IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001714

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

Inquest into the Death of Narisha Faye Cash

Delivered On:	19 December 2025
Delivered At:	Coroners Court of Victoria at Melbourne
Hearing Dates:	24, 25, 26 October 2022 20 February, 4 May 2023
Findings of:	Coroner Catherine Fitzgerald

Representation:

Counsel Assisting the Coroner	Lindsay Spence Principal In-House Solicitor Instructed by Jessica Syrjanen Coroners Court of Victoria
Mathew Cash, Senior Next of Kin	Sarah Schwartz with Siobhan Doyle Victorian Aboriginal Legal Service

Emergency Services Telecommunications Authority	Raph Ajzensztat Instructed by Lander & Rogers
Chief Commissioner of Victoria Police	Andrew Imrie Instructed by Norton Rose Fulbright
Sergeant Kirby Healy	Catherine Boston Instructed by MinterEllison
Police Call Taker & Police Dispatcher 1	Fiona Ellis Instructed by Barry Nilsson
Police Dispatcher 2	Alice Smith K & L Gates

Keywords	Emergency services, 000, call taking and dispatch, ESTA, Triple Zero Victoria, threats of suicide, police response, health-led response, RCVMHS Recommendation 10

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INTRODUCTION

1. On 26 March 2020, Narisha Faye Cash[1] (**Nish**) passed away[2] at her home in Sunshine West. She was 41 years old.

2. In the hours prior to her passing, Nish called 000 for emergency assistance and was expressing suicidal intent. As a result of her call, she was transferred to a Police Call Taker at what was then known as the Emergency Services Telecommunications Authority (**ESTA**), now Triple Zero Victoria.[3] The Police Call Taker asked Nish a series of questions about the nature of her emergency. The information was then reviewed by a Police Dispatcher who attempted to allocate a Victoria Police unit to attend Nish's home. From the outset, there were issues allocating an available police unit. Ultimately, it was 1 hour and 41 minutes before a police unit attended her home, and by that time Nish had passed away from an apparent drug overdose.

3. Nish's passing was reported to the coroner as a 'reportable death' pursuant to s 4 of the *Coroners Act 2008* (**the Act**) and a coronial investigation was commenced. Relevantly, her passing satisfied more than one of the criteria in s 4(1), as it appeared to have been an unexpected and unnatural death pursuant to s 4(2)(a) of the Act.

4. The focus of any coronial investigation must necessarily be the identity of the deceased, the cause of death, and the circumstances in which the death occurred, to enable the requisite findings in s 67 of the Act to be made. These findings state those facts and discuss them in detail, including reference to Nish's personal struggles and the challenges she experienced in her life. I acknowledge that it is not possible for these findings to adequately account for the complexity of her life and how much Nish was loved by her family and friends, and how deeply they miss her. Her sudden loss has had an enormous impact on her family and broader community.

[1] The family have requested that she be referred to as 'Nish'.
[2] Due to cultural considerations, the end of Nish's life will be referred to as her "passing" wherever possible. Any references in this finding to a "passing" are references to a "death" pursuant to the definition in s 3 of the *Coroners Act 2008*.
[3] ESTA is now known as Triple Zero Victoria. For ease of reference, these findings will refer only to ESTA, acknowledging that whilst the name of the organisation has changed, its functions have not.

THE CORONIAL INVESTIGATION

The role of the coroner

5. The role of the coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the cause of death, and the circumstances in which the death occurred.[4] The purpose of a coronial investigation is to establish facts, not to cast blame or determine criminal or civil liability.

6. The findings from coronial investigations help to contribute to the reduction of the number of preventable deaths and coroners may make comments or recommendations about any matter connected to the death under investigation, including matters relating to public health and safety or the administration of justice.[5]

The police coronial brief

7. Victoria Police assigned Detective Senior Sergeant (**DSS**) Jamie Walker, from the Brimbank Crime Investigation Unit, as the Coroner's Investigator (**CI**) for the investigation into Nish's passing. DSS Walker conducted inquiries on the coroner's behalf and submitted a thorough coronial brief of evidence.

8. From the outset of the coronial investigation, it was identified that there may have been a delay in police attendance at Nish's residence. DSS Walker specifically identified that the allocation of available resources in response to Nish's emergency was an issue, and provided an analysis of the police resources which were potentially available to respond to Nish's emergency on the night she passed.[6]

9. DSS Walker explained that Nish's home address fell within the Brimbank Police Services Area (**PSA**) and broader North West Metro Division (**NWMD3**) area, which also included the Melton PSA.

10. During any policing shift, there is a Patrol Supervision Senior Sergeant (**265**) within the Division area who holds responsibility for "supervision, management and oversight of the police response" in that area for that shift, and resourcing issues within the Division

[4] *Coroners Act 2008* (Vic) s 67(1). ('*Coroners Act*')
[5] *Coroners Act* ss 67(3), 72(2).
[6] Statement of DSS Jamie Walker, Inquest Brief, 121. ('IB')

must be reported to the 265.[7] Within each PSA, there is a corresponding Patrol Supervision Sergeant (**251**) for each shift, who is "responsible for supervision of all police units on patrol during their shift within their PSA." DSS Walker noted that if additional resourcing is required, this should be reported by the 251 to the 265.[8]

11. DSS Walker concluded that there were potentially police units in the Brimbank and Melton PSAs available to attend to the event relating to Nish at the time of her initial call to 000 at 9:33 pm, as well as at the time the event was first dispatched to a police unit who were already attending another job at 10:05 pm. DSS Walker also noted that no ambulance was requested for Nish by any police members, radio operators, or 000 call takers until the first police unit arrived on scene at 11:10 pm, and by that time Nish had passed.

Further investigations

12. Following review of the police coronial brief, I directed further investigations to explore the following issues:

    a. Why no police unit attended Nish's home until 1 hour and 41 minutes after the initial 000 call;

    b. Why an ambulance was not called to attend until Nish was found unresponsive by police; and

    c. Whether Nish's passing may have been prevented with earlier police or ambulance attendance, and any potential prevention opportunities.

Inquest

13. An inquest hearing was held and proceeded over five days in total, during which time eight witnesses were called to give evidence, and the inquest brief and other exhibits were tendered. The scope of the inquest was as follows:

    1. ESTA's management of:
        a. Ms Cash's triple zero call at 9.30pm; and

[7] Statement of DSS Jamie Walker, IB 121.
[8] Ibid.

b. Constable Jenkin's update regarding Ms Cash at approximately 10.03pm

2. Victoria Police's response including the allocation and coordination of resources within the patrol and division at the relevant times.

14. Following the conclusion of the inquest, additional evidence was obtained to supplement the inquest brief having regard to issues which arose during the proceedings. It also became necessary to allow some witnesses, who were not called to give evidence or represented at the inquest, an opportunity to obtain legal representation and file written submissions. Ultimately, all interested parties filed extensive written submissions.

Standard of proof

15. In the coronial jurisdiction, facts must be established on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.

16. Coroners should not make adverse comments or findings about individuals or entities unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences.

17. I have made findings based on the totality of the coronial investigation into the passing of Nish, including the brief, all exhibits, and the evidence given by the witnesses at the inquest. I will only refer to the evidence directly relevant to my findings or necessary for narrative clarity.

Factual issues and submissions filed

18. I have carefully considered the written submissions filed by all the interested parties and will only refer to them where necessary.

[9] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336.

19. I note that detailed submissions were made on behalf of Mr Mathew Cash, the brother of Nish, by the Victorian Aboriginal Legal Service (**the family's submissions**). The family's submissions ran to 24 pages and invited the making of 43 specific factual findings, as well as recommendations. The family's submissions covered all aspects of the emergency call and response, and addressed the following broad topics:

    a. cause of death;

    b. the response time by emergency services;

    c. Nish's state of mind (whether the passing was accidental or Nish intended to take her own life);

    d. ESTA's management of the 000 call;

    e. the police response to the initial "threat of suicide" job at 9:34 pm;

    f. the telephone calls between the first Police Dispatcher (**PD1**), Constable Jenkins and Nish;

    g. the telephone call between Constable Jenkins and the second Police Dispatcher (**PD2**), and PD2's response;

    h. the police response to the 10:05 pm D24 update about Nish's job (being the information from Constable Jenkins); and

    i. whether Nish's passing was preventable.

20. I acknowledge that the family's submissions characterised much of what occurred in the response to Nish's emergency as both individual and system failings. Broadly, it was submitted that the totality of the evidence revealed "major failings in the way that emergency services […] respond to calls relating to mental health, suicide and overdoses".[10] The ultimate submission made on behalf of the family was that there were five specific "lost opportunities"[11] where Nish's emergency should have been responded to earlier by police or ambulance, and that her passing may have been prevented "if emergency services had responded appropriately to her calls for help on 26 March

[10] Closing submissions on behalf of Mathew Cash (23 June 2023) at [7].
[11] Ibid at [150]-[151].

2020".[12] However, to the extent that the family's submissions advocated for findings to be made with regard to the conduct of individuals, it was submitted that these were relevant to systemic issues identified in the inquest and not allegations of misconduct by any individual.[13]

21. Counsel Assisting also made submissions that whilst it was necessary to make findings of fact with respect to the conduct of individuals, any adverse comments which arose should be directed at a systemic, organisational level.[14]

22. The submissions from the remaining interested parties were responsive to the submissions made by Counsel Assisting, and the family's submissions, in those terms. Their submissions generally addressed any submissions which were adverse in nature, and any potential recommendations directed to them.

BACKGROUND

23. Nish, a proud Jingilli woman on her mother's side, shared strong connections to her culture. She was born on 19 January 1979 and grew up in South Australia. Nish was the daughter of Lynette Cash and Michael Morrison.

24. In 2012, Nish's mother passed away.[15] She had little contact with her father. Nish has two half-siblings: a brother, Mathew Cash, and a sister, Aleena Cash.[16] From 14 years of age until adulthood, Nish lived with her grandparents.[17]

25. Nish had a daughter from a long-term relationship which ended when her daughter was a young child. Her daughter's father has had custody of her since that time, and they live in Adelaide.[18]

26. From about 2000, Nish struggled with drug and alcohol abuse.[19] These problems appear to have become acute following the end of her relationship with her daughter's father. A close friend described Nish as having an "alcohol dependency" and "dabbling" with

[12] Ibid at [159].
[13] 4 May 2023 T 7:4-15.
[14] 4 May 2023 T 3:19 - 4:16.
[15] Statement of Mathew Cash, IB 21; statement of Jacqueline Watkins, IB 17.
[16] Statement of Mathew Cash, IB 21.
[17] Statement of Mathew Cash, IB 21.
[18] Statement of Jacqueline Watkins, IB 17; statement of Mathew Cash, IB 22.
[19] Statement of Mathew Cash, IB 21; statement of Benjamin Scudds, IB 35.

cannabis use. Nish had also disclosed misuse of over-the-counter pain medication to a friend.[20] Her alcohol and drug problems were of such severity that she was hospitalised on several occasions.[21]

27. Nish was diagnosed with depression and bipolar disorder and was prescribed medications to manage these conditions. She had prior admissions to hospital due to mental health concerns[22] and she had a history of threatened and attempted suicide.[23] Her medical history included type 2 diabetes mellitus and migraines.

28. Although Nish experienced many personal challenges, she was actively involved in the arts industry throughout her adult life and was well regarded in that community. She was employed for many years in the arts, and did freelance work, exhibiting around Australia. She and a group of artist friends organised an annual multi-day art event called "Ladie Killerz" and Nish had previously owned a business with her daughter's father. She was a renowned graffiti artist.[24]

29. Towards the end of 2018 or the start of 2019,[25] Nish moved to Melbourne, Victoria. This was apparently due to ongoing personal and family issues she experienced in South Australia.[26] Initially, Nish stayed with an Aunty in St Albans.

30. Nish's adjustment to life in Melbourne was difficult, as she struggled to find consistent work. Her abuse of alcohol and prescription medication worsened in this context, and she reportedly overdosed on heroin around New Year's Eve in 2018.[27] Nish's Aunty recalled that on three occasions while Nish was living at her house, Nish had to be taken to the Sunshine Hospital emergency room after consuming excessive prescription medication in combination with alcohol. She also attempted to take her own life by cutting her wrists.[28] Nish received support from a mental health counsellor and was taking prescribed medication for her physical and mental health at the time of her passing.[29]

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[20] Statement of Samantha Jones, IB 30.
[21] Statement of Mathew Cash, IB 21.
[22] Statement of Samantha Jones, IB 30.
[23] Statement of Mathew Cash, IB 22.
[24] Statement of Samantha Jones, IB 29; statement of Christie Allison, IB 24.
[25] Statement of Mathew Cash, IB 22; cf. statement of Samantha Jones, IB 32.
[26] Statement of Christie Allison, IB 24.
[27] Statement of Samantha Jones, IB 31.
[28] Statement of Jacqueline Watkins, IB 18; statement of Samantha Jones, IB 31.
[29] Statement of Samantha Jones, IB 31.

31. Due to her ongoing difficulties with alcohol abuse, Nish's living arrangements with her Aunty became untenable. In February 2019, Nish moved to West Footscray where she shared a house with her close friend Samantha Jones and Ms Jones' daughter.[30] Ms Jones and Nish had been friends for approximately 15 years, having met through the art scene, and they shared an interest in painting.[31] After a few months, that living arrangement also broke down due to Nish's alcohol abuse. Nish then admitted herself to Odyssey House, a residential rehabilitation program for people seeking treatment for drug, alcohol and mental health issues. She stayed there for approximately six months and successfully abstained from alcohol and painkillers during that time.[32]

32. Following her discharge from Odyssey House, Nish commenced employment with Ngwala Willimbong Aboriginal Corporation (**Ngwala**) as a case worker in the housing and homeless program. She was regarded as "a wonderful and cheerful colleague and a very popular staff member".[33] Due to her competency in the role, she was soon given a more responsible role in a support program assisting prisoners upon their release. Ngwala staff believed that Nish was "very positive and excited" about this new role.[34]

33. Whilst Nish appeared to excel at Ngwala, her manager noted that she became sad regarding issues with her ex-partner in South Australia. Nish's manager also thought that she was "inundated in terms of her workload and that appeared to have affected her mental health" and she "seemed overwhelmed by it all". The organisation funded counselling for Nish to assist her with her personal issues.[35] Nish's colleagues at Ngwala were unaware of the severity of her pre-existing mental health and drug and alcohol issues, and whilst there was an awareness of her personal situation, there was nothing about her behaviour at work that was seen by her colleagues as anything out of the ordinary.[36]

34. With the advent of the COVID-19 pandemic, working from home arrangements were put in place at Ngwala, meaning that the only interaction Nish was having with her manager was a de-brief in a phone call at 3:00 pm. This initially occurred daily but was reduced

[30] Statement of Samantha Jones, IB 31.
[31] Statement of Samantha Jones, IB 29.
[32] Statement of Samantha Jones, IB 32.
[33] Statement of Demos Kroukos, IB 38; see also statement of Karen Derschow, IB 41.
[34] Statement of Demos Kroukos, IB 39.
[35] Statement of Karen Derschow, IB 42.
[36] Statement of Karen Derschow, IB 41.

to three days per week. According to her manager, Nish "sounded very bubbly" during their phone conversations, but as contact was limited "it was hard to judge her mood".[37]

35. In December 2019, Nish moved into a house at 12 Krambruk Street, Sunshine West with Mary Quinsacara, a friend she had known for 10 years. Ms Quinsacara knew Nish to be "generally a very positive, generous, loving and outgoing person", but observed that in the months preceding her passing, Nish became unusually withdrawn and was "hiding away in her room quite a bit".[38] She told Ms Quinsacara that she found her job at Ngwala stressful and felt "burnt out" from it. Ms Quinsacara formed an impression that the job was negatively impacting Nish's mental health. Ms Quinsacara also thought that the relationship breakdown with Taniesha's father "was a cause of anxiety" for Nish, and that she appeared depressed.[39]

36. In the weeks leading up to her passing, Nish was smoking cannabis and drinking alcohol every night and Ms Quinsacara observed that Nish was consuming alcohol in larger quantities. She was aware that Nish had been to "rehab" in the last year and had a mental health plan. Nish told Ms Quinsacara that she was accessing a mental health service, which she found useful.[40]

37. According to Ms Quinsacara, Nish reported feeling "nervous and apprehensive" about her new role at Ngwala and was also upset about the suicide of a colleague. She thought that Nish's mental health was "very 'up and down'" in the week prior to her passing, and observed that Nish was "heavily intoxicated and stoned" each night that week.[41]

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

Circumstances in which the death occurred: s 67(1)(c) of the Coroners Act

38. On 26 March 2020, Ms Quinsacara left for work at about 9:00 am and didn't see Nish before she left the house. She thought that Nish was still in bed and was meant to be working from home that day.

[37] Statement of Karen Derschow, IB 42.
[38] Statement of Mary Quinsacara, IB 13.
[39] Statement of Mary Quinsacara, IB 12.
[40] Statement of Mary Quinsacara, IB 13.
[41] Statement of Mary Quinsacara, IB 13.

39. Sometime during the day, Nish sent a message via Instagram to an estranged acquaintance, Benjamin Scudds, who is also known by the name 'Delta'. They knew each other from the early 1990s but grew apart in the mid-2000s and had not been in contact since 2018. Nish messaged Mr Scudds on Instagram asking to rekindle their friendship. There was a series of messages between them which ended with Mr Scudds asking Nish not to contact him again that day.[42]

40. When Ms Quinsacara returned from work at about 5:00 pm, Nish was "heavily drunk and stoned" and talking about something that she was very upset about. Ms Quinsacara listened to Nish but decided to go to her room as she felt unable to assist her "because of the state she was in."[43] From her room, Ms Quinsacara could hear Nish speaking on the phone to one of her friends, and it seemed that the friend was trying to calm her down.[44]

41. At about 5:11 pm Nish sent a text to her friend Samantha Jones which stated, "Can u please call me when u can. I'm really upset n feeling awful right now". Ms Jones spoke to Nish at about 5:30 pm and they discussed the messages she had exchanged with Mr Scudds and some other separate arguments Nish was having with "two other guys". During the conversation, Ms Jones formed a view that Nish had been drinking but she did not think she was "heavily drunk".[45] Nish also mentioned a colleague who had apparently taken their own life a week earlier, and there was some discussion between them pertaining to suicide, although Ms Jones did not believe that Nish would ever "hurt herself on purpose". They also discussed Nish's new job, which she said she was nervous about. They spoke for about an hour. Ms Jones was not concerned about the phone call and did not think it was "anything other than a normal chat".[46]

42. Nish called her friend Christie Allison at about 6:00 pm, and they also discussed the interaction between Nish and Mr Scudds.[47] Nish told Ms Allison that she had tried to reach out to him, but he had "written her off". Nish was crying and very upset, but Ms Allison didn't think that she was drunk. Nish ended the call saying that someone else

[42] Statement of Benjamin Scudds, IB 36.
[43] Statement of Mary Quinsacara, IB 13.
[44] Statement of Mary Quinsacara, IB 14.
[45] Statement of Samantha Jones, IB 32.
[46] Statement of Samatha Jones, IB 33.
[47] Statement of Christie Allison, IB 26.

was calling her and she would call Ms Allison back, however she did not receive another call from Nish.[48]

43. At about 9:00 pm, Ms Quinsacara went to speak to Nish and found her outside speaking to the driver of a car which was pulled over on the street outside their house. Nish appeared to know the driver. Ms Quinsacara and Nish went back inside the house and she told Nish that she was not feeling comfortable at the house and "needed some space". She thought that Nish appeared hurt by this, but there was no argument between them. Nish went to her room and Ms Quinsacara left and went to a friend's house for the night. She had no further contact with Nish, [49] but at about 11:30 pm, Ms Quinsacara saw a post on Nish's Instagram account which read "Goodnight Irene. Lov u all. I'm done with this."[50] Ms Quinsacara was concerned about the posting because Nish was intoxicated and she had previously seen Nish make a similar post when she was depressed and threatening to hurt herself. However, she thought that Nish would go to bed and "sleep it off".[51] It is not clear what time Nish posted the Instagram message, but by the time that Ms Quinsacara read it, Nish had been found unresponsive by police.

44. At 9:29 pm, Nish made a mobile phone call to 000 which was answered by a Telstra Operator from Telstra's E000s service.[52] The Telstra operator asked Nish "Emergency, Police, Fire, Ambulance?" to which she responded "Oh, I just want to kill myself."[53] The call was then transferred to a Police Call Taker (**PCT**) at ESTA.[54]

45. A PCT from ESTA (**PCT1**) answered the transferred call almost immediately at 21:30:01.[55] PCT1 asked Nish, "Hi caller, where do you need the police?" to which Nish responded, "I just want to fuckin' do myself in I can't take this anymore".

46. The call with Nish resulted in PCT1 creating an "event" in the Computer Aided Dispatch (**CAD**) system at 21:33:35. PCT1 manually selected the event type "*597 - P -EME-THR*

[48] Statement of Christie Allison, IB 27.
[49] Statement of Mary Quinsacara, IB 14.
[50] Image of Instagram post, attachment to statement of Mary Quinsacara, IB 16.
[51] Statement of Mary Quinsacara, IB 15.
[52] Statement of Thomas Dunbar, IB 230-231.
[53] Inquest Exhibit B - Audio of triple zero call made by Nish to Telstra prior to transfer to ESTA.
[54] Inquest Exhibit C - Telstra's response to Form 4 dated 23 Nov 22 re: decision to transfer Nish's call to ESTA PCT.
[55] For accuracy and clarity, the timings of the emergency services interactions with Nish are recorded in 24-hour time format.

ATTEMPT OR THREAT SUICIDE" which has a default priority of 'Priority 2'.[56] PCT1 then asked Nish a series of questions in accordance with a structured call taking process (**SCT**) for event type 597.[57]

47. An audio recording of the 000 call establishes that Nish made several statements of suicidal intent and self-harm during the call with PCT1, including:

> "I just want to fuckin' do myself in. I can't take this anymore.
> "I've got so much going on that I can't deal with it anymore."
> "I just want to kill myself."
> "I want to fuck myself up."
> "I'm gunna slash my wrists."
> "They can't deal with me and I can't deal with myself"
> "I just want to fuckin' end it".

48. Nish confirmed that she was not injured and she had no weapons with her. When asked if she had taken drugs or alcohol, she confirmed she had consumed alcohol. She said she was on her own as her housemate had left. She told PCT1 she had bipolar and "a lot of other mental health issues". She indicated she had prior involvement with police which led to her being stripped and taken to hospital, and she had previously been put on a gurney.[58]

49. PCT1 told Nish, "I've asked police to come and look after you" and confirmed Nish's address.[59] At 21:35:25, the call was transferred to Lifeline by PCT1 to enable Nish to speak to a crisis support worker prior to police arriving.[60] Nish agreed to stay on the line to be transferred to Lifeline.[61] The call to Lifeline was not recorded as Lifeline does not make recordings of calls made to their services.[62]

50. At 21:35:56, PCT1 completed their involvement in the process by finalising their entry in the CAD system , which contained a summary of the information gathered from Nish during the SCT process between 21:30:01 and 21:34:33 as follows:

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[56] Statement of Thomas Dunbar, IB 234 and 381.
[57] Statement of Thomas Dunbar, IB 231 and 233.
[58] Transcript of 000 call, IB 126-132; IB Exhibit 13 - Audio recording of 000 call from Narisha Cash to 000.
[59] Transcript of 000 call, IB 132; IB Exhibit 13 - Audio recording of 000 call from Narisha Cash to 000.
[60] Statement of Thomas Dunbar, IB 234.
[61] Transcript of 000 call, IB 132; IB Exhibit 13 - Audio recording of 000 call from Narisha Cash to 000.
[62] Inquest Exhibit G - Coroner's Investigator correspondence re: enquiries undertaken with Lifeline.

SUICIDAL F -COMP
HOUSEMATE HAS LEFT HER
SHE HAS BEEN STUCK AT HOME
STATED SHE CAN'T DEAL WITH STUFF ANYMORE
COMP WANTS TO KILL HERSELF
COMP GOING TO SLASH HER WRISTS
NO W
NIL INJ
COMP A AFF
COMP THERE ALONE
LAST TIME POL ATT THEY STRIPPED HER AND TOOK HER SOMEWHERE
DX BIPOLAR
TC LIFELINE
NFD

51. At 21:33:35, a Police Dispatcher (**PD1**) took over management of the event when it was accepted in CAD by PCT1, which is the time at which the event became visible to PD1.[63] At 21:34:58, PD1 attempted to dispatch Nish's event to a police unit to attend her house. Audio recordings of the D24 police radio communications (**D24**) record PD1 asking over the radio "any unit clear for a threat of suicide 12 Krambruk Street in Sunshine West."[64] However, no police unit accepted the job.

52. The Patrol Supervision Sergeant (251) on duty was Sergeant[65] Kirby Healy (**Sgt Healy**) (call sign NKD251). As part of her role, Sgt Healy was monitoring the police radio for the Brimbank Police Service Area (**PSA**).[66] When no police unit accepted the job in relation to Nish, Sgt Healy asked over the radio about the "suicide threat job" and was given a summary by PD1 as follows:

> …12 Krambruk Street, Sunshine West. Narisha Cash born in 79. Hysterical on the phone. Said she's suicidal. Says that her housemate's left her and that she's stuck at home saying she can't deal with stuff anymore and wants to kill herself. She's gonna slash her wrists. She doesn't have any weapons though and ah she's alcohol

[63] Statement of Thomas Dunbar, IB 383; Inquest Transcript 397:19-22. ('T')
[64] Transcript of D24, IB 363.
[65] As was her rank at the time of these events.
[66] Statement of Sgt Kirby Healy, IB 47.

> affected and there alone and um diagnosed with bipolar. She says last time police attended they stripped her and took her somewhere and they've transferred the call to Lifeline at this stage. I've got nothing shown for the last 30 days there.

53. At 21:37:14, Sgt Healy directed that the event be put through to the Sunshine Police Station Watch House (**watch house**)[67] to contact Nish, as she did not believe that there were any available police units who could attend to the job.[68] Sgt Healy's intention was to obtain further information regarding Nish's emergency and for an update to then be provided to her.[69] Sgt Healy's own unit (NKD251) was enroute to attend a scene in relation to a car accident in Browne Avenue, St Albans and she accounted for the other units in her area as already attending to other jobs as follows:

> NSS309 – car accident at Brown Ave
> NKD302 –enroute to a family violence dispute (replaced by NKD310 at 9:47 pm due to shift change)
> NSS303 – processing an offender at Sunshine Police Station.[70]

54. At 21:37, at Sgt Healy's direction, PD1 contacted the watch house where Constable Amber Jenkins (**Const Jenkins**) was on reception duties with another police officer. The telephone call was recorded.[71]

55. PD1 informed Const Jenkins that Nish was "suicidal 'cause her housemate has left and she can't deal with stuff anymore". PD1 asked for a call to be made to Nish and noted she had been transferred to Lifeline. PD1 noted that Nish was "a bit hysterical on the phone apparently". PD1 assigned the job to Const Jenkins and it was marked as dispatched to her as callsign NSS900, the Sunshine Watch House.[72] PD1 then went on a scheduled break at about 10:00 pm and had no further involvement in the job.[73]

56. At 21:39, Acting Senior Sergeant Laura Woolfe (**A/S/Sgt Woolfe**) logged onto the police radio channel, ready to commence her shift as the new North West Metro Divisional Patrol Supervising Sergeant (265) at 22:00. She received a handover from the afternoon

[67] Also referred to as "reception".
[68] Transcript of D24, IB 364.
[69] Statement of Sgt Kirby Healy, IB 48.
[70] Ibid.
[71] Transcript of call between PD1 and Const Amber Jenkins, IB 134-135.
[72] Statement of Thomas Dunbar, IB 235.
[73] Ibid.

265, A/S/Sgt Pat Cantone, via the telephone at approximately 21:30 and was advised that all units in the Division 3 area were "tied up" attending jobs and unavailable. Having regard to the time, this handover likely occurred at the same time that Nish was speaking to PCT1 and the job had either not been broadcast or was in the process of being broadcast over police radio. When A/S/Sgt Woolfe announced that she was on duty as the incoming 265 on the police radio, she was unaware of the job relating to Nish. Whilst monitoring the police radio communications as the 265, A/S/Sgt Woolfe was also attending to other tasks and did not ultimately become aware of Nish's job until she heard the D24 broadcast that police were in attendance and had found her non-responsive.[74]

57. At 21:40, Const Jenkins called Nish on her mobile phone number as directed by Sgt Healy. The call was not answered and forwarded to voicemail.

58. At 21:47, a new unit, NKD310, came on shift to replace NKD302, who were ending their shift prior to attending a family violence job assigned to them. At this time, Sgt Healy was still waiting for an update regarding contact with Nish from the watch house.[75] Shortly thereafter, NKD310 was diverted to a different job, a female threating suicide at Derson Street, St Albans. Sgt Healy had prior knowledge of this female, as police had previously been called out to her residence when she had attempted to hang herself. Based on this information, Sgt Healy decided to prioritise unit attendance at this job. The attendance of NKD300 at the Derson Street job ultimately resulted in ambulance attendance and the transfer of the suicidal female to hospital, with police exercising powers under s 351 of the *Mental Health Act 2014*.[76]

59. Const Jenkins called Nish again at 21:56 (16 minutes after the last attempted call) and spoke with her for 4 minutes and 37 seconds. Const Jenkins explained who she was and told Nish she was checking on her welfare due to the threat to kill herself. According to Const Jenkins, Nish sounded as though she was drunk or under the influence of drugs, as she was slurring her words.[77] Nish stated that her house mate had gone and "she had taken Valium and Seroquel". Const Jenkins asked how much, and Nish stated she had taken more than her normal amount but couldn't say how much. Const Jenkins asked her

[74] Statement of Sgt Laura Woolfe, IB 52-53, 57.
[75] Statement of Sgt Kirby Healy, IB 49.
[76] Statement of Sgt Kirby Healy, IB 49.
[77] T 26:14-22

if she did this "in an attempt to hurt herself", to which Nish responded "Yes", also saying she would have taken heroin if she had any.[78]

60. Const Jenkins asked Nish about her mental health and Nish advised that she had been in a mental health facility in Adelaide.[79] Const Jenkins believed Nish's manner changed and became "defensive" when she advised her that police would attend and she said she didn't want them to come.[80] Const Jenkins suggested an ambulance should attend, but Nish "was not happy" with that suggestion, saying they would not help, and Nish ended the phone call.[81]

61. This telephone call was not recorded, but Const Jenkins made contemporaneous notes of the call[82] which recorded "Seroquel Valium" and the following information:

> Said housemate gone. Couldn't understand the issue behind it…very incoherent & crying uncontrollably. Rang D24 to get unit around as Narisha refused Ambulance and admitted to wanting to kill herself.

62. At 22:02:56, Const Jenkins made a telephone call to ESTA and provided an update about Nish's situation. By this time, PD1 was on a scheduled break and a different Police Dispatcher (**PD2**) had taken over police dispatching duties.[83] The D24 recordings evidence that Const Jenkins told PD2 that Nish stated she had "taken too much Seroquel, too much Valium, in an attempt to hurt herself". Const Jenkins also told PD2 that she mentioned getting ambulance assistance to Nish, but that Nish had responded that they weren't going to help and hung up the call. Const Jenkins then stated, "I'm not sure whether or not we can get a unit there, because it's looking like a 351", to which PD2 responded "Yep, we'll need to attend."[84]

63. PD2 recorded the conversation with Const Jenkins in the CAD event chronology as "NSS900- FEMALE STATING SHE HAS TAKEN TOO MUCH VALIUM AND SEROQUIL – UNIT WILL NEED TO ATTEND".[85]

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[78] Statement of Const Amber Jenkins, IB 45.
[79] T 29:7-10.
[80] T 29:10-19
[81] T 34:12-27.
[82] Handwritten notes of Const Amber Jenkins, IB 335-336.
[83] Statement of Thomas Dunbar, IB 235.
[84] D24 transcript: Const Jenkins to D24, IB 138.
[85] ESTA procedures: ESTA Event Chronology Report, IB 143.

64. At 22:05:39, PD2 dispatched the event to a police unit, Sunshine 309 (call sign NSS309), which was already busy on scene attending to the earlier job involving the car accident at Browne Ave, St Albans with Sgt Healy's unit.[86] Sunshine 309 comprised First Constable Jemma Toohey (**FC Toohey**) and Constable Joshua Berney (**Const Berney**). The D24 broadcast from PD2 was as follows:[87]

> Sunshine 309, one for your plate when you're clear your collision. Um 12 Krambruk Street, Sunshine West re a suicidal female, Narisha Cash born in 79. It got passed to the 900. They've spoken with her. She's stating that she's taken too much Valium and Seroquel so a unit will need to attend. She apparently is diagnosed with bipolar. Um she didn't want ambos. She said they wouldn't help her. Um received.[88]

65. Sunshine 309 acknowledged that dispatch and queried "Sorry, did you say she didn't want ambos?" to which PD2 responded "Yeah. When the 900 suggested ah ambos attending they said - she said, 'No, they won't help me', and she hung up on the 900". Sunshine 309 acknowledged this as follows:

> Um we're gonna be tied up just for a little while. We're waiting for the driver of the offending vehicle to come back. He's said he's about 10 minutes away but we'll see how that goes.[89]

66. PD2 then confirmed on air with Sgt Healy that she had been monitoring the communications with Sunshine 309, and PD2 noted this in the CAD event chronology at 22:06:33.[90]

67. Sgt Healy also made enquiries via D24 with unit NSS303 to determine their availability, and it was confirmed that they were still unavailable as they were processing an offender at Sunshine Police Station.[91]

68. At 22:31, the nightshift 251, Sergeant Lloyd Jansz (**Sgt Jansz**), logged on to replace Sgt Healy who was rostered to finish her shift at 22:30. Ordinarily, there is a handover

[86] Statement of Thomas Dunbar, IB 236.
[87] Ibid.
[88] Transcript of D24, IB 371.
[89] Ibid.
[90] Statement of Thomas Dunbar, IB 236; D24 transcript IB 371.
[91] Statement of Sgt Kirby Healy, IB 49.

between the outgoing and incoming 251 about what each unit is doing, their starting and finishing times, and whether any overtime is necessary. Sgt Healy provided an update on the status of units NKD300, NSS309 and NSS303. However, Sgt Healy did not advise Sgt Jansz of the job relating to Nish during this handover or advise that unit NSS309 had the job on their plate when they cleared the car accident scene.[92]

69. By 22:54:12, Sunshine 309 was still busy at the motor vehicle accident scene and had not attended Nish's residence. At that time a new unit, Sunshine 311, commenced on shift at Sunshine Police Station. Recognising that there had still been no attendance to Nish's job, PD2 then assigned Sunshine 311 to the event.[93] This unit comprised First Constable Daniel Laoang (**FC Laoang**) and Constable Joshua Matheson (**Const Matheson**).

70. At 23:04:15, Sunshine 311 left Sunshine Police Station and arrived at 12 Krambruk Street, Sunshine West at 23:10:29.[94] While enroute, Const Matheson checked the address and Nish's name on his IRIS device,[95] which did not bring up any safety concerns.[96]

71. FC Laoang knocked on the door of Nish's house but received no response. He and Const Matheson looked through a window and could see Nish lying on the floor in an apparently unconscious state. They knocked loudly on the window but when this did not produce a response they entered the house through the unlocked front door.

72. Const Matheson checked for vital signs and noted that Nish was "lifeless and had discolouration to her hands and feet". He squeezed her shoulder and observed that she was warm to the touch and did not appear rigid. He heard what he thought was "an exhale or attempt to breathe" from her but could not feel any air movement from her mouth. He commenced cardiopulmonary resuscitation (**CPR**), and FC Laoang updated D24 and requested ambulance attendance.[97]

73. When Ambulance Victoria (**AV**) paramedics attended the scene at 23:17, CPR was still in progress.[98] On examination by paramedics, Nish was found to be "unresponsive, and

[92] Statement of Sgt Kirby Healy, IB 50.
[93] Statement of Thomas Dunbar, IB 236.
[94] Statement of Thomas Dunbar, IB 237.
[95] Mobile technology (on iPads and iPhones) that allows police members to perform location, vehicle, licence and person checks and access information from national databases in real time while out in the field.
[96] Statement of Const Joshua Matheson, IB 63.
[97] Statement of Const Joshua Matheson, IB 63-64; statement of FC Daniel Laoang, IB 59-60.
[98] Statement of DSS Jamie Walker, IB 120.

pulseless with a low body temperature and no signs of life".[99] CPR was continued by paramedics and defibrillation pads were applied. Nish was in asystolic cardiac arrest and paramedics assessed that there was no prospect of successful resuscitation. Resuscitation was ceased and Nish was pronounced deceased at 23:32.[100]

74. Members of the Wyndham Criminal Investigation Unit attended the scene, which was processed and photographed by investigating police. Numerous open and empty blister packets of prescription medication were found, both in Nish's name and without labels.[101] One and a half empty wine bottles were also located. No "suicide note" or equivalent signs or documentation of an intention to end her own life were found. Police assessed that Nish had likely passed from a drug overdose.[102]

Identity of the deceased: s 67(1)(a) of the Coroners Act

75. On 1 April 2020, Narisha Faye Cash, born 19 January 1979, was visually identified by her Aunty, Jacqueline Watkins.

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

Cause of death: s 67 (1)(b) of the Coroners Act

77. On 1 April 2020, Dr Mohamed Hussain Mohamed Ameen Izzath, Fellow Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy upon the body of Nish.

78. Dr Ameen Izzath reported the findings from the autopsy in his Autopsy Report dated 8 September 2020. The cause of death was given as "1(a) Combined Drug Toxicity (ethanol and benzodiazepine)".

79. Dr Ameen Izzath explained that toxicological analysis of post-mortem samples "showed high levels of ethanol in blood (0.26 g/100ml) and vitreous humour (0.30 g/100ml), and low levels of benzodiazepines (diazepam and nordiazepam) and anti-psychotic drugs (mirtazapine and quetiapine)".

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[99] Statement of Julian Fry, IB 69.
[100] Statement of Julian Fry, IB 69; Ambulance Victoria electronic Patient Care Record, IB 169-173; Ambulance Victoria Verification of Death Form, IB 175.
[101] Including quetiapine, Quetia, Axit 45, Valium, Metex XR, RBX Sopiramata, and Diaformin.
[102] Statement of SC Ainsley Kopelke, IB 73; statement of DSC Lauren O'Connor, IB 71.

80. Regarding the mechanism of death, Dr Ameen Izzath opined that "elevated levels of ethanol with the presence of benzodiazepines would have suppressed the central nervous system resulting in failure of respiratory/cardiac centres".

81. I accept the expert opinions of Dr Ameen Izzath.

WHETHER THE PASSING WAS PREVENTABLE

Interpretation of toxicology evidence

82. The medical cause of death is clear. Nish passed from combined drug toxicity, primarily a combination of elevated levels of ethanol and the presence of benzodiazepines.

83. A key issue that was the subject of evidence in the brief and explored at inquest was whether Nish could have survived if there was earlier ambulance attendance. This issue was also the subject of written submissions made by Counsel Assisting and the interested parties. I have carefully considered the submissions made by interested parties who submit that no finding is available that Nish's passing was preventable, as well as the contrary submission made by Nish's family.[103]

84. Expert evidence regarding this issue was given by Professor David Ranson, Forensic Pathologist and (then) Deputy Director of VIFM, and Associate Professor Dimitri Gerostamoulos, Chief Toxicologist and Head of Forensic Science at VIFM.

85. According to the evidence of A/Prof Gerostamoulos, the concentration of ethanol in blood was 0.26 grams per 100ml. This is a significant amount of alcohol, five times greater than the legal driving limit.[104] The concentration of diazepam (a benzodiazepine sedative) at 0.2 milligrams per litre was consistent with therapeutic use, and inconsistent with overdose.[105] The concentration of mirtazapine (an anti-depressant) was 0.4 milligrams per litre, which was slightly higher than a therapeutic concentration. The concentration of quetiapine (an antipsychotic) was 0.4 milligrams per litre, which was also consistent with therapeutic dosing.[106]

[103] As articulated in the closing submissions of Counsel Assisting and those filed on behalf of ESTA, the Chief Commissioner of Victoria Police, PCT, PD1, and PD2.
[104] T 153:9-11.
[105] T 154:5-8.
[106] T 154:11-18.

86. A/Prof Gerostamoulos explained that the concentration of alcohol which was detected alters respiratory and cardiac function. When combined with other drugs that work on the central nervous system (**CNS**), such as diazepam, mirtazapine and quetiapine, they "increase the adverse effects of alcohol".[107] The risk of death is particularly increased for people with high levels of alcohol in addition to other CNS depressant drugs, as compared to people with low or equivalently high levels of alcohol, with no depressant drugs in their system.[108]

87. In Nish's case, both alcohol and diazepam definitively contributed to her passing, but a possible contribution from the mirtazapine and quetiapine could not be excluded as they may have caused a "small incremental increase in that depressant effect on the central nervous system." The concentrations of diazepam, mirtazapine and quetiapine detected would not normally be considered as lethal concentrations in the absence of alcohol, and they were not detected in excessive amounts, hence, the primary contributor to her passing was the level of alcohol.[109]

Time of the passing and survivability

88. Professor Ranson gave evidence that death from CNS depression is gradual and does not occur instantaneously. Recoverability is therefore on a spectrum and depends on what stage in the process has been reached.[110] Professor Ranson opined that CNS depression from mixed drug toxicity, such as occurred in Nish's case, was "potentially survivable".[111]

89. Professor Ranson agreed with the proposition that between the time of Nish's last known phone call at approximately 10:00 pm, and the time when she was found by the police members, just after 11:10 pm, there was a window of opportunity in which Nish may have survived. Noting that CNS depression is a gradual event which occurs at various speeds, Professor Ranson stated that "there would be a time where there was a lowered degree of impairment […] and, during that window, there will be an opportunity of

[107] T 155:12-21.
[108] T 155:23-29.
[109] T 157:2-11; T 158:5-21; T 158:28 - 159:2; T 190:7-10.
[110] T 161:29 - 162:8.
[111] T 163:13-19.

intervening, maintaining respiration, maintaining cardiac function with cardiac stimulants, and so on".[112]

90. However, even at a stage where there is a lowered degree of impairment, survival is not guaranteed. Whilst the opportunity to survive is better in that period, those opportunities are lost as time goes on, and Professor Ranson was unable to say what the rate of those lost opportunities were for Nish.[113]

91. It was noted by Professor Ranson that Nish may have declined rapidly following the last call at about 10:00 pm and thereafter been in a "deeply obtunded state for the longer period until she was found" or, alternatively, her deterioration could have been more gradual and she may have been "only in that very severe state right at the end". There was no way of knowing the rate of her decline.[114] This is reflective of the uncertainty in the evidence regarding the time when Nish passed and the circumstances in which she consumed alcohol and prescription medication, including the time at which she did so and in what amounts.

92. The evidence of A/Prof Gerostamoulos was that Nish must have consumed a significant amount of alcohol over some hours, as the detected concentration of alcohol could not have been reached in an hour or half-hour period. However, given their long half-lives, the prescription drugs could have been taken within the preceding 12-24 hours. He added that it was also possible that Nish had consumed the prescription medications a lot earlier, but also later taken some additional diazepam, mirtazapine or quetiapine.[115] It was not possible to comment on whether Nish took medication between her call to emergency services at 9:30 pm and her subsequent call with Const Jenkins at 9:56 pm, but she may have. She may also have continued to consume alcohol.[116]

93. When Nish was speaking to Const Jenkins on the phone at about 10:00 pm, there may not have been significant central nervous system depression at that time, but Professor Ranson noted that it is not known what occurred after that time, and that within a period as short as five to fifteen minutes, "people can become considerably affected".[117]

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[112] T 170:20-29.
[113] T 170:30 - 171:15.
[114] T 177:1-7.
[115] T 166:20-23.
[116] T 175:19-20; T 17:22-23.
[117] T 165:2-22.

According to Professor Ranson, it was therefore not possible to identify the time Nish passed away with any certainty.[118]

94. Similarly, A/Prof Gerostamoulos opined that all that could be said was that Nish passed away sometime between the time of the phone call with Const Jenkins at approximately 10:00 pm and the time when she was reached by police at 11:10 pm.[119]

95. Professor Ranson agreed that the circumstances as described by Nish to emergency services, namely, that she had consumed alcohol together with "more than her normal amount" of Valium and Seroquel, constituted a "medical situation" requiring a medical response.[120] He opined that Nish's passing was attributable to the consumption of a combination of a significant amount of alcohol, benzodiazepines and other drugs, leading to a deterioration and finally resulting in death. Professor Ranson's evidence was that early medical intervention would have involved "immediate support of respiratory function" and transfer to hospital. The medical intervention required was "at a significant level of care", such as an Intensive Care Unit.[121] He explained that the full level of care could not be provided by paramedics on scene, but that paramedics could provide cardiac drugs and ventilation to set a patient up for greater degrees of respiratory support in a hospital.[122]

96. Medical assessment in such circumstances involves enquiries being made about what the patient has consumed. However, Professor Ranson noted that doctors and nurses in an emergency setting do not necessarily believe everything they are told by a person in an overdose situation. A/Prof Gerostamoulos also commented that people may not remember what they have consumed or how much. People are therefore treated based on their presenting symptoms.[123] Regardless of what is communicated by a patient, Professor Ranson explained, in a clinical setting it is possible to monitor the patient and perhaps gather more information about what they have taken.[124] Both experts also agreed that if someone states that they have consumed alcohol, it is important to also ask whether

[118] T 165:1.
[119] T 166:24 - 167:3; T 173:13-16.
[120] T 184:30.
[121] T 171:9-14, 27-29.
[122] T 172:2-11.
[123] T 182:26-31.
[124] T 182:17-25.

they have consumed drugs such as benzodiazepines to enable an assessment of the risk to their life.[125]

97. Noting that Nish made the 000 call at around 9:30 pm, and is known to have still been conscious and able to communicate during the phone call at around 10:00 pm, Professor Ranson was asked to consider Nish's chances of survival in a hypothetical situation in which Nish was already in hospital and receiving medical care by 10:00 pm. Professor Ranson was still unable to be precise about survivability in such a scenario, but considered that it would have provided "an opportunity there to apply those relevant medical support features which would have a reasonable prospect of survivability", depending on other unknown variables such as the extent of drug absorption.[126]

98. A/Prof Gerostamoulos added that "a good proportion" of people who attend hospital following overdose survive, stating "Those who actually attend hospital tend to survive, but it does depend on when they actually attend and how far the toxicity has progressed […] so, whilst people do - can get to hospital and do generally survive, there are occasions when they do not…but we do know that if intervention is provided early enough, then there is good opportunity for someone to survive".[127] Professor Ranson agreed with this answer, noting that "the earlier in that process you get intervention, the greater your opportunity for survival", but was unable to give possibility or probability values.[128]

Conclusions regarding preventability

99. The totality of the evidence establishes that Nish was at a lower degree of impairment until at least about 10:00 pm, when she was last known to be communicating on the phone with Const Jenkins. At that time, she was noted by Const Jenkins to be highly intoxicated, "incoherent" and slurring her words. Having regard to the toxicology evidence, Nish's presentation and the proximity to her passing, I am satisfied that by that stage, Nish's deterioration had commenced because of her high level of alcohol consumption and ingestion of prescription medication. Furthermore, having regard to the evidence of A/Prof Gerostamoulos and Professor Ranson, I am satisfied on the balance

[125] T 181:26-31 and 182:1.
[126] T 177:16-23.
[127] T 178:2-12.
[128] T 178:13-20.

of probabilities that Nish was likely to have survived if she received appropriate medical intervention, by way of paramedic treatment and transfer to hospital, prior to 10:00 pm or very shortly thereafter.

100. Nish's chances of survival after that point in time (when nothing is known about her level of impairment or consciousness) are far more difficult to assess due to the inherent uncertainty in the evidence on several matters. Significantly, it cannot be established what time she passed, or what her rate of decline was after 10:00 pm, and it is therefore not known how long she remained at the lower degree of impairment demonstrated in her phone call with Const Jenkins. Whilst she must have consumed a significant amount of alcohol over a period of hours, it is not known when she started or ceased drinking, and the rate of absorption cannot be ascertained. Nor is it known when she ingested the prescription medication which contributed to her passing, or at what amounts or intervals, noting that it could have been up to 12-24 hours earlier, and she may have consumed medication between the first call to 000 and the second phone call with Const Jenkins.

101. Whilst Nish's condition deteriorated following the phone call with Const Jenkins, and this ultimately led to her passing, the rate of her decline remains unknown. The evidence is that she may have rapidly declined soon after that phone call, or closer to the time she was found by police, or at any time within that period. Her decline may also have been more gradual. Her opportunity to survive depended at all times on how far the toxicity had progressed when she received medical supports. As such, whilst it is possible Nish could have survived with earlier paramedic attendance and transfer to hospital following the call with Const Jenkins, it is not known how long she remained at a state of less severe impairment, and I cannot determine when the window of opportunity to survive closed.

102. I am therefore not satisfied on the balance of probabilities that Nish's passing was preventable after 10:00 pm. However, it remains a possibility that she may have survived if she received medical care in the period after 10:00 pm. That possibility likely diminished as time progressed up to the time that she was found unresponsive by police at 11:10 pm.

INTENTION

103. It is apparent that Nish had a significant history of suicidality, prior drug overdose, substance abuse and mental health issues prior to, and proximate to, her passing. She also

had stressors in her personal and family relationships, as well as her employment. Relevantly, she voiced clear suicidal intent in her interactions with ESTA and police personnel immediately prior to her passing. She also stated that she had taken prescription medication as an attempt to harm herself in circumstances where her consumption of prescription medication has contributed to her passing. In isolation, this evidence supports a finding that she intended to end her own life. However, there is other countervailing evidence regarding her intention.

104. Undoubtedly, Nish experienced personal challenges and difficulties with her mental health and substance abuse, but she also had a history of seeking and accepting help in relation to those issues, and on the night in question, she reached out to emergency services for assistance. Whilst she was experiencing personal stressors and some work stress, she was performing well in her job, and her colleagues did not observe any concerning behaviours by her.

105. Significantly, the toxicology evidence establishes that Nish did not ingest an excessive amount of prescription medication, and that the medication consumed by Nish would not have caused her passing were it not for the significant amount of alcohol she had consumed. I note that she was routinely consuming alcohol to excess in the week before her passing and was described by her housemate as being drunk every night. Excessive alcohol use was therefore not out of character for her. Whilst Nish indicated to Const Jenkins that she had taken more than her "normal" amount of Seroquel and Valium in an attempt to hurt herself, it is not known what Nish regarded as being her "normal" amount of medication, or whether this equated with the dosages prescribed to her. Regardless, the evidence does not demonstrate that the medication she consumed was by itself sufficient to have caused her passing. There is also no evidence that Nish understood the potentially fatal consequences of consuming a high volume of alcohol and no more than a therapeutic level of prescription medication, which is what ultimately led to her passing. In the absence of any evidence to that effect, her consumption of medication and alcohol does not of itself support a finding that she intended to end her own life.

106. Nish's contact with 000 for assistance, her provision of information to the PCT, her willingness to remain on the call and be transferred to Lifeline, and her conversation with

Const Jenkins, are all actions by her which are inconsistent with her having acted with an intention to end her own life.

107. On the night of her passing, Nish was intoxicated, distressed and alone. She was experiencing a severe mental health crisis when she called 000, and her judgment and ability to look after her own safety on the night of her passing was significantly impaired. Despite this, she still contacted 000. I am satisfied that she did so because she wanted assistance with her psychological distress and suicidality in the form of immediate intervention by the attendance of emergency services.

108. Having regard to all the available evidence, I am satisfied that Nish did not intend to bring about her own passing, and that her passing was the unintentional consequence of the deliberate ingestion of alcohol and prescription medication.

THE EMERGENCY RESPONSE

Evidence regarding ESTA police call taking and dispatch

109. From the time of Nish's call to 000, it took 1 hour and 41 minutes for a police unit to attend her home and no ambulance was called until she was located unresponsive by police members. A key issue in the investigation was whether this response to her emergency was appropriate in the circumstances. This involved a detailed examination of the management of Nish's 000 call, the timing of the response by police, and the question of whether an ambulance should have been called to attend to Nish at an earlier time.

110. These matters are of particular significance in Nish's case given the cause of death and the expert evidence which establish that her passing was not inevitable. Rather, there was a window of opportunity in which her passing may have been prevented with appropriate medical treatment. As stated above, I am satisfied that Nish's passing was preventable with appropriate medical intervention prior to 10:00 pm, and that there remains the possibility that she would have survived with medical intervention after that time.

111. Analysis of these issues led to extensive evidence being provided on behalf of ESTA in both statement and documentary form, as well as in *viva voce* evidence given by Thomas Dunbar, (then) Acting Manager of the Quality & Assurance Team at ESTA. In his

substantive role as Quality Improvement Investigator, Mr Dunbar conducted the ESTA investigation into the call taking and dispatch of Nish's event. That initial investigation did not identify any issues in relation to the management of the call taking and dispatch by ESTA staff, which was said to be in accordance with relevant policy and procedure. However, Mr Dunbar gave evidence during the inquest which appeared to depart from that position in several respects. This was unexpected and ultimately necessitated separate legal representation of ESTA staff members following completion of the inquest, with written submissions filed on their behalf as interested parties.

112. In my analysis of the ESTA call taking and dispatch functions below, I have had regard to the totality of the evidence and the varying submissions made by all of the interested parties about the conduct of the 000 call taking and dispatch functions.

Evidence regarding ESTA ambulance call taking and dispatch

113. From the outset of the coronial investigation, a specific line of enquiry was whether Nish's emergency required an ambulance response. Specifically, questions were asked of ESTA relating to the procedures that would have been followed if the information from Nish's call with Const Jenkins had been received by an Ambulance Call Taker.

114. A statement was provided on behalf of ESTA by Jessica Taylor, Quality Improvement Audit Lead. I note Ms Taylor had professional experience as an ESTA Ambulance Call Taker, Ambulance Dispatcher, Auditor and Assistant Team Leader.[129]

115. Ms Taylor explained that ESTA is responsible for all call taking and dispatch functions for Ambulance Victoria.[130] As with 000 calls for police assistance, 000 calls for ambulance assistance are received through the Telstra E000 service and are processed according to ESTA Standard Operating Procedures (**SOPs**).[131]

116. Calls transferred to an Ambulance Call Taker (**ACT**) by a Telstra E000 operator are initially processed using a set of preliminary questions, after which an ACT utilises a formal, structured call taking process (**SCT**) comprising a question and answer methodology known as the Medical Priority Dispatch System (**MPDS**). This is contained

[129] Statement of Jessica Taylor, IB 390.
[130] Ibid.
[131] Ibid.

in software known as ProQA. When an ACT enters information obtained during the call into ProQA, it is automatically populated into the Computer Aided Dispatch (**CAD**) system. An ACT has 32 MPDS protocols to choose from in ProQA, and the ACT will select the appropriate protocol based on information about the main complaint provided by the caller. The ProQA system then presents the ACT with specific questions to ask the caller, to obtain relevant further information and determine the event type. The ACT then accepts the event type in CAD, with the priority determined by the event type.[132] The default priority of an event type is determined by Ambulance Victoria criteria and is not altered by ESTA staff. Priority is ranked from 0 (the most urgent) to 5 (the least urgent).[133]

117. Once the event is accepted in CAD by an ACT, an Ambulance Dispatcher (**AD**) manages the dispatch of the event according to the assigned priority. Events may be dispatched directly to an AV unit, or referred to an AV Duty Manager, Clinician or Communications Support Paramedic for dispatch, who, as AV personnel, can alter the event priority or response. Priority 3 events and some priority 2 events are referred to the AV secondary triage service (known as **REFCOMM**) for assessment by AV paramedics, registered nurses or mental health triage nurses. Unlike ESTA staff, these AV staff can change the event priority or the response, which may include a determination that an ambulance is not required. Following assessment, REFCOMM staff may also provide self-care advice to the caller and refer them to alternative service providers, with or without ambulance attendance.[134]

118. Some event types are designated "multi-agency" events (**MAE**), which require the attendance of other Emergency Services Organisations (**ESOs**) in addition to ambulance, with the relevant ESO being notified when the event is accepted in CAD. Additionally, other ESOs may be directly notified by an ACT or AD creating an associated event type. An example provided was a notification made to Victoria Police when information is received that a medical patient is violent. Ms Taylor noted that it was not unusual for AV personnel to request police attendance, nor for police to request ambulance assistance.[135]

[132] Ibid 391.
[133] Ibid.
[134] Statement of Jessica Taylor, IB 392.
[135] Ibid.

Ambulance requests for overdose/self-harm/suicide

119. Ms Taylor was asked to outline what would occur in response to a 000 call where the caller provided information that prescription medication had been consumed as a deliberate attempt to self-harm/suicide. In response, Ms Taylor noted that it "is not uncommon for ACTs to receive calls from individuals who threaten to or attempt to self-harm or suicide, including through ingestion of prescription medication",[136] and that more than 30,000 such events were created in 2021.[137] Where the substances have already been ingested, Ms Taylor's evidence was that an ACT would likely triage the call using "Protocol 23 - Overdose/Poisoning (Ingestion)". However, Ms Taylor noted that Protocol 23 has 47 sub-event types, with default priorities varying from 1 to 3. In 14 of these sub-event types, the call is referred to REFCOMM for secondary triage. In 11 of these sub-event types, Victoria Police will also be notified, as they relate to circumstances in which the patient is "reported as violent or combative" or has the potential to be.[138]

120. It was therefore not possible for Ms Taylor to state which exact event type would be selected in response to general information received that a caller was attempting to self-harm/suicide, as questions asked during the SCT would determine the ultimate event type recommended for dispatch by ProQA. Ms Taylor also noted that several protocols in the MPDS related to managing mental illness, threats of self-harm and suicide, and more than one protocol could be followed depending on the information provided by the caller.

121. Ms Taylor indicated that in circumstances where a caller threatening self-harm or suicide provides information that would initiate dispatch of an ambulance, but the caller indicates that they do not want, or no longer require, ambulance attendance, the request to cancel the initial request is actioned by ESTA. However, in a scenario where an ESO such as Victoria Police requests ambulance attendance and states that the person does not want ambulance attendance, an ambulance will be dispatched in accordance with the request, notwithstanding the indication that the person who needs the ambulance does not want it.[139]

[136] Ibid 393.
[137] Ibid 395.
[138] Statement of Jessica Taylor, IB 394.
[139] Ibid 394-395.

Relevance of ESTA ambulance response to Nish's case

122. The evidence from Ms Taylor demonstrates that ambulance assistance is routinely sought and dispatched where information is received from a 000 caller that a deliberate overdose of medication has occurred. Whilst the ultimate sub-event type selected may vary according to the specific information provided by a caller, the existence of "Protocol 23 - Overdose/Poisoning (Ingestion)" indicates that Nish's circumstances, as she described them to Const Jenkins during their phone call, plainly constituted a medical emergency requiring an ambulance response (potentially in combination with police) or, at the very least, an emergency which required further clinical assessment by Ambulance Victoria staff. There is also other evidence to this effect.

123. It is notable that where a Telstra E000 operator receives a call and the caller does not advise which ESO is required, but provides information that they have already self-harmed, the call would be connected to ambulance services by default.[140] During the inquest, there was also exploration of a "legacy" ESTA Police Call-Taking event type which is no longer utilised: "Event type 334 – DRUG OVERDOSE".[141] In his statement evidence, Mr Dunbar explained that this event type was previously used "for events where a person had overdosed on drugs but was not violent", and that it would direct a PCT to immediately transfer the call to an ACT.[142] At the inquest, Mr Dunbar accepted that this event type would have applied to Nish's circumstances, and that the 334 event type existed as recognition that AV is the appropriate ESO for a drug overdose, which is a medical emergency.[143] Moreover, there is no multi-agency event currently available for an overdose in the context of a self-harm event/ suicide attempt that would activate police and AV.[144] Finally, I note the evidence of Professor Ranson, who stated that the information provided by Nish about her alcohol and drug consumption required a medical response.

124. I am therefore satisfied that the information Nish provided to Const Jenkins indicated an urgent medical emergency which required clinical assessment and ambulance

[140] Inquest Exhibit C - Telstra's response to Form 4 dated 23 Nov 22 re: decision to transfer Nish's call to ESTA PCT.
[141] T 426:11 - 428:16; T 429:12 - 430:30.
[142] Statement of Thomas Dunbar, IB 386.
[143] T 427:18-23; T 428:9-16.
[144] T 481:24-27.

attendance. Yet, there was no clinical assessment of Nish's emergency and no ambulance response at any time prior to police attendance, even though the same information, when provided to an ACT, is categorised as requiring an ambulance response and, at the very least, further clinical triage to determine if an ambulance is necessary and the urgency required. In my view, the stark disparity in response to Nish's emergency is solely attributable to the management of the response being led by law enforcement. Furthermore, the potential for such disparity in approach between the two emergency service pathways is inappropriate.

125. The evidence raises several issues for consideration, including:

    a. why Nish's call for emergency assistance required a law enforcement response;

    b. whether this was in accordance with relevant policies and procedures; and

    c. whether there would have been any different outcome if her emergency was instead managed as a medical emergency.

Initial call to 000

126. When Nish called 000, she was asked a standard question by the Telstra Operator who answered the call, "Emergency, Police, Fire, Ambulance?", to which she responded "Oh, I just want to kill myself". Pursuant to Telstra procedure, the 000 call made by Nish was then transferred to a PCT, as she did not specify which ESO she required. Thus, from the outset, Nish's mental health crisis was assessed by default as requiring a response by law enforcement.

127. Evidence received from Telstra explained that the rationale for a transfer to police in such circumstances is that there is no information known about the situation and "Police have the expertise to determine how to respond and will engage Ambulance and Fire to attend as required."[145] As outlined above, a notable exception to this default position is in circumstances where a caller advises a Telstra Operator that they have already self-

[145] Inquest Exhibit C - Telstra's response to Form 4 dated 23 Nov 22 re: decision to transfer Nish's call to ESTA PCT

harmed, in which case Telstra policy directs that the call is transferred to ambulance services.[146]

128. After the transfer of Nish's call, she was spoken to by PCT1. The role of a PCT is to action all calls received in accordance with the standard operating procedures (**SOPs**), which require an event type to be manually allocated, compliance with the structured call-taking (**SCT**) process for that event type, and consideration of whether the default priority assigned to the event is appropriate.

129. PCT1 processed the call from Nish using a set procedure which applies to all call taking and must be followed by all PCTs.[147] These procedures initially determine the priority level assigned to the event, which in turn guides Police Dispatchers (**PD**) in sequencing the dispatch of jobs to police units.[148]

130. Based on information provided by Nish, PCT1 manually selected the event type '597 – EME- THR- Attempted Threat or Threaten Suicide' (**597 event type**) which has a default event priority 2 for police dispatch. The 597 event type covers a wide variety of circumstances, including:

    a. threats of suicide and self-harm;

    b. attempted suicides (in progress); and

    c. episodes of self-harm which have occurred.[149]

131. PCT1 then used the SCT script for the 597 event type to elicit information from Nish regarding her emergency and recorded her responses in CAD.[150] This was an appropriate event type in the circumstances. However, it was identified during the inquest that there were some aspects of the information provided by Nish which were not recorded in CAD by PCT1. Specifically, PCT1 did not record that Nish was previously taken to hospital by police, and although PCT1 recorded that Nish had a diagnosis of bipolar disorder,

[146] Ibid.
[147] Statement of Thomas Dunbar, IB 230.
[148] Statement of Thomas Dunbar, IB 231.
[149] T 395:19-30.
[150] Statement of Thomas Dunbar, IB 385-386 and 233 (confirming the questions asked were in accordance with the SCT process).

there was no record made of her full statement that she had "a lot of other mental health issues".

132. In his evidence, Mr Dunbar agreed that the information that Nish was previously hospitalised was relevant to assessing her risk,[151] and Sgt Healy gave evidence that her response to Nish's job may have been different if she had been provided that additional information by PCT1.[152]

133. However, the information received from Nish did not convey why police had previously taken her to hospital, and the bare fact that Nish had previously been taken to hospital by police could not have been particularly useful information without knowing why. Similarly, it is not clear how additional information about other mental illnesses, in addition to diagnosed bipolar disorder, would have altered the response to Nish's emergency when Nish clearly conveyed that she was suicidal, had a diagnosed mental illness and had previous police involvement.

134. I note that when recording information from an emergency call, the task of a PCT is to record the critical information from the caller, not a verbatim record of the call.[153] In my view, PCT1 therefore provided an appropriate summary of the critical information from the call in accordance with the SOPs. The summary was sufficient to enable a police dispatcher to determine the resourcing needed, the priority of dispatch, and to convey an accurate picture of the nature of the emergency over the police radio. The omitted information did not alter the essential character of the emergency, namely, that Nish was suicidal on a background of diagnosed mental illness with prior police involvement.

135. A further issue raised about the 000 call with Nish concerned the questions she was asked by PCT1 in the following terms:

OPERATOR:	…Listen, have you had any drugs or alcohol tonight?
MS CASH:	Yes.
OPERATOR:	What have you had?
MS CASH:	I've had alcohol.

[151] T 452:28 - 453:26.
[152] T 257:31 - 258:13.
[153] T 404:9-15.

136. This combined question about drug and alcohol use was asked by PCT1 in accordance with the SCT process. However, having regard to the evidence of A/Prof Gerostamoulos that it was the combination of alcohol and therapeutic levels of prescription drugs which caused Nish's passing, it may have been more helpful if this question was asked in a manner which elicited as much accurate information as possible about what specifically had been consumed. I also note that A/Prof Gerostamoulos observed that people may not recall what they have consumed, particularly when numerous drugs are taken, some of which will affect memory. In the circumstances of an emotionally heightened caller, whose cognition may be affected, more accurate information could potentially be elicited by asking about alcohol and drug use as separate propositions from the outset. Whilst the question asked if "any" drugs have been consumed, consideration should also be given to whether the question should ascertain what type(s) of drugs have been consumed, noting that it was Nish's consumption of prescribed medication, in amounts which were not excessive, that contributed to her passing.[154]

137. A review of the SCT should occur to consider separating the questions regarding alcohol and drugs and further interrogating the amounts consumed and over what period of time. Whilst ESTA PCTs and police members are not clinicians, and they do not have the expertise to make an assessment about the consequences of ingesting particular quantities of drugs or alcohol, such questioning may lead to relevant information about the caller's state of mind and intention, leading to a better assessment of the immediacy of risk to self and the need for medical assessment. Any indication of deliberate ingestion of alcohol and drugs in the context of suicidal intent being expressed should lead to an immediate change in pathway to a medical response and the relevant SOPs should reflect this.

138. Having regard to the clear suicidal statements made by Nish, I am satisfied that PCT1 appropriately allocated the 597 event type. Although, an issue arose as to whether the information provided by Nish regarding her mental health diagnosis was sufficient for PCT1 to have created a further "associated event type" namely, "594- PSYCHIATRIC PATIENT" (**594 event type**). This is a multiagency event type involving both police and

[154] T 402:2-9.

ambulance dispatch.[155] If this associated event type had been created by PCT1 in Nish's case, a job would also have been created for ambulance dispatch.

139. When PCT1 asked Nish "Have you been diagnosed with anything or do you have any health problems?" at the end of the call, this was not part of the SCT process for the 597 event type. In evidence, Mr Dunbar suggested that this additional question would have been asked to ascertain "whether they needed to maybe change the event type based on further information and just to seek further clarification".[156] Mr Dunbar also suggested that it was within the purview of PCT1 to have created an associated 594 event type, stating that it was possible that such an event type could have been selected, and that "it should have been a consideration of the call taker".[157]

140. According to Mr Dunbar, when selecting an event type, a PCT needs to make a selection which reflects "the nature of the incident as accurately as possible."[158] However, there is no specific policy or training provided that PCTs should consider an associated 594 event type when a 597 event type has been created, nor does the SCT for event type 597 prompt consideration of an associated 594 event type.

141. It is of interest that Mr Dunbar gave evidence that PCT1 should have considered creation of the 594 event type, despite the absence of such an expectation in the SOPS or in the SCT process. However, on balance, it is not clear that there was any requirement or expectation that PCT1 should have created a 594 event. That being said, in the circumstances, a 594 event clearly could have been created by PCT1. This indicates that ambulance involvement in Nish's emergency was in fact appropriate from the outset of her contact with emergency services, as she was a person expressing suicidal intent and she had a diagnosed mental illness.

142. Had a request for ambulance dispatch been generated, this would have been managed in accordance with the relevant SOPs for that ESO.[159] I am unable to determine what the likely ambulance response time would have been if an associated 594 event type had been created during Nish's initial 000 call at 9:30 pm, or what would have occurred if an

[155] Statement of Thomas Dunbar, IB 381.
[156] T 406:7-10.
[157] T 406:13 - 407:28.
[158] Statement of Thomas Dunbar, IB 381.
[159] T 409:11-30.

ambulance had attended to Nish. Much would have depended on the time paramedics arrived. However, the significance of this evidence is that an ambulance would have been requested, and this was at a time when Nish was known to have still been conscious and able to communicate. Whilst it cannot be known whether a request for an ambulance at this early stage would ultimately have altered the outcome, it may have.

143. The evidence indicates that there is a need for Triple Zero Victoria to review its policies, procedures and training to ensure that there is clarity for PCTs regarding when event types 597 and 594 should be selected, either alone, or in combination. This is especially so where the caller has indicated that in addition to being suicidal, they have a diagnosed mental illness.

144. The final issue in relation to the 000 call concerned the priority allocated to the call and the significance of that classification. As a default, each event type has a 'priority' allocated (priority 1, 2 or 3) which initially determines the time within which the job needs to be dispatched to a police unit by an ESTA PD and guides them in the sequence of dispatch of events to police and other ESOs.[160] The default priority allocated to a 597 event type is priority 2.[161] The required timeframe to dispatch a police priority 2 event is five minutes from the time the event is accepted by the PCT.[162] The default priority can be adjusted by the PCT in accordance with the SOPs. A PCT's determination regarding priority will be informed by the criteria for these priorities set out in the Victoria Police Manual,[163] the location of the job, and the content of the call.[164]

145. It is apparent that PCTs receive many calls where persons threaten to take their own life. In all these cases there is an active threat requiring an emergency response which will vary in urgency depending on the known information. Every call where a person seeks assistance threatening suicide is a potentially life-threatening situation, but that risk to life has not necessarily materialised.

146. Nish called 000 seeking help in a mental health crisis. She was threatening suicide, potentially by slashing her wrists, but she had not self-harmed at that time and was not

[160] Statement of Thomas Dunbar, IB 231.
[161] Statement of Thomas Dunbar, IB 381.
[162] Statement of Thomas Dunbar, IB 235.
[163] Victoria Police Manual: Procedures and Guidelines – Patrol responsibilities and communications, IB 277.
[164] Statement of Thomas Dunbar, IB 382; T 414:27 - 415:10.

armed or injured. The means in her contemplation at that time were not of a level of lethality such that it would cause an immediate end to her life. She was highly distressed and alcohol affected, but not unable to communicate, psychotic or threating violence. She was generally co-operative during the call, and just before the call ended (having been told police would be coming to assist her), she agreed not to hang up and to remain on the line to be transferred to Lifeline.[165] I assess that her willingness to be connected to Lifeline while awaiting the arrival of police indicates that her statements about wanting to end her own life were not indicative of an immediate intention to do so.

147. I am therefore satisfied that Nish's emergency was potentially life threatening, but she was uninjured at the time of her 000 call, and the default priority 2 classification by PCT1 was appropriate. This required dispatch within five minutes, and pursuant to the Victoria Police Manual priority criteria, any subsequent decision making by Victoria Police about resourcing of her emergency should have been guided by the need to respond to Nish's emergency as soon as possible.

Attempt to dispatch by PD1

148. From the time the event was created in CAD, PD1 was "responsible for the management and allocation of the event to a police unit in the timeframe required based on the priority set out in the SOPs"[166] PD1 attempted to dispatch the job to a police unit within the required five-minute timeframe, but no unit accepted the job. It appears that this was not an unusual occurrence. During the inquest, evidence was heard that it was not unusual for all units in a Division to be "tied up" at jobs.[167]

149. In response to an enquiry from Sgt Healy about the job, PD1 provided the relevant information recorded in CAD over the radio. In my view, PD1 provided all relevant information necessary to enable Sgt Healy to determine the appropriate police resourcing needed at that time.

150. When Sgt Healy subsequently directed PD1 to transfer the call through to the watch house, PD1 appropriately complied with this direction by assigning the job to

[165] Transcript of 000 call, IB 132.
[166] Statement of Thomas Dunbar, IB 383.
[167] T 343:24 - 344:11.

Const Jenkins and caused it to be marked as dispatched to her callsign, NSS900, the Sunshine Police Station Watch House.[168]

The decision by Sergeant Healy to refer Nish's call to the watch house

151. It was appropriate for Sgt Healy in her role as the 251 Patrol Supervision Sergeant to make enquiries about Nish's unallocated job and give further direction to PD1 about how it was to be resourced.[169] Sgt Healy gave evidence that the reason for her decision to have the job referred to the watch house was to obtain further information about the situation and to possibly resolve it without the need for police attendance, noting her belief that no police unit was available. At that time, she did not regard the job as involving any immediate threat to life.[170]

152. Referral to the watch house is a common means utilised by police members to obtain further information about a job to assist with resourcing decisions when no units are available, and to reassure the caller that police are aware of the job. It also appears that many jobs relating to a mental health crisis are resolved without police attendance, by making a phone call of this kind. Resolution without police attendance can include referral to a Crisis Assessment and Treatment Team or family and friends; as well as follow-up the next day with a medical practitioner or referral services.[171] This evidence is supported by data contained in the Royal Commission into Victoria's Mental Health System (**RCVMS**) Final Report, which shows that in 2019-20, a total of 88,045 psychiatric event notifications were received by Victoria Police, and in 46,197 of these events (52.5%), Victoria Police managed the event without police attendance being required.[172]

153. As the 251 Patrol Supervisor, Sgt Healy could also have made enquiries about what other police resources were available to attend Nish's job at that time, and there is evidence that there may have been other units available in the North West Metro Division 3 area at that time who could have responded to the job.[173] However, Sgt Healy's referral of

[168] Statement of Thomas Dunbar, IB 235; T 39:17-19.
[169] Statement of Thomas Dunbar, IB 235; Victoria Police Manual: Procedures and Guidelines – Patrol responsibilities and communications, IB 290.
[170] T 209:29-31; T 205:25 - 206:18.
[171] A/S/Sgt Woolfe T 348:7-30; Sgt Healy T 211:12 - 212:5; Const Jenkins T 43:18-25.
[172] RCVMHS Final Report, Chapter 9, p 559..
[173] Statement of DSS Jamie Walker, IB 121-122.

the job to the watch house was in accordance with common police practice for jobs of this nature, and Sgt Healy promptly made enquiries about the unallocated job. Sgt Healy indicated in her evidence that once a job is directed to the watch house, it remains there until an update is provided back to the 251 Patrol Supervisor,[174] and it is regarded as dispatched to the watch house during that time. As such, referral to the watch house was a decision made by Sgt Healy about appropriate police resourcing of the job at that time. In circumstances where the known information did not indicate an immediate threat to life, I am satisfied that Sgt Healy appropriately discharged her responsibilities as the 251 Patrol Supervisor when referring the job to the watch house.

Call by PD1 to Constable Jenkins at the watch house

154. In accordance with the direction from Sgt Healy, PD1 contacted Const Jenkins at the Sunshine watch house and asked her to call Nish. Having regard to her role, Const Jenkins was not monitoring all radio communications and when the call was received from PD1, Const Jenkins had no prior knowledge of the job relating to Nish. She was therefore wholly reliant on the information provided to her by PD1.[175]

155. A comparison of the information recorded in CAD and the recording of the call between PD1 and Const Jenkins demonstrates that not all the available information was conveyed to her by PD1 in the same terms that it was conveyed to Sgt Healy. Specifically, PD1 did not inform Const Jenkins of the following:

    a. Nish made specific threats to slash her wrists;

    b. Nish was not injured and had no weapons;

    c. Nish had consumed alcohol;

    d. Nish had a history of mental health issues; and

    e. Nish had prior interaction with police resulting in transfer to hospital.

156. In his evidence, Mr Dunbar stated that PD1 should have conveyed information to Const Jenkins in the same manner as they would over radio to police members in the

[174] T 275:29-31.
[175] T 20:19 - 21:19.

field.[176] However, the source of that expectation is unclear as it is not contained in an ESTA SOP. A more important consideration is whether this omission made any material difference to the outcome.[177]

157. During her evidence, it was put to Const Jenkins that she was not told that Nish had bipolar disorder and was alcohol affected, nor that she had stated she would slash her wrists and wouldn't wait for police to attend. Const Jenkins indicated that if she had been told this information she would have advised that a police unit needed to attend immediately and that ambulance was also required.[178] However, the weight of this evidence is diminished by several factors.

158. Firstly, I am not satisfied that Nish indicated she would not wait for police to attend during her call with PCT1. Whatever her earlier statements may have indicated, by the end of the call, and in response to being told police would attend to her, Nish agreed to be transferred to Lifeline and not to hang up. By that stage, she did not indicate any immediate intention to end her life prior to police arrival. The combination of omitted circumstances put to Const Jenkins was therefore not accurate.

159. Secondly, the sole purpose of the call by Const Jenkins was to obtain further information about Nish's emergency and to ascertain whether a police unit was still needed for Nish, who was described by PD1 to Const Jenkins as being "suicidal" and "hysterical".[179] Const Jenkins recalled that during the call, Nish conveyed she was suicidal and seeking to hurt herself, crying uncontrollably and incoherent. Const Jenkins attributed this to use of drugs or alcohol, describing Nish as slurring her words like a "drunk person".[180] By the end of the call, Const Jenkins concluded that Nish intended to end her own life,[181] and that she required an ambulance in addition to police due to a potential drug overdose and the need for medical treatment.[182] I am therefore not satisfied that Const Jenkins' was disadvantaged in her assessment of Nish's situation by virtue of the omitted information, as much of it was disclosed by Nish during the call. It is therefore unlikely

[176] T 462:13-25.
[177] Submissions on behalf of PD1 (14 July 2023) at [22].
[178] T 51:17 - 53:6.
[179] Transcript of D24 from PD1 to Const Jenkins, IB 134-135.
[180] T 26:12-31.
[181] T 30:15-21.
[182] T 31:9-31.

that there would have been any different communication from Const Jenkins to PD2 if she had been supplied the omitted information.

160. Ultimately, I am not satisfied that the conduct of the call by PD1 made any material difference to the management of Nish's emergency, and it is therefore not necessary to resolve the question of whether PD1 should have conveyed more complete information to Const Jenkins.

Contact with Nish by Constable Jenkins

161. Const Jenkins gave evidence that there was no training provided for the "watch house process", rather, it was something she learnt on the job, [183] and she was familiar with the practice of the watch house seeking further information for police "welfare check" call-outs. She understood that the purpose of such a call was to elicit further information about the severity of the situation and the urgency with which police attendance was needed, and this would assist the allocation of resources.[184]

162. It was during the call with Const Jenkins that Nish provided the critical information that she had taken Seroquel and Valium in amounts more than she normally would in an attempt to hurt herself.[185] In response, Const Jenkins formed a view that Nish needed medical treatment due to a potential drug overdose, which necessitated ambulance attendance. Furthermore, Const Jenkins suggested that it was for this reason that she directly raised the prospect of ambulance attendance with Nish.[186] Const Jenkins also agreed that she assessed the severity of the risk to Nish as being at the higher end and regarded the situation as requiring a degree of urgency.[187] She regarded Nish as intending to take her own life by way of overdose.[188] It was also appreciated by Const Jenkins that a police response would not be sufficient in Nish's circumstances, with the following explanation being provided by her:

> Because I mean, at the end of the day the police can arrive, but also ambulance needs to – if she has had an overdose, as she said that she's taken too much of her

[183] T 22:26 - 23:12; T 65:26 - 66:11.
[184] T 23: 1-7.
[185] T 26:5-7; T 28:4-8.
[186] T 31:9-19; T 65:2-7.
[187] T 37:3-29.
[188] T 37:1-2.

> normal dose then ambulance would at least be able to assist her in terms of taking her to a medical facility to get medical treatment.[189]

163. Const Jenkins explicitly stated that she recognised the situation as a disclosure of an overdose of Valium and Seroquel that required medical help, and ambulance attendance was needed in addition to police.[190] Const Jenkins also gave no weight to Nish's comments that ambulance would not help when she made an assessment of whether an ambulance was needed, and despite Nish's comments, she remained of the view that ambulance attendance was required.[191] According to Const Jenkins, she formed a view that a unit needed to get to Nish "immediately".[192]

164. Const Jenkins appropriately recognised that Nish required ambulance attendance, and with some urgency. However, during her subsequent call with PD2, she made no mention of an ambulance being needed, or of her belief that the situation involved a potential drug overdose. Nor was it communicated by her to PD2 that there was any urgency to the situation.

165. By way of explanation for these omissions, Const Jenkins stated that she believed telling PD2, "it's looking like a 351" (being a reference to s 351 of the *Mental Health Act 2014*) would trigger an automatic dispatch of an ambulance at the same time, as part of a multi-agency response with police attendance.[193] Whilst acknowledging that s 351 was a power given to police and not AV paramedics, Const Jenkins explained that it was her understanding from her experience as a police officer that ambulance was used for transport when the s 351 power was exercised by police.[194] It has not been disputed that her belief in this regard was erroneous,[195] and Const Jenkins ultimately conceded that she did not convey the urgency of Nish's situation to PD2.[196]

166. Whilst I accept that it was not Const Jenkins' role to prioritise or allocate resources,[197] having formed the firm views which she did, it is surprising that they were not directly

[189] T 31:14-19.
[190] T 31:20-31.
[191] T 36:3-8.
[192] T 37:21-29.
[193] T 32:22-28; T 33:5-26.
[194] T 33:27 - 34:11.
[195] Sgt Healy at T 212:15-31; A/S/Sgt Woolfe at T 349:31 - 350:18; T Dunbar at T 447:25 - 448:15.
[196] T 39:28-31; T 42:1-3.
[197] Closing submissions on behalf of the Chief Commissioner of Victoria Police (26 June 2023) at [15].

conveyed by her to PD2. After all, the purpose of her call to Nish was to assist appropriate allocation of resources by the 251 Patrol Supervisor, and this objective was understood by Const Jenkins.

167. I do not accept the submission made on behalf of the Chief Commissioner of Victoria Police that Const Jenkins' belief that an ambulance was needed should have played no role in the dispatch of appropriate resources. Nor do I accept that her assessment that an ambulance was required was of some lesser significance than the bare information from Nish that she had consumed too much medication.[198] I note that the submissions made by the CCP on this point are not supported by reference to any relevant police policy or procedure which regulated or guided Const Jenkins in her conduct of the call with Nish. In my view, Const Jenkins' belief that an ambulance was required was significant. This is supported by the concession made by the CCP that the information conveyed by Nish to Const Jenkins was a change in her circumstances indicating a medical emergency which required an ambulance.[199] This was a significant change in the nature of the emergency, which was recognised by Const Jenkins at the time.

168. Overall, I find it difficult to reconcile the evidence of Const Jenkins that she recognised the situation as a medical emergency, with the nature of the information she conveyed to PD2. Const Jenkins did not dispute that she could have requested that an ambulance be dispatched. She also stated that if she had her time again, she would specify that an ambulance was needed to attend in addition to police, due to the potential overdose.[200] Const Jenkins also agreed that it was not necessary in the circumstances for police to attend to Nish first, and that if Ambulance Victoria arrived first, Nish may have been treated and taken to hospital without any attendance by police or the need for the exercise of police powers pursuant to s 351.[201]

169. However, in circumstances where the watch house procedure was something learnt by Const Jenkins "on the job" with no formal training, I make no adverse comment in relation to Const Jenkins for not specifying to PD2 her belief that ambulance attendance was needed and why. I also accept the submissions made on behalf of the Chief Commissioner of Victoria Police that it was ultimately not the responsibility of Const

[198] Ibid [14].
[199] Ibid [10(a)].
[200] T 39:28-T 40:5.
[201] T 41:2-30.

Jenkins to ensure appropriate resourcing was allocated to the event, and that subsequent events "subsumed" her involvement in the job.[202] Still, I am troubled by the notion that a police member would assess that an ambulance was required for an overdose and not state this explicitly.

170. Whilst I am ultimately not satisfied that Nish intentionally overdosed, the appropriateness of the response to her emergency should be assessed by reference to the information which was available to emergency services at the time. Based on the information conveyed by Nish to Const Jenkins, and from that point in time, her situation should have been treated as a medical emergency which was life threatening and necessitated the attendance of paramedics.

171. It cannot now be known whether a request for an ambulance from the time of the call with Const Jenkins would have altered the trajectory of what occurred, but it is possible. In that sense, the failure to treat Nish's situation from this point onwards as a medical emergency, and without a specific request for ambulance attendance, was a lost opportunity to provide an appropriate emergency services response. The real significance of this lost opportunity is what it demonstrates about the limitations of using police members as the first response ESO for a mental health crisis.

172. I note that Const Jenkins explained in her evidence that she was previously a paramedic, and it appears to be the mere coincidence of that experience which led to her assessment that an ambulance was needed for Nish. A different police member without that experience may not have come to this view, and, as events transpired, Sgt Healy did not recognise the situation as being a medical emergency. Police are not clinicians, and this divergence in response indicates a limitation in the ability of police to make appropriate assessments regarding mental health crises.

173. It is also of note that Const Jenkins' subsequent communication with PD2 focussed primarily on whether a police response was still required, namely, the potential need for the use of police powers under s 351 of the *Mental Health Act 2014*. This was despite Const Jenkins' belief that an ambulance was required for an apparent overdose. It is perhaps unsurprising that when a response to a mental health crisis is led by police, the

[202] Closing submissions on behalf of the Chief Commissioner of Victoria Police (26 June 2023) at [12]-[13], [16]-[17].

primary consideration of the members involved may default to considerations of what police powers are available, and what police resources are needed and available. Again, this may indicate a limitation in the ability of police to appropriately respond to mental health crises.

Police dispatch following the call with Constable Jenkins

174. Following the conversation with Nish, Const Jenkins relayed information obtained during the call to a new ESTA Police Dispatcher on shift, PD2, who had no prior involvement in the job relating to Nish. In response, PD2 updated the information in the event chronology, dispatched the event to police unit Sunshine 309 (NSS309), and broadcast the job to that unit, confirming with Sgt Healy that she was aware of it.

175. As with Const Jenkins, a question arose as to whether PD2 should have requested an ambulance at this time. In his statement, Mr Dunbar indicated that there was no basis for PD2 to update the event type or priority level in response to the information received, and that PD2 appropriately dispatched the job to NSS309 within 90 seconds.[203] Mr Dunbar also noted that though PD2 was not required to ask Const Jenkins whether an ambulance should be requested, the SOPs did not prevent this.[204] During his evidence, Mr Dunbar went further, stating that whilst the SOPs did not require PD2 to notify Ambulance Victoria, PD2 could have given consideration to doing so and there was some requirement to re-evaluate new information and action as appropriate.[205] Mr Dunbar stated that this was up to the initiative of the PD, but agreed he was surprised an ambulance response or assessment of the information by PD2 didn't occur, and there may have been some element of non-compliance with the SOPs.[206] It was unclear whether Mr Dunbar was suggesting that PD2 should have notified an ambulance.[207] I found the evidence of Mr Dunbar to be unclear with regard to the role and responsibilities of PD2 on this issue.

176. The SOPs for "Police Event Dispatching/Event Management" and "Dispatcher Responsibilities", and the "ESTA Police Dispatch SOP" were obtained. Those

[203] Statement of Thomas Dunbar, IB 238.
[204] Statement of Thomas Dunbar, IB 384.
[205] T 485:20-27.
[206] T 423:11-19; T 485:18-22.
[207] T 425:13-22.

documents do not specify whether Police Dispatchers are expected to notify or request an ESO resource outside of their own ESO in the absence of a specific request to do so.[208] However, it is specified that the "responsibility of event management decision making rests with the PFC [Police Forward Commander]" and that "Deployment decisions of Police resources is always the responsibility of the PFC".[209] There is also an expectation that Police Dispatchers "[m]ake enquires requested by operational units". Although a Dispatcher may be requested to assist with Event Management, that request "does not transfer the responsibility for the operational decision to the Dispatcher".[210]

177. I accept the submissions made on behalf of ESTA and PD2 that it is not the role of a PD to perform a call-taking function when speaking with police, by effectively interrogating the information that they provide.[211] The mere reference by Const Jenkins to the job "looking like a 351" and requiring a unit to attend also did not require PD2 to consider whether an ambulance was needed.

178. PD2 accurately conveyed the information about Nish taking too much Seroquel and Valium over the police radio. It was not specifically stated by PD2 that this was done to harm herself, but it was noted that the broadcast related to "a suicidal female".[212] In any event, Sgt Healy was already aware that the job was for an "Attempt/Threaten Suicide" event type. It was therefore apparent that the information about Nish taking too much medication was in the context of a threat of suicide which had not resolved and still required police attendance. The omission of the information about Nish intending to harm herself therefore made no material difference.

179. It is also unsurprising that PD2 did not themselves make an assessment that the job now related to a potential overdose, in the absence of that indication from Const Jenkins. It was the uncontested evidence of Mr Dunbar that PDs do not receive any relevant training which would qualify them to be making any assessment of the information supplied by Nish.[213] I therefore accept the submission made on behalf of PD2 that it was not open to

[208] Inquest exhibits J3, J4, J5 and J6.
[209] Ibid- ESTA Police Dispatch SOP, p 38.
[210] Ibid- Police Event Dispatching/Event Management,6.2 and 6.2.1
[211] Submissions on behalf of Police Dispatcher 2 at [7]-[14]; Closing submissions on behalf of ESTA (23 June 2023) at [26(f)-(g)].
[212] Transcript of D24, IB 371.
[213] T 445:8-13.

them to draw a conclusion that there was an "overdose".[214] Their role was to convey the additional information received by Const Jenkins to Sgt Healy, and that is what occurred.

180. Though Nish's reported circumstances had materially changed, I am satisfied that PD2 was not required to request an ambulance in the circumstances, or to make further enquiries of the 251 or any other police member about this issue. PD2's responsibility was to convey the information received from Const Jenkins to the field, and to carry out dispatch of police resources within the mandated timeframe. PD2 appropriately performed these tasks.

181. Having regard to the lack of clarity between the SOPs and the evidence of Mr Dunbar, it would be prudent for Triple Zero Victoria to review its policies and procedures, and provide further detail about the circumstances in which a PD may exercise their own initiative to request the involvement of other ESOs, in the absence of any specific request to do so.

The response by Sergeant Healy

182. At all times, responsibility for event management decisions, including resourcing, was in the remit of the 251 Patrol Supervisor, Sgt Healy.[215]

183. Nish's event was allocated by PD2 to Sunshine 309, a police unit which was already tasked to another event. Though a member of Sunshine 309 advised that they would likely be at least another 10 minutes at their current job, this was at best a vague indication and, as it transpired, wholly inaccurate. Sgt Healy was aware of this allocation to Sunshine 309 and took no issue with it. The job was still with Sunshine 309 at 11:00 pm, unattended, when it was re-allocated to a new unit on shift.

184. Sgt Healy made no mention of the unallocated job when conducting handover with the incoming 251, Sergeant Lloyd Jansz, at approximately 10:20 pm,[216] and made no efforts to find another unit after Sunshine 309 was allocated the job. This indicates there was no

[214] Submissions on behalf of Police Dispatcher 2 at [38].
[215] T 197:25 - 198:12.

[216] IB 66.

appreciation that Nish needed a medical response, or that her crisis had escalated and required a more urgent attendance by police.

185. The evidence establishes that at the time the job was dispatched to Sunshine 309 with the associated radio communications with PD2, that unit was present with Sgt Healy still attending to an earlier car accident in Browne Ave, St Albans. This is confirmed by the police members' Body Worn Camera (**BWC**) footage, which was recording when the dispatch occurred.

186. The car accident was a single vehicle collision with a parked car. There were no persons injured and the driver had fled the scene. It was suspected that the collision was caused by a driver affected by drugs and/or alcohol. By the time of PD2's broadcast at 10:05 pm, police had finished processing the initial accident scene. Sgt Healy was present with her offsider and the members of Sunshine 309, Const Berney and FC Toohey at the corner of Browne Ave and Denton Ave, St Albans, the location where the alleged driver had abandoned his vehicle in the middle of the road. The police members were waiting for the arrival of a tow truck to remove the vehicle and clear the road.[217]

187. As recorded in the BWC footage, following Sgt Healy's enquiry with D24 about the availability of the Sunshine 303 unit, the following exchange occurred:

> FC Toohey : Can we get ambos on the way?
> Sgt Healy: For the other one?
> FC Toohey: Although I doubt they'll go in.[218]

188. FC Toohey gave evidence at the inquest that she made this enquiry of Sgt Healy as she believed that the situation was a medical emergency and ambulance was "one of the best resources to attend". She also noted that police do not have medical training and that ambulance could attend and make an assessment without police attendance. FC Toohey stated she would have requested an ambulance if it had been her decision.[219] Const Berney gave similar evidence, noting that the mention of Seroquel and Valium led him to believe "ambulance probably should be the first on scene".[220] S/Sgt Woolfe also gave

[217] See generally the inquest evidence of FC Toohey at T 71-72; Cst Berney T122-123; Sgt Healy T 214.
[218] IB Exhibit 23, file number 2 - BWC of FC Berney; Inquest Exhibits E1–E4 - Audio files of Exhibit #23, file number 2, excerpt #5 after noise reduction techniques applied.
[219] T 82:20-29; T 90:17-20; T 83:3-5; T 83:20-22; T 83:23 - 84:10.
[220] T 129:25-31.

evidence that a police member should have attended Nish's home as soon as someone was available, and that she would have referred the job to Ambulance Victoria.[221]

189. Sgt Healy had no recollection of the exchange with FC Toohey, but speculated that she may not have asked for an ambulance due to information that Nish was intending to slash her wrists and didn't want an ambulance. This may have led her to conclude Nish would have been hostile if an ambulance arrived without police, and she was concerned about the exercise of s 351 powers.[222] Sgt Healy conceded that there was no point in time when she regarded an immediate response by Ambulance Victoria as being necessary.[223] She did not regard the information about Seroquel and Valium as triggering a need for a medical response, and did not perceive that the situation involved active steps being taken to suicide, rather than a threat.[224]

190. Const Berney and FC Toohey ultimately remained at the scene until 11:21 pm arranging for the towing of the abandoned vehicle.[225] This was far in excess of the 10 minutes initially indicated to D24. For her part, Sgt Healy remained at the scene until approximately 10:40 pm, when the tow truck arrived, and finished her shift at 11:00 pm.[226]

191. Sgt Healy concedes that a specific handover about Nish's job should have been provided to the incoming 251. It was her intention to provide an update and she would ordinarily have done so, but she accepts that this did not occur. She did not consider briefing up to the 265 for additional resources as she did not appreciate that Nish's situation was a medical emergency.[227]

192. Having regard to the BWC footage, I am satisfied that Sgt Healy must have turned her mind to the need for ambulance attendance to some degree, having been prompted by FC Toohey. As she had no recollection of this, and there was no further discussion about it at the time, her thought processes in response to that suggestion are unclear. However, I accept that she did not appreciate that the information conveyed about Nish's situation

[221] T 356:7-13.
[222] T 234:6-20; T 235:1-6.
[223] T 234:22-25.
[224] T 233:10-25.
[225] ESTA Event Chronology Report, IB 319.
[226] Statement of Sgt Kirby Healy, IB 50.
[227] Closing submissions on behalf of Sgt Kirby Healy (23 June 2023) at [16]-[19].

was indicative of an urgent medical emergency. I also accept the submissions made on her behalf that it cannot be expected that all police members would have appreciated this fact.

193. In my view, the failure by Sgt Healy to recognise that the event required a medical response led to the following inadequacies in the resourcing response to Nish's emergency:

    a. No consideration was given by Sgt Healy to releasing the Sunshine 309 unit, or to her own unit attending Nish's residence at an earlier time;

    b. No consideration was given by Sgt Healy to briefing up to the 265 for other available resources to attend Nish's residence at an earlier time;

    c. No consideration was given by Sgt Healy to requesting ambulance attendance;

    d. There was no handover to the incoming 251 about the delay in resourcing Nish's job.

194. Accepting that Sgt Healy did not appreciate that Nish needed a medical response, there were other deficiencies in the police response which existed even in the absence of an appreciation of that factor.

195. The welfare check for Nish was a Priority 2 job and the response time required was "as soon as possible response - person injured but not life threatening." As noted in the submissions of Counsel Assisting, a significant difficulty in assessing the adequacy of the decision-making by Sgt Healy is that there is no accepted standard response time for a job of this nature.[228] Furthermore, the inquest heard evidence that it is not reasonable for police to be given response timeframes, having regard to resourcing and the "fluid and dynamic" nature of police work.[229] Within that context, it is the risk assessment by police members about the priority of the job and the information received about it which is critical when resources are being allocated.[230]

[228] Submissions of Counsel Assisting the Coroner at [70].
[229] T 356:1-6.
[230] T 357:22-25.

196. Whilst I accept that specific response timeframes for a priority 2 job may not be feasible, they also cannot be entirely open-ended, and there must come a point where the delay in response becomes unacceptable. This appears to be recognised in the stated responsibilities of the 251 and 265 as they relate to the policy for requests for additional police resources. However, it remains unclear how Patrol Supervisors can determine whether a response has occurred "as soon as possible", when resourcing has become an issue requiring escalation, and at what point a request should be made to the 265 for assistance with jobs involving mental health crises or threats of suicide. The ability of police members to make appropriate risk assessments in such circumstances is perhaps questionable, as demonstrated by the facts of this case.

197. Despite the absence of any specific timeframes, the general tenor of the evidence was that the police response to Nish's emergency took too long,[231] and this conclusion can also be reached on a commonsense basis. I regard the referral to the watch house as appropriate, as it appears to be a standard response, but from 10:00 pm, when the update was received, there should have been urgency in the response requiring police to attend for a welfare check, having regard to the period of time which had already elapsed since the initial call, and the fact that Nish was still regarded as suicidal. There were other police resources in the PSA which were potentially available to attend to the event, and this could have occurred if Sgt Healy had escalated the event to the 265.

198. However, it cannot now be known what would have occurred if a police unit had attended to Nish at an earlier time, having regard to the inability to determine what time she passed away, or her rate of decline. It cannot be known what state of toxicity Nish would have been in when police arrived, what her symptomology would have been, or whether this would have resulted in police assessing that ambulance attendance and transfer to hospital were necessary. It remains possible that earlier attendance by police would not have revealed that Nish needed medical assistance without an appreciation of the significance of the information she had provided. In such circumstances the welfare check could only have resulted in a transfer to hospital if a police member exercised their powers under s 351 of the *Mental Health Act 2014*. Her medical deterioration may then

[231] Sgt Healy T 324:27 - 325:2; Victoria Police Oversight Interim Final Report, IB 326 and 331.

have been observed incidentally. The variation in possibilities indicates that assessing what may have occurred after 10:00 pm is an entirely speculative exercise.

199. For the reasons stated above in relation to the conduct of Const Jenkins, it also cannot be known what would have occurred if ambulance attendance was requested by Sgt Healy at the time of the update at 10:05 pm.

200. Sgt Healy should have provided a handover about Nish's event to the incoming 251, and should have appreciated that leaving the job unattended for over an hour with no prospect of immediate police attendance by the Sunshine 309 unit was not acceptable for a threat of suicide. Allowing the event to remain with Sunshine 309 was not appropriate in circumstances where there was no real prospect they would be available soon, and it was apparent they were still at the scene when Sgt Healy finished her shift. However, the evidence does not establish that the outcome would likely have been different if these deficiencies did not occur, only that it is possible. The deficiencies are therefore best characterised as lost opportunities for earlier attendance by emergency services, in circumstances where Nish did not receive an appropriate emergency services response.

201. The evidence discloses that systemic improvements in ESTA and police processes may be needed, to ensure that in any case where information is received that excess medication has been consumed, in the context of threatened suicide or a mental health crisis, an appropriate consideration of the event as a medical emergency will occur by those tasked with resourcing it. Systemic improvements are also necessary to provide sufficient guidance to police members regarding appropriate response times in cases where welfare checks relate to threats of suicide. In both cases, it appears that police members require the assistance of clinical expertise in making determinations about the type of ESO response required and the urgency of it. The complexity of these issues indicates that police are not the appropriate first responders to mental health crises as a default, and that the response to such emergencies should not be led by law enforcement.

COMMENTS

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

Prevention opportunities

202. When Nish called 000 she was experiencing a severe mental health crisis. She was suicidal, highly distressed, and intoxicated. She wanted help, and she turned to emergency services for assistance. This is evidenced by the fact of her initial call to 000, her communications with PCT1 in which she answered all questions asked of her, her willingness to stay on the line to speak to Lifeline, and her conversation with Const Jenkins in which she answered further questions about her situation.

203. Having regard to the information initially provided by Nish, what she needed was a check on her physical welfare to ensure she was safe, and assistance with her mental health so that she could survive the mental health crisis she was experiencing. When she supplied information that she had ingested medication to harm herself, she required a medical assessment and ambulance attendance.

204. Yet, by reason of the processes and procedures in place at the time, Nish's emergency was categorised from the outset as requiring only a police response.

205. When she called 000, Nish's threat to end her own life was referred by the Telstra operator to police by default. The answers she provided to PCT1 resulted in her emergency being categorised as requiring the attendance of a police unit to check on her. When it became apparent that there was no available police unit to accept the job, Sgt Healy, as the 251, was responsible for deciding how police would resource the job. She utilised the "watch house procedure" to ascertain if the event still needed allocation to a police unit, or whether it could be resolved without any police attendance at all. The call to Nish by Const Jenkins resulted in confirmation that police attendance was still needed, the purpose of which would be to assess whether there was a basis for the exercise of police powers under s 351 of the *Mental Health Act 2014*. If the requirements of that section had been satisfied, Nish would have been detained and taken to an Emergency Department for assessment of her mental health. However, if the requirements of s 351 were not satisfied, police would not have been empowered to take further action in relation to Nish's mental health.

206. Whilst the use of police powers may well be necessary in circumstances where it is assessed that there is an immediate danger to life requiring police intervention, Nish's emergency was not treated by police as life-threatening at any stage. The police

assessment that her emergency did not require urgent police attendance is evidenced by the priority 2 category initially assigned to the job in CAD (not life-threatening), the use of the watch house procedure, and the total lack of urgency when no unit was available to attend to her. This included allocating the job to a police unit which was already occupied on another job, with no firm indication of when it would be free to attend, and no follow-up when the job was still unattended by that unit a significant period of time later.

207. The response to Nish's emergency involved numerous ESTA employees and police members, none of whom had clinical experience in mental health, and all of whom necessarily performed their roles and decision-making responsibilities through a law enforcement lens. No health services were involved. Thus, every decision made in relation to Nish's mental health crisis, including the assessment of its severity and how urgently a response was needed, was made from a law enforcement perspective.

208. As a result, all decisions made in relation to the resourcing of her emergency call were concerned with ascertaining whether police attendance was needed, and what police unit would be dispatched. Yet, the available information did not indicate at any time that Nish's emergency could not have been safely responded to without police. She had not committed any offence, she was not noted to be violent, or armed, or presenting any danger to others, and she had no relevant history to that effect.

209. In my view, Nish did not require a police response as a first line response at any time. From the outset, she required an assessment grounded in mental health clinical expertise to determine the severity of her mental health crisis, how quickly a response was needed, and whether it was police, ambulance or both, which was required. Following her disclosures to Const Jenkins, an ambulance should have been requested, as the information Nish provided suggested that she had already taken specific steps to harm herself and had potentially taken an overdose of prescription medication. This indicated that there was a medical emergency which necessitated a medical assessment and, potentially, medical treatment and transfer to hospital.

210. The categorisation of Nish's emergency as requiring a law enforcement response contributed to an inappropriate response to her emergency. The information she provided needed clinical assessment from the outset, but this was not mandated by the ESTA

police call taking process, and there was a failure to seek medical assessment, or any assistance, for her in a timely manner when that should have been apparent. However, other than the timing of the response by police, the management of her emergency was largely in accordance with the relevant policies and procedures in existence at the time, which dictated a police response to her mental health crisis.

211. The coronial investigation explored several questions about the emergency services response that Nish received, including whether ambulance attendance was needed and why it took so long for police to attend her home. Central to the issues explored was a consideration of whether the response may have been different if it had not been led by police, and whether opportunities could be identified which may help prevent similar passings from occurring in the future.

212. It was identified that these matters fall squarely within the ambit of Recommendation 10 of the Royal Commission into Victoria's Mental Health System (**Recommendation 10**). Central to that recommendation was the finding by the Commission that poor outcomes could be the consequence of police-led responses to mental health crises, and that health personnel, not police, should lead the response to such crises wherever possible. Essentially, the Commission findings identified that police were not an appropriate first response for mental health crises. It was not disputed during the inquest, or in the submissions filed, that if Recommendation 10 had been implemented at the time of Nish's emergency, a different approach would have been adopted.[232]

213. A key purpose of the coronial system is to contribute to a reduction in the number of preventable deaths through Coroners' findings and the making of recommendations.[233] The specific terms of Recommendation 10 and the timetable for its implementation were therefore central to identifying any prevention opportunities arising from the circumstances of Nish's passing, and to the formulation of coronial recommendations.[234]

[232] Closing submissions on behalf of the Chief Commissioner of Victoria Police (26 June 2023), at [19]-[22].
[233] *Coroners Act* s 1; and noting that in exercising any function under the Act, regard should be had to the desirability of promoting public health and safety and the administration of justice.
[234] Section 72(2) *Coroners Act 2008*. As outlined in the Preamble to the Act, the independent investigation of deaths through the coronial system of Victoria plays an important role in contributing to the reduction of the number of preventable deaths and the promotion of public health and safety. This prevention role is a specific purpose of the Act, and it is achieved through the findings of the investigation of deaths and the making of recommendations by coroners: s 1(c) *Coroners Act 2008*.

Royal Commission into Victoria's Mental Health System

214. On 2 March 2021, the Final Report (**the report**) of the RCVMHS was tabled in the Victorian Parliament. The report made 65 recommendations, in addition to nine recommendations made in the Interim Report. It proposed a comprehensive overhaul of mental health care in Victoria, covering legislative change, oversight, service delivery, funding, resourcing and infrastructure.

215. The Commission acknowledged that even with full implementation of the report's broad recommendations aimed at averting deteriorations in mental health, the mental health system will always need to respond to crises and emergencies. It noted that such crises will vary in severity, but at the extreme end of the spectrum, "a mental health crisis is an emergency requiring an immediate response" and this includes a suicidal crisis. Furthermore, the Commission regarded responding to people in suicidal distress as the "core business for mental health crisis response services".[235]

216. Significantly, the Commission found that not only were more people presenting to mental health crisis and emergency services, and with more complex needs,[236] but that there was "an increased reliance on the police to respond to people experiencing illness or psychological distress" resulting from a lack of mental health services.[237] The data illustrating this point was striking. Between 2014 and 2018, mental health related attendances by Victoria Police increased by an average of more than 10 per cent each year, and police-led mental health transfers to hospitals increased by 13 per cent in the same period.[238] In 2017-2018, police responded to approximately 43,000 mental health related callouts, meaning that on average, police were responding to a mental health crisis once every 12 minutes in that year.[239]

217. It was noted in the report that the data correlated with a submission by Victoria Police that police are "increasingly being relied upon to operate as gatekeepers to the mental health service system".[240] This was said to have occurred by default due to a lack of

[235] Royal Commission into Victoria's Mental Health System - Final Report (February 2021), vol 1, 508-509. ('RCVMHS Final Report')
[236] Ibid 512.
[237] Ibid 514.
[238] When compared to a 3.6 per cent increase for non-mental health events and general population growth of 2.3 per cent.
[239] RCVMHS Final Report, vol 1, 514-515.
[240] Victoria Police submission to the Royal Commission into Victoria's Mental Health System (5 July 2019).

alternative services available. Submissions to the Commission noted that the use of police often caused distress and embarrassment for those experiencing a mental health crisis. From a policing perspective, the adverse impacts of relying on police in this manner were also noted.[241]

218. The report cited data supplied by ESTA which revealed the scale of police involvement in mental health crises when compared to ambulance attendances. Between the years 2019-2020, calls received by ESTA where mental health was the primary problem resulted in 88,045 psychiatric event notifications to Victoria Police, compared with 32,154 psychiatric event notifications to Ambulance Victoria. In 46,197 of the event notifications to police (well over half of the total), Victoria Police managed the event without requiring police attendance. There were 38,156 events which were attended only by Victoria Police. Only 3,692 events resulted in attendance by both police and ambulance.[242] However, I note that the data only covered Victoria Police psychiatric events ("event type 594") and Ambulance Victoria psychiatric events ("Card 25 events"). The analysis excluded Ambulance Victoria intentional poisoning/overdose events ("Card 23 events"), which are generally responded to by Ambulance Victoria only.[243]

219. Since the report was authored, the trend of increasing police attendance at mental health emergencies appears to have accelerated. Between the years 2023–24, police were called out to a mental health related crisis on approximately 54,400 occasions, or 1 every 10 minutes. As such, responses by police to mental health crises has increased by 26.5 per cent between 2017–18 to 2023–24. In 26,943 of these callouts, two or more vehicles were dispatched, and 10,600 people were taken into the care and control of police for transfer to a mental health assessment.[244] This increase in police attendance is entirely contrary to the Commission's recommendations, which aimed to reduce police involvement in mental health crises.

220. The clear intent of the Commission's recommendation was for health professionals to lead the emergency services response when called on to assist people experiencing

[241] RCVMHS Final Report, vol 1, 558.
[242] Ibid 559.
[243] Ibid.
[244] *The Age*, "Four-year delay in transferring power from police to paramedics for mental health callouts" (7 April 2025), referring to figures from the Victorian Parliament Public Accounts and Estimates Committee's *2023-24 Financial and Performance Outcomes Report* (April 2025), 80.

mental health crises, when it is safe and practicable to do so. In Chapter 9 of the report, "Crisis and emergency responses", the framework in place for Victoria's emergency services organisations to respond to persons experiencing mental health crises was comprehensively reviewed. The report ultimately recommended:

> [A] major shift away from police being the first responders in these situations, moving instead towards a health-led response. Whenever possible and safe, Ambulance Victoria will be the default emergency services responder when people call Triple Zero (000). Police will be involved only where necessary to ensure the safety of consumers, families and supporters, workers and/or the community."[245]

221. The report also noted universal agreement that there should be a health-led approach, rather than an approach led by law enforcement.[246]

222. The Commission accepted the submission by Victoria Police that despite mental health training for police, they are not clinicians, and therefore they required more support from mental health professionals.[247] To that end, it was recommended that Victoria Police fund a telehealth consultation service for in-field police officers which could provide access to mental health clinical consultation and referral services. A secondary triage telephone service was also recommended, to assist people who did not require a police dispatch. Furthermore, the Commission expected that Victoria Police and the Department of Health would "continue to improve mental health training and education for police officers, with specific attention given to any cultural or procedural issues that may lead to avoidable harm to people experiencing mental health crises."[248]

223. Under the model recommended by the Commission, it will fall to the staff of the ambulance service when taking calls to decide if police involvement is necessary, and in what capacity.[249] Even at the scene, paramedics (consulting with mental health clinicians where necessary) will take the lead role wherever possible and safe.[250] The extent of current co-operation between Ambulance Victoria paramedics and mental health

[245] RCVMHS Final Report, vol 1, 519.
[246] Ibid 560.
[247] Ibid 564.
[248] RCVMHS Final Report, vol 1, 564.
[249] Ibid 560.
[250] Ibid 561.

clinicians was noted, with expanded resourcing for paramedics envisaged. Current supports were noted to include Ambulance Victoria diverting some of its callers to speak to mental health clinicians in its secondary triage services.[251]

224. The Commission emphasised that police will inevitably still be required to attend some mental health situations, but the report stated that "unless there is an evident risk of harm, all alternatives should be explored before police are involved".[252] Examples of situations which may still necessitate a police response included the following situations:

    a. There was considerable risk of harm to the person or others;

    b. Police powers were needed to enter property;

    c. Police powers were needed to transport people to hospital involuntarily under mental health legislation.[253]

Recommendation 10 of the Royal Commission into Victoria's Mental health System

225. Recommendation 10 is as follows:

> **Recommendation 10:**
>
> **Supporting responses from emergency services to mental health crises**
>
> The Royal Commission recommends that the Victorian Government:
>
> 1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.
>
> 2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:
>
>   a. Triple Zero (000) calls concerning mental health crises are diverted to AV rather than Victoria Police; and
>
>   b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).

[251] Ibid 561.
[252] Ibid 564.
[253] Ibid 564.

3. ensure that mental health clinical assistance is available to ambulance and police via:

    a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;

    b. in-person co-responders in high-volume areas and time periods; and

    c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.[254]

226. Implementation of the full suite of recommendations in the report was articulated by the Commission as a 10-year reform agenda, to occur in three waves—broadly speaking, by end of 2022, by end of 2026, and by end of 2031. This timeline was suggested in accordance with the Royal Commission's terms of reference which directed that it develop recommendations appropriate for the short, medium and long term.[255] The Commission proposed that Recommendation 10 be fully implemented by the end of 2024 as part of a staged process, with Recommendation 10.2 to be completed by the end of 2022, and Recommendations 10.1 and 10.3 to be completed by the end of 2024.[256]

227. The Commission noted that the staged implementation was "intended to provide the Victorian Government with a starting point to aid the implementation process. It also serves to illustrate what reforms the Commission considered are priorities, and what may take more time."[257] I note that the Commission acknowledged the recommendations were ambitious and it did not underestimate the challenges involved for government in implementing them. However, it was also the Commission's view that "given the high stakes involved, full implementation of these recommendations must be a high priority for the Victorian Government."[258] Having regard to the timeline suggested for the implementation of Recommendation 10, the Commission clearly regarded this reform as being a high priority.

228. On the day of the tabling of the report on 2 March 2021, the Victorian Government committed to implementing the Commission's recommendations in full, with the process of implementation to commence immediately. In announcing this commitment, the then

[254] RCVMHS Final Report, vol 1, 507.
[255] Royal Commission Letters Patent and Terms of Reference (22 February 2019): https://rcvmhs.archive.royalcommission.vic.gov.au/Terms_of_Reference_signed.pdf
[256] RCVMHS Final Report, vol 5, 237.
[257] RCVMHS Final Report, vol 5, 226.
[258] RCVMHS Final Report, vol 1, 517.

Premier, the Hon Daniel Andrews MP, referred to the recommendations as "a blueprint for delivering the biggest social reform in a generation: Building our mental health system – from the ground up". In committing the Victorian Government to the suite of recommendations in the report, Premier Andrews stated that "none of this work can be achieved overnight. It will take our ongoing action and effort and commitment"[259] and referred to the scale of the task of implementation as follows:

> As reform, it won't be simple, it won't be fast, and it won't be easy. But without a doubt Speaker, it will save lives. There isn't a moment to lose. This is the time to get this done.[260]

229. As part of the coronial investigation, information was obtained from the Department of Health (**DOH**) regarding this implementation process and expected completion dates, as the DOH is overseeing the project governance and implementation of the report's recommendations.

230. In the initial response provided by DOH, provided on 13 February 2023, it was indicated that the delivery of Recommendation 10 had commenced. The work said to be underway was focussed on "design of systems and processes for both the point at which a caller requests assistance from emergency services (point of call), and the point at which care is provided on-scene (point of care)." The work included analysis of Triple Zero calls "to determine which calls are in scope for diversion from Victoria Police to Ambulance Victoria." It was stated that it was "too early in the design process" to provide specific details about the service model design for Recommendation 10.[261]

231. In response to questions about the proposed timeline and any key dates for delivery, DOH noted that the Commission proposed that Recommendation 10 be delivered by the end of 2024. However, it was stated that "Government will be considering a proposed implementation pathway and timeframes in early 2023". DOH also noted that at a very early stage, all the project stakeholders had identified that Recommendation 10.2 could not be delivered by the end of 2022 as suggested by the Commission, so work on

[259] Statement From the Premier, 2 March 2021, *https://www.premier.vic.gov.au/statement-premier-88*.
[260] Premier's Speech to Parliament on MHRC, 2 March 2021, via: https://www.premier.vic.gov.au/statement-premier-88
[261] Inquest Exhibit I - Statement of Nicole Lynch, Executive Director, Strategy and Policy, Mental Health and Wellbeing Division, Department of Health (undated).

Recommendation 10.2 was being incorporated into delivery of Recommendation 10 as a whole. The reforms in Recommendation 10 were described as "complex".[262]

232. DOH confirmed that enabling an ambulance-led response to event types where suicide is threatened, where safe and reasonably practicable, "is in scope for analysis in this project and a key consideration for service model design". However, it was stated that it was too early in the design process to advise whether such calls would be regarded as "mental health crises" and therefore diverted to Ambulance Victoria rather than Victoria Police.[263]

233. Relevantly, the DOH provided further information about the scope of the implementation work, including that:

    a. Service model design will consider how assessments will need to be made during the call-taking dispatch process, and through risk assessments at the point of care, to identify the appropriate response for mental health crisis calls;

    b. Safety considerations will continue to be considered in determining if police attendance is required;

    c. The health-led model, once implemented, will enable dual police and ambulance responses to be led by paramedics where safe and possible to do so.[264]

234. The information provided by DOH at that time did not enable me to assess whether a call made in the same or similar terms to Nish's initial call to 000 would be diverted to Ambulance Victoria in future, either by the Telstra E000 operator or a PCT, when Recommendation 10 is ultimately implemented.

235. A further update was sought from DOH at the beginning of 2025, noting the anticipated completion date for the implementation of Recommendation 10 was the end of 2024. In a statement dated 13 March 2025, DOH advised that since the last response provided to the Court, the Victorian Government had determined that implementation of Recommendation 10 would be delivered alongside Recommendations 8 and 9 and "the

[262] Ibid.
[263] Inquest Exhibit I - Statement of Nicole Lynch, Executive Director, Strategy and Policy, Mental Health and Wellbeing Division, Department of Health (undated).
[264] Ibid.

department has revised timelines for delivery (noting that aspects of delivery remain subject to funding". DOH explained that despite previously indicating that Recommendation 10 would be delivered by the end of 2024:

> The department was not able to meet this timeline due to the following issues: the complexities of the mental health crisis reforms (which extend beyond Recommendation 10); the impacts of COVID-19 on the capacity of the emergency services workforces; the interdependencies between different parts of the mental health crisis system, and; the overlapping impact of reforms in one part of the system on demand and response in other parts of the system, as well as the legal and industrial changes required to move to a health-led response.[265]

236. DOH stated that as a result, in April 2024, Recommendations 8, 9 and 10 were consolidated into "one work program". Work on "Phase 1" was underway, which includes Recommendation 8, 9 and 10.3, and "[p]lanning for the transition to Phase 2" had also commenced. The "objective" of Phase 2 was said to be implementation of mental health crisis service models designed in Phase 1, and to "begin the transition to a health-led response". Phase 3 is the final phase, where "the department will work on embedding improved service models and finalising implementation of the health-led response".[266] No timelines were provided for the estimated completion of these phases of the new work program.

237. In response to a specific question asking when implementation of Recommendation 10 would be completed, DOH noted that "[t]he timeline to implement the consolidated Recommendations 8, 9 and 10 depends on future funding decisions by the Victorian Government" and the author of the statement was therefore "unable to provide an estimated date for its completion."[267]

Oversight of implementation of recommendations from the RCVMHS report

238. The delayed implementation of the report's recommendations was the subject of comment in the publicly available *Report on the 2023–24 financial and performance*

[265] Statement of Jane Poxon, Acting Executive Director, System Design and Planning, DOH, dated 5 March 2025.
[266] Ibid.
[267] Ibid.

outcomes prepared by the Victorian Parliament's Public Accounts and Estimates Committee (**the Committee**) in April 2025.[268]

239. The Committee noted that the responsibilities of the Mental Health and Wellbeing Commission (**MHWC**) included oversight, monitoring and reporting on the progress of implementing the recommendations made by the Royal Commission.[269] As part of its report, the Committee made a recommendation as follows:

> **Recommendation 8:** The Department of Health or the Mental Health and Wellbeing Commission publicly report on progress against each of the sub-components of the recommendations of the Royal Commission into Victoria's Mental Health System, including any revised implementation dates and reasons for delays. This information should be included as part of the consolidated annual reporting and more detailed reporting on its website.[270]

240. The MHWC has acknowledged its responsibility to oversee the implementation of the report recommendations. As stated in its Annual Report for 2023-2024, under the *Mental Health and Wellbeing Act*, the MHWC has functions and powers which require it to "Hold the government to account for […] the performance, quality and safety of the mental health and wellbeing system, including the implementation of recommendations made by the Royal Commission into Victoria's Mental Health System".[271]

241. The Committee also made the following further findings and recommendations relevant to the delayed implementation of Recommendation 10:

> **Finding 34:** Recommendation 10 of the Royal Commission into the Mental Health System relating to responses to mental health crises has not been implemented within the original timeframe set out in the Commission's final report. There is no explicit timeframe for full implementation of a health-led, rather than police-led, response to mental health emergencies.[272]

[268] See https://www.parliament.vic.gov.au/4a91c3/contentassets/9c901becc6e04a42ae59e52a710d9852/paec-60-11-2023-24-financial-and-performance-outcomes.pdf.
[269] Public Accounts and Estimates Committee, *Report on the 2023–24 financial and performance outcomes* (April 2025), 55.
[270] Ibid xxvii.
[271] Mental Health and Wellbeing Commission, *Annual Report 2023-24* (September 2024), 8.
[272] Ibid xxviii.

> **Recommendation 13:** The Department of Justice and Community Safety, Victoria Police and the Department of Health consider separately reporting on the specific actions taken to progress implementation of Recommendation 10 of the Royal Commission into Victoria's Mental Health System, including revised implementation dates and reasons for any delays.
>
> **Recommendation 14:** The Department of Justice and Community Safety and Victoria Police report on its websites the activities undertaken and the outcomes achieved as a result of funding received in the 2021–22 and 2023–24 Budgets to progress Recommendation 10 of the Royal Commission into Victoria's Mental Health System.[273]

242. As part of the coronial investigation, both the DOH and the MHWC were given an opportunity to provide a response regarding the Committee's findings and recommendations.

243. Jenny Atta PSM, Secretary of the DOH, responded that the DOH "continues to actively support implementation of Recommendation 10 using existing funding and established reform structures". Progression of the implementation was said to be "aligned with the Mental Health and Wellbeing Next Phase of Reform Plan".[274]

244. The Mental Health and Wellbeing Next Phase of Reform Plan contains no estimated completion date for the Recommendation 10 reforms. The only apparent reference in the document to the timeline of the reform is a reference to "Key initiatives" for 2025-2027 as "Continued design and phased implementation of enhanced mental health crisis responses".[275] This is unsurprising, as Ms Attta noted that "full transition to a health-led model will proceed through a phased approach over future years" and the "timing for implementing the changes will depend on system readiness and future government funding decisions".[276]

245. Included in Ms Atta's response was the Government Responses to the Committee's recommendations. Recommendations 13 and 14 are recorded as having the

[273] Public Accounts and Estimates Committee, *Report on the 2023–24 financial and performance outcomes* (April 2025), xxix.
[274] Letter from Jenny Atta PSM, Secretary to the Department of Health, dated 21 November 2025.
[275] Department of Health, *The next phase of reform: Mental Health and Wellbeing in Victoria* (December 2024), 46
[276] Letter from Jenny Atta PSM, Secretary to the Department of Health, dated 21 November 2025.

Government's "Support-in-Principle".[277] The related Recommendation 8, directed to the DOH or the Mental Health and Wellbeing Commission, also received "Support-in-Principle".[278] Under the heading, "Action taken to date and commitment to further action", it is noted that the DOH reports on its progress in delivering the Royal Commission reforms over the previous 12 months through the annual report of the Chief Officer for Mental Health and Wellbeing. The DOH undertook to "identify further opportunities to report publicly on Royal Commission implementation progress".[279]

246. On behalf of the MHWC, Maggie Toko, Chair Commissioner of the MHWC, also provided a response to the committee's findings and recommendations. Ms Toko explained that the MHWC "does not play a direct role in implementing recommendation 10 of the RCVMHS. The Commission's role is to ensure the Victorian Government is accountable for implementing all recommendations through reporting on their progress as required of the Commission by sections 415(j)(ii) and 427(e) of the Mental Health and Wellbeing Act 2022."

247. Ms Toko noted that a "white paper on the implementation of all recommendations of the RCVMHS" and the 2024-25 Annual Report (then due to be tabled in the Parliament of Victoria in November/December 2025) would acquit the responsibilities of the MHWC and provide information on the MHWC's assessment of progress "based on publicly available information". The MHWC acknowledged the importance of Recommendation 10 and advised that further work was being undertaken to "explore the status of this recommendation and any changes currently evident to the community when someone experiences a mental health crisis in the community." Ms Toko further noted that, "Ideally, information should be provided on reasons for delays that result in implementation timelines deviating from those outlined in the Royal Commission, together with revised timelines", but also acknowledged that there were "often valid reasons that delay implementation of any initiative" and "providing revised timeframes for implementing co-dependent initiatives can be inexact".

248. The MHWC Annual Report for the 2024-25 financial year has since become available. It refers to publicly available information, and in relation to the progress of

[277] *Government Responses to the Recommendations of Public Accounts and Estimates Committee's Report on the 2023-24 Financial and Performance Outcomes* (11 September), 10.
[278] Ibid 8.
[279] Ibid.

Recommendation 10 notes, "Partial progress publicly evident" for [Recommendations] 10.1, 10.2 and 10.3".[280] There is no detail regarding what progress has been made to date, the reasons for delay, or the expected timeframe for full implementation of Recommendation 10. It is questionable whether this amounts to meaningful oversight of accountability, but I note that the MHWC is limited in its remit to a review of publicly available information.

Mental Health and Wellbeing Act 2022

249. From September 2023, provisions in the *Mental Health and Wellbeing Act 2022* now dictate that there is to be a health-led response when powers are exercised under Chapter 5 of that Act. This includes s 232, the replacement for what was previously s 351 of the *Mental Health Act 2014*, enabling detention of persons for the purpose of mental health assessment.

250. Whilst this change does represent a move to a health-led response to mental health crises, it is limited to actions which occur at the point of contact, and not the point of call taking and assessment prior to that time. There is no indication in the materials before me that there has been any amendment to those processes since Nish's passing, and it appears they are still the subject of consideration as part of the process of implementing Recommendation 10. Until that full implementation occurs, the reform envisaged by the Royal Commission, and accepted by Government, remains largely unrealised.

Significance of the implementation of Recommendation 10

251. If the changes envisioned by Recommendation 10 were in place at the time of Nish's passing, her emergency may have resulted in her mental health crisis being led by health professionals, rather than police, from the moment her 000 call was received. Specifically, there would have been a health-led assessment of her emergency and the resources necessary to meet it. If it was determined that she required police as well as an ambulance, the response would still have been led by paramedics, with necessary support provided by mental health clinicians to police.

252. For the reasons outlined in this finding, a health-led response may have prevented Nish's untimely passing by ensuring that the required response to her emergency was

[280] Mental Health and Wellbeing Commission, *Annual Report 2024-25* (September 2025), 64.

appropriately assessed and led by persons with clinical expertise. In this hypothetical situation, if Nish disclosed the information that she had consumed too much prescription medication to harm herself, it is likely she would have received a medical response to her emergency. This is apparent when regard is had to the evidence that disclosure of such information to a Telstra 000 operator would have led to an immediate transfer to an Ambulance Call Taker, and to the evidence from Ms Taylor about the SCT procedure and relevant event types available to ACTs in such circumstances. The evidence establishes that when seen through a clinical lens, the information supplied by Nish indicated that ambulance attendance was required. Moreover, it was necessary from the outset of her contact with emergency services for assistance indicating she was experiencing a suicidal crisis.

253. In submissions filed on behalf of the Chief Commissioner of Police, it was noted that "a central issue in this case - uncertainty about whether (or when) an ambulance (or some other health service) should have been involved – is already comprehensively addressed by legislation and the complex ongoing process of implementing Recommendation 10".[281] The submissions filed on behalf of ESTA made a similar point in response to proposed recommendations.[282] I note that both ESTA and the Chief Commissioner of Police are "project partners" working with the DOH on the implementation of Recommendation 10.

254. It has now been over four years since the report was tabled and the RCVMHS recommendations were accepted by the Victorian Government. Based on the information before me, the proposed implementation dates for Recommendation 10 have not been met and completion of the implementation is dependent on future funding and design decisions by the Victorian Government. No anticipated completion date for Recommendation 10 is available.

255. I am unable to assess whether the acknowledged central issues in this case, namely, uncertainty about whether (or when) an ambulance (or some other health service) should have been involved – will be addressed by the combination of the introduction of new legislation in the *Mental Health and Wellbeing Act 2022* and the implementation of

[281] Closing submissions on behalf of the Chief Commissioner of Victoria Police (26 June 2023) at [21].
[282] Closing submissions on behalf of the Emergency Services Telecommunications Authority (23 June 2023) at [42]-[44].

Recommendation 10, or whether, if Nish's circumstances arose again, the response to her emergency would be health-led, or any different.

256. For as long as Recommendation 10 remains unrealised, the Victorian community is left with an emergency response framework for mental health crises that has been found to be inappropriate and inadequate by a Royal Commission. Four years ago, it was recognised at the highest level of Government that the implementation of the RCVMHS recommendations would save lives. Nish's passing tragically demonstrates how opportunities for life-saving intervention may be lost when the response to a mental health crisis is not appropriate.

257. The Public Accounts and Estimates Committee Report found that there is a paucity of publicly available information about the progress of implementing the RCVMHS recommendations. I agree. The significance of the recommendations for those suffering from a mental health crisis is such that it is in the public interest that there be transparency and accountability about the work being done.

258. I also note that the implementation of Recommendation 10 may have particular significance for Aboriginal and Torres Strait Islander people. According to information collated by the Coroners Court of Victoria,[283] the rate of fatal overdose passings among Aboriginal and Torres Strait Islander people is significantly higher than for non-Indigenous people. Recommendation 10 has the potential to create a more appropriate emergency response for Aboriginal and Torres Strait Islander people, like Nish, and may help address the issue of over-representation in fatal overdose passings where emergency assistance is sought.

RECOMMENDATIONS

259. In the absence of any substantial available update on the implementation work completed to date, or an expected completion timeline for Recommendation 10, I am satisfied that there is a need for recommendations arising from this case, with the aim of contributing

[283] *Fatal overdose among Aboriginal and Torres Strait Islander people*, Victora, 2018-2021. Between these dates the crude average annual rate of fatal overdose was 24.1 fatal overdoes per 100.000 population per year compared to the 7.8 fatal overdoses per 100,000 population per year for the non-indigenous population.

to the reduction of the number of preventable deaths and the promotion of public health and safety.

260. Pursuant to s72(2) of the *Coroners Act 2008*, I make the following recommendations:

To Triple Zero Victoria and Victoria Police

Recommendation 1: That Triple Zero Victoria and Victoria Police review the Police Structured Call-Taking process across all event types, in respect of questions asking whether alcohol and/or drugs have been consumed, and consider if two separate and specific questions should be asked, in lieu of a single combined question, to encourage accuracy of information provided by the caller.

Recommendation 2: That Triple Zero Victoria and Victoria Police review its policies, procedures and training to ensure there is clarity for Police Call-Takers in respect of when event types (i) '597-P-EME-THR ATTEMPT OR THREAT SUICIDE' and (ii)'594-PSYCHIATRIC PATIENT' should be selected, either alone or in combination, especially in circumstances where a person with a diagnosed psychiatric condition is experiencing a mental health crisis and threatening suicide/self-harm.

Recommendation 3: That Triple Zero Victoria and Victoria Police review Police event types and associated event types, specifically in respect of overdoses in the context of self-harm/suicide, to ensure Triple Zero Victoria Ambulance call taking and dispatch functions are notified/activated.

Recommendation 4: That Triple Zero Victoria and Victoria Police review their policies, procedures and training in respect of the role and responsibilities of Police Dispatchers, to clarify whether it is the role of the Police Dispatcher to consider whether the following are appropriate:

a. event type/associated event type; and

b. priority; and

c. ESOs notified.

Recommendation 5: That Triple Zero Victoria and Victoria Police consider amending the CAD system to introduce flagging/alerting of "threat of suicide" events that have

been dispatch assigned and allocated to a unit, or to a supervising 251, and for which there has been no update or action for a set period of time.

To Victoria Police and Ambulance Victoria

Recommendation 6: That Victoria Police consult with Ambulance Victoria to:

a. Clarify the policy/procedure documents that exist between their organisations, in respect of Victoria Police requesting AV assistance (in circumstances where Victoria Police do/do not specifically identify safety concerns); and

b. Communicate these policies throughout both organisations.

To the Department of Health

Recommendation 7: That the Department of Health implement Recommendation 10 in its entirety.

To the Department of Health, Ambulance Victoria, Victoria Police, Triple Zero Victoria and the Department of Justice and Community Safety

Recommendation 8: That the Department of Health, Ambulance Victoria, Victoria Police, Triple Zero Victoria and the Department of Justice and Community Safety, in implementing Recommendation 10 arising from the Royal Commission into Victoria's Mental Health System, review the circumstances of Nish's passing (as detailed within the Finding into death after Inquest).

To the Department of Justice and Community Safety, Victoria Police, the Department of Health and Triple Zero Victoria

Recommendation 9: That the Department of Justice and Community Safety, Victoria Police, the Department of Health and Triple Zero Victoria separately publicly report on the specific actions taken to progress implementation of Recommendation 10 of the Royal Commission into Victoria's Mental Health System, including revised implementation dates, and the reasons for any delays.

Recommendation 10: That the Department of Justice and Community Safety, Victoria Police, the Department of Health and Triple Zero Victoria separately report on their websites the activities undertaken and the outcomes achieved as a result of funding received in the 2021–22 and 2023–24 Budgets to progress Recommendation 10 of the Royal Commission into Victoria's Mental Health System, and any future funding received.

CONCLUSION

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

    a) the identity of the deceased was Narisha Faye Cash, born on 19 January 1979;

    b) the death occurred on 26 March 2020 at 12 Krambruk Street, Sunshine West from Combined Drug Toxicity (ethanol and benzodiazepine);

    c) in the circumstances described above.

262. I offer my sincere condolences to the family and friends of Nish, and I acknowledge their ongoing grief at her unexpected passing. I thank Mathew Cash for sharing his personal reflections on his sister's life in his coronial impact statement which he read at the conclusion of the inquest. Nish was clearly a much loved mother, daughter, sister, aunty and community member, and the impact of her loss has been immense.

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:

Mathew Cash (Senior Next of Kin)

Triple Zero Victoria

Chief Commissioner of Victoria Police

Sergeant Kirby Healy

Police Call Taker 1

Police Dispatcher 1

Police Dispatcher 2

Ambulance Victoria

The Department of Health

The Department of Justice and Community Safety

The Mental Health and Wellbeing Commission

Inspector Jamie Walker, Coronial Investigator

Signature:

Catherine Fitzgerald

Coroner

Date: 19 December 2025

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. 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.