who commendably and appropriately assessed that a '000' response was required, which she rapidly actioned) and willingly spoke to the Referral Service Triage Practitioner when contacted. In my view, this indicates Ms Khan's desire to seek help, despite feeling suicidal. It is tragic that she died following what appears to be a 'cry for help'.

162. However, I do not consider that adverse comments are warranted in relation to the events that flowed from the '000' call, and it cannot now be known whether the outcome would have been different had emergency services attended to Ms Khan at an earlier point. A pertinent comment arises as to the call-taking process that I will now turn to.

## COMMENTS

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

163. I note my strong support for Recommendation 13 of the Legislative Council's Legal and Social Issues Committee's inquiry into Ambulance Victoria, namely:

*Recommendation 13 – That the Inspector General of Emergency Management undertake and publish a review of emergency ambulance call answer performance in order to improve the call-taking process and reduce cases of over-triaging.*

I convey my sincere condolences to Ms Khan's family for their profound loss.

## 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:

Murside Aytekin, Senior Next of Kin

Ambulance Victoria (C/- Meridian Lawyers)

Triple Zero Victoria

Victoria Police (C/- Lander & Rogers)

Western Health

Senior Constable Ned Weatherly, Coronial Investigator

Signature:



Coroner Ingrid Giles

Date: 19 March 2026

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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.

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