



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000035

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Sheridan Louise Burnell
Date of birth:	18 March 1996
Date of death:	2 January 2021
Cause of death:	1a: Mixed drug toxicity
Place of death:	106 Canterbury Road West, Lara, Victoria, 3212

INTRODUCTION

1. On 2 January 2021, Sheridan Louise Burnell was 24 years old when she died at home. At the time of her death, Sheridan had been living with two close friends and their infant son in Lara, Victoria.

Personal and mental health background

2. Sheridan was the oldest of three children born to parents Rodney and Heidi Burnell.
3. In 2009, Sheridan was diagnosed with Attention Deficit Hyperactivity Disorder (**ADHD**) and was prescribed Ritalin.¹ She successfully completed Year 12 with several achievement awards. She went on to complete an undergraduate degree in Environmental Science at Deakin University and commenced a master's degree in teaching. In this period, due to worsening mental health, she struggled to maintain a full-time study load and moved to part-time study. In 2020, during the COVID-19 pandemic lockdowns, she struggled with a teaching placement at a local secondary school.
4. In 2018, Sheridan and her mother left the family home. Some months later, both she and Sheridan returned to the family home. Sheridan's mental health issues appear to have become acute in the same year. She had a complex treatment history that included a number of private inpatient admissions at the Wyndham Clinic in 2018, two brief public mental health admissions, and seven emergency presentations to University Hospital Geelong between September 2019 and December 2020 for mental health assessments in connection with incidents of self-harm and prescription drug overdoses. On each occasion involving a drug overdose, Sheridan ingested excessive quantities of medications which she had been prescribed to manage her mental health.
5. In late 2019, Sheridan moved into 160 Canterbury Road West, Lara, the home of her long-time friends Aiden and Erin Brunacci and their newborn son. Erin agreed to help Sheridan with monitoring her medications and a system was devised whereby Sheridan would be given a container with one day's worth of medication each day. The remainder of Sheridan's medications were hidden in a shoe box in Aiden and Erin's bedroom.

¹ Methylphenidate is a stimulant medication used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy. It is a Schedule 8 medication which is potentially addictive and therefore subject to strict legislative controls.

6. In addition to ADHD, Sheridan had been diagnosed with depression, anxiety and Borderline Personality Disorder (**BPD**), and was being investigated for Autism Spectrum Disorder (**ASD**). In 2020, her treating team included:
 - a) Dr Alberto Veloso, a private General Paediatrician, Child and Family Psychiatrist at Relational Minds, who was also supported by a nurse practitioner;
 - b) Dr Shankar Srinivasan, her regular general practitioner (**GP**) at Westgate Health Co-op; and
 - c) the Jigsaw Corio Youth Mental Health Service at Barwon Health Mental Health Drugs and Alcohol Services (**Jigsaw**).
7. Sheridan was referred to Jigsaw in April 2020² following an admission at the Werribee Mercy Psychiatric Unit, where she had been transferred from Wyndham Private Psychiatric Hospital with suicidal ideation. Following an assessment, she was allocated a case manager who treated Sheridan with Dialectical Behavioural Therapy (**DBT**) over the following months. An ASD screening tool was administered that was positive, indicating that a full ASD assessment was warranted.
8. On 26 October 2020, Sheridan attended her last appointment with Dr Veloso. At that appointment, Sheridan reported chronic low mood and chronic urges to self-harm. Sheridan also reported that she had been self-harming more, requiring stitches, and was planning to defer her university studies. She agreed that her diazepam use needed to be reduced and discussed the possibility of an inpatient admission for this purpose. Dr Veloso assessed her risk of suicide as being “Low or contained at present”.
9. On 20 November 2020, Sheridan was reviewed by a Jigsaw consultant psychiatrist for the first part of an ASD assessment. The plan at that meeting was for her private psychiatrist (Dr Veloso) to continue governance and oversight of her medication, as had been the arrangement since the start of her treatment with Jigsaw. Sheridan’s case manager continued to treat her with individual DBT sessions up until her death.
10. On 19 December 2020, Sheridan was admitted to University Hospital Geelong with multiple self-inflicted cuts of varying severity to her left arm. In progress notes, the emergency doctor conducting the initial assessment recorded that Sheridan explained the cuts were inflicted to

² This was Sheridan’s third episode of care with the Jigsaw service.

help her manage “stress and suicidal thoughts” but that there was “no suicidal ideation or plan”. Sheridan was discharged on 20 December 2020.

11. On 23 December 2020, Sheridan attended a telehealth appointment with her regular GP, Dr Shankar Srinivasan. Dr Srinivasan noted her recent hospital admission and that she had an appointment scheduled with Dr Veloso on 28 January 2021.
12. Sheridan’s last contact with Jigsaw was a telephone call on 31 December 2020, when Sheridan identified that she was feeling low and having difficulty coping with several recent changes in her life, including family issues and the recent sale of her childhood home. She denied any current suicidality, plan or intent and reported she would be “alright” and confirmed she would contact the service if needed. She had an in-person appointment scheduled with Jigsaw on 7 January 2021 and was booked in for a private admission to Essendon Private Clinic on 28 January 2021, arranged by Dr Veloso, to review her medications.
13. At the time of her passing, Sheridan’s prescribed medications were as follows:
 - a) Sertraline (Zoloft) 200mg in the morning to treat low mood associated with BPD;³
 - b) Lamotrigine 75mg in the morning as a mood stabiliser in the context of BPD;⁴
 - c) Quetiapine (Seroquel) 200mg at night to reduce anxiety, dissociation and help insomnia in BPD;⁵
 - d) Diazepam 5mg three times a day to reduce anxiety;⁶ and
 - e) Methylphenidate 10mg three times a day for ADHD to support her functional goals.⁷
14. In the weeks prior to her death, Sheridan had been planning to move out with her mother and was actively seeking a place for them to live. By this time, Sheridan’s parents were in the process of formalising a divorce and the family home had been sold, but they were still living together while separated.

³ Last dispensed on 23 December 2020, 100 mg x 60 tablets.

⁴ Last dispensed on 16 December 2020, 50 mg x 56 tablets and 25 mg x 56 tablets.

⁵ Last dispensed on 16 December 2020, 200 mg x 30 tablets.

⁶ Last dispensed on 23 December 2020, 5 mg x 50 tablets.

⁷ Last dispensed on 7 November 2020, 10 mg x 100 tablets.

THE CORONIAL INVESTIGATION

15. Sheridan's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
16. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
17. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
18. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Sheridan's death. The Coroner's Investigator conducted inquiries and submitted a coronial brief of evidence.
19. This finding draws on the totality of the coronial investigation into the death of Sheridan Louise Burnell including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.⁸
20. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

⁸ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

21. On Friday 1 January 2021, Aiden and Erin provided Sheridan with two days' supply of medications as they were going away for a few days' holiday with their son.
22. Later in the day, Sheridan visited her father at his home. Sheridan's mother, Heidi, was also present. Sheridan spent the day with her mother, then went out for dinner with her father to celebrate his birthday.
23. Later in the evening of 1 January 2021, Sheridan spent time on the phone with her close friend Kathryn Crisp. Sheridan disclosed that she was struggling with urges to self-harm and suicidal ideation. Sheridan reassured Ms Crisp that she would be fine overnight and said that she planned to call Jigsaw the next day to check in. Ms Crisp was also aware that Sheridan was booked in for a private inpatient admission later in January to review her medications under supervision.
24. At around 11:00 am on the morning of Saturday 2 January 2021, Sheridan visited her mother with her dog for a planned outing but her mother was feeling unwell and declined to go out. Sheridan left the house, leaving her dog, and was heard to say, "Fuck this shit".
25. At about 12:57 pm that day, Sheridan sent a Facebook message to Ms Crisp stating "I did it again". Sheridan called Ms Crisp one minute later and, during a conversation that lasted approximately 2 minutes, she told Ms Crisp she had taken a large amount of prescription medication. Ms Crisp advised Sheridan that she was going to call 000 and asked that Sheridan leave her front door unlocked.
26. At about the same time, Sheridan also sent a text message to her friend Madeleine Packer. Ms Packer called Sheridan and they briefly spoke. Sheridan told Ms Packer that she had taken medication but would not clarify what particular medication or how much she had taken. Ms Packer recalled that Sheridan sounded upset and embarrassed. Ms Packer ended the call with Sheridan to contact Ms Crisp, who she knew was aware of Sheridan's circumstances.
27. Ms Crisp called 000 at 1:00 pm and advised the call-taker of Sheridan's circumstances and location, being 106 Canterbury Road, Lara West. The call-taker advised Ms Crisp not to attempt to contact Sheridan again for five minutes to ensure the line was clear for Ambulance Victoria to attempt contact with Sheridan. The call was coded as a Priority 3 event, with a

target response time of 60 minutes, and deemed to be suitable for referral to Ambulance Victoria's Secondary Triage service, also known as 'Refcomm'.

28. After speaking with Ms Crisp, Ms Packer again called Sheridan to let her know that they had called 000 and to reassure her that they loved her and were not upset with her. Sheridan said she was sorry several times and sounded tired. Ms Packer ended this second call expecting that emergency services would contact Sheridan.
29. At about 1:17 pm, Ms Crisp attempted to contact Sheridan by text message but received no response. Between 1:20 pm and 2:23 pm, Ms Crisp attempted to call Sheridan five times, but there was no answer.
30. An Ambulance Victoria Secondary Triage Practitioner attempted to call Sheridan on three occasions at approximately 1:34 pm. All the calls were unanswered and, in the absence of any additional information about her condition, the call remained coded as requiring a Priority 3 response.
31. At 2:10 pm, an ambulance was dispatched to Sheridan's house, 70 minutes after the initial 000 call.
32. At about 2:11 pm, Ms Crisp called 000 for a second time and was advised that the Secondary Triage Service had not succeeded in reaching Sheridan by phone and that an ambulance had been arranged. Ms Crisp told the call-taker she was very worried about Sheridan as she usually stayed on the phone when she had taken an overdose. Ms Crisp phoned a mutual friend, Brandon Orlov, and asked him to attend at Sheridan's house.
33. At approximately 2:12 pm, an ambulance was recorded as being enroute to Sheridan's address and it arrived at 2:19 pm. Attending paramedics knocked on the door multiple times but there was no answer. They requested that the ambulance dispatcher call Sheridan's phone, but again there was no answer. At about 2:26 pm, the attending paramedics requested police assistance. Immediately after this request, they entered the premises through the unlocked front door and found Sheridan lying on her side on the couch in the lounge room. She was unconscious and cyanotic but still breathing. The paramedics moved Sheridan to the floor to allow greater access and a short time later she went into cardiac arrest. A Mobile Intensive Care Ambulance (MICA) was requested and CPR was commenced at 2:27 pm. Mr Orlov arrived at around this time and found the house open and paramedics already performing CPR.

34. A second ambulance arrived at Sheridan's address at 2:44 pm, shortly followed by the requested MICA unit.
35. Despite maximal resuscitative efforts, Sheridan was unable to be revived and was formally pronounced deceased at 3:11 pm.
36. Police attended and examined the scene and found no suspicious circumstances. A large quantity of empty and partially empty prescription medication packaging⁹ was located, catalogued and photographed, including:
 - a) sertraline 100 mg tablets;
 - b) lamotrigine 50 mg and 25 mg tablets;
 - c) quetiapine 200 mg tablets;
 - d) Panadeine Forte 500 mg/30 mg tablets; and
 - e) diazepam 5 mg tablets.
37. At the time of her death, Sheridan had active prescriptions for all these medications.

Identity of the deceased

38. On 2 January 2021, Sheridan Louise Burnell, born 18 March 1996, was visually identified by her friend Brandon Orlov.
39. I am satisfied that the identity of the deceased is Sheridan Louise Burnell.

Medical cause of death

40. Specialist Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination and provided a written report of his findings dated 7 January 2021.
41. The post-mortem examination of the body showed findings in keeping with the clinical history. A post-mortem CT scan revealed no fractures or other abnormalities.
42. Toxicological analysis of post-mortem blood samples identified the presence of the following:

⁹ The medications and packaging were seized and catalogued

- f) codeine (~2.6 mg/L)
 - g) paracetamol (~41 mg/L)
 - h) quetiapine (~3.8 mg/L)
 - i) lamotrigine (~24 mg/L)
 - j) sertraline (~1.3 mg/L)
 - k) diazepam (~0.5 mg/L) and its metabolite nordiazepam (~0.4 mg/L)
43. Dr Beer explained that the drugs detected were consistent with excessive and potentially fatal use, and that the combination of drugs found could cause death in the absence of other contributing factors.
44. Dr Beer provided an opinion that the medical cause of death was 1(a) mixed drug toxicity.
45. I accept Dr Beer's opinion.

CONCERNS OF CARE

46. After Sheridan's death, Ms Crisp lodged formal complaints with Ambulance Victoria and the Health Complaints Commissioner in relation to three main concerns:
- a) That her 000 call at 1:00 pm on 2 January 2021, coded as a Priority 3 event, should have been responded to within 60 minutes as per Ambulance Victoria protocols. This did not occur, and Ms Crisp considered that this delay contributed to Sheridan not being able to be resuscitated.
 - b) That her 000 call was assessed as being "Refcomm suitable" – that is, suitable for referral to the Secondary Triage service. Ms Crisp expressed concern that this was considered appropriate for a person who was alone and therefore had nobody on scene to report changes in their breathing or state of consciousness.
 - c) That her call was not escalated or re-triaged as higher acuity when the secondary triage service was unable to make phone contact with Sheridan. Ms Crisp considered that it would have been reasonable in those circumstances to escalate the call on an assumption that Sheridan's condition had deteriorated.

47. As a result of receiving Ms Crisp’s complaint, AV undertook a case review that was completed on 24 February 2021 by AV’s Triage Service Clinical Lead. The review examined the secondary triage in Sheridan’s case to investigate the reasons for delay and/or reasons that the call was not escalated when AV was unable to make phone contact with Sheridan. Ambulance Victoria provided a response to Ms Crisp on 1 March 2021 and advised that, as a result of the events surrounding Sheridan’s passing, a recommendation had been put forward that AV policy be updated to reflect an escalation process for vulnerable patients such as Sheridan, where no contact can be made despite multiple call-backs. This response is discussed further below.
48. In her statement dated 24 September 2021, Sheridan’s mother also expressed concerns about the time between Ms Crisp’s 000 call and the arrival of an ambulance, as well as the appropriateness of Sheridan’s medication regime, her treatment at University Hospital Geelong, and how Sheridan was able to gain access to so much medication.

FURTHER INVESTIGATIONS

49. To better understand these issues, further information was obtained from the Emergency Services Telecommunications Authority (**ESTA**) (subsequently re-named as Triple Zero Victoria)¹⁰ and Ambulance Victoria (**AV**) regarding the management of Ms Crisp’s 000 call and the dispatch of emergency services on 2 January 2021.

Emergency services triage and dispatch

50. In a statement provided on behalf of ESTA, Ms Jessica Taylor, Quality Improvement Audit Lead, explained the call-taking procedures used by ESTA to triage 000 calls for ambulance and police assistance and provided further details about the triaging of Sheridan’s case.
51. Ms Taylor explained that ESTA is responsible for ambulance call-taking and dispatch functions for the entire state of Victoria. When a person calls 000, the call is initially accepted by Telstra’s E000 service, and the caller is asked whether they require the services of police, fire or ambulance. Based on the caller’s response, the Telstra E000 operator will transfer the call to an ESTA call-taker (**CT**) trained in the relevant emergency service. Where a caller requests ambulance, the Telstra E000 operator transfers the call to an ESTA ambulance call-taker (**ACT**). What happens next depends on how the call is triaged. The ACT proceeds with

¹⁰ ESTA was re-named as Triple Zero Victoria after Sheridan’s death. There has been no significant change in its functions. For ease of reference, the findings refer to ESTA as it was the relevant name at the time of the death.

a structured call-taking process, which includes asking the caller scripted “key questions” that are designed to obtain relevant information. On the basis of the answers given, the call is assigned an ‘event type’, which in turn determines the priority assigned to the call.

52. AV determines the default level of priority for each event type, and AV personnel are able to make assessments and alter the event priority where appropriate. The standard emergency ambulance event priorities on 2 January 2021 were as follows:
- a) Priority 0 – Most critical events requiring an immediate response (lights and sirens);
 - b) Priority 1 – Time critical events requiring an immediate response (lights and sirens);
 - c) Priority 2 – Acute events requiring an urgent response;
 - d) Priority 3 – Non-urgent events, referred to AV’s Secondary Triage service for further assessment; and
 - e) Priority 4 and 5 – Non-emergency events where there is no available non-emergency ambulance resource.
53. Certain lower-acuity event types are determined by AV to be suitable for AV's Secondary Triage service, also known as “Refcomm”. These include Priority 3 events, and some Priority 2 events. The Secondary Triage service is staffed by AV paramedics, registered nurses and mental health triage nurses. The purpose of the secondary triage is to gather further pertinent clinical information to determine whether the incident should be upgraded or may be suitable for an alternative disposition, such as the patient self-presenting to an emergency department. Once an assessment has been completed by Secondary Triage, the assessing practitioner may update an event priority or response. Secondary Triage Practitioners can also provide self-care advice to the caller or refer them to alternative service providers if, after assessment, it has been identified that the event is suitable for such a response or that an emergency ambulance is not required.
54. In a statement provided on behalf of AV, Acting Director of Patient Safety and Experience Mr David Allan explained that AV's Secondary Triage team receive approximately 40% of all ambulance events created by 000 calls, and that half of these do not need emergency ambulance response. In 2024, through this process of allocating ambulance resources according to patient needs, 453 people per day who did not need an emergency ambulance were instead connected to more appropriate care.

Dispatch of emergency services on 2 January 2021

55. Ms Crisp first called 000 at 1:00 pm on 2 January 2021 and was put through to an ACT. Ms Crisp reported that her friend had ‘taken another overdose’, and that she was not at their location. The ACT obtained information from Ms Crisp, as a third party, by asking scripted key questions, and recorded the following:
- a) the patient’s overdose was intentional;
 - b) the patient was not violent;
 - c) it was not known if the patient was changing colour;
 - d) the patient was completely alert (responding appropriately to Ms Crisp at the time of her call 2 minutes earlier);
 - e) it was not known if the patient was breathing normally;
 - f) the patient had taken an unknown substance; and
 - g) it was not known when the patient had taken the substance(s).
56. ESTA event J21010270437 was created and the call was assigned an event type ‘23C7I - Overdose/Poisoning: UNK or no other code applicable (intentional)’, which initiates a Priority 3 response. As noted above, Priority 3 responses have a target response time of within 60 minutes and are considered suitable for transfer to AV’s Secondary Triage service. Because Ms Crisp was a third party and not physically present with Sheridan, the ACT obtained Sheridan’s details and mobile number so that a Secondary Triage Practitioner could call Sheridan for more information. Ms Crisp confirmed that she had asked Sheridan to leave her front door unlocked. The ACT advised Ms Crisp “it’s definitely all arranged” but did not provide an estimated time of arrival for an ambulance despite Ms Crisp requesting that information, stating “they [Secondary Triage] will want to speak with her first”.
57. At 1:03 pm, an ESTA ambulance dispatcher “held” the event for 30 minutes as required by the relevant ambulance protocols. This means that an ambulance was not immediately dispatched, to allow the Secondary Triage service up to 30 minutes to obtain further information and further assess the event.

58. At 1:28 pm, a Secondary Triage Practitioner “dispatched” themselves to the event, meaning that the practitioner selected the event from a list of held events. Between 1:28 and 1:34 pm, the Secondary Triage Practitioner attempted to call Sheridan three times, but there was no answer. At 1:37 pm, this practitioner un-assigned themselves from the event. This caused the event to present to a second ambulance dispatcher for dispatch, and the event remained a Priority 3.
59. At 1:39 pm, the ambulance dispatcher initiated the ‘Recommend closest unit’ function on the Computer Aided Dispatch (CAD) system in order to identify whether an ambulance was available.
60. At 1:41 pm, the event was “held” for a further 30 minutes by an AV Communications Support Paramedic (CSP). At 1:51 pm, the CSP “held” the event a second time for 30 minutes or until ambulance unit LAAR7366 became available. This unit were due to complete a meal break at 2:08 pm.
61. At 2:10 pm, ambulance unit LAAR7366 was dispatched to Sheridan’s address.
62. At 2:11 pm, Ms Crisp called 000 a second time to enquire whether an ambulance had arrived at Sheridan’s address. She advised the ACT that she was not at the scene and was unaware of any changes in Sheridan’s conditions, but that Sheridan had stopped responding to her calls. The ACT advised Ms Crisp that they (meaning the Secondary Triage service) had not been able to reach Sheridan by phone and that an ambulance had been arranged but had not yet arrived.
63. At 2:12 pm, AV unit LAAR7366 marked themselves as enroute to the event and arrived at Sheridan’s address at 2:19 pm. At 2:22 pm, an ambulance dispatcher recorded that the on-site paramedics had requested a call-back, as there was no answer at the door. At 2:24 pm, an ESTA ambulance team leader again attempted to call Sheridan, without success.
64. At 2:25 pm, the ESTA ambulance team leader created an associated event requesting police assistance. At 2:28 pm, a MICA unit was dispatched to Sheridan’s address on request by the LAAR7366 paramedics.
65. At 2:29 pm, the LAAR7366 paramedics were recorded as having gained entry to the premises.

Emergency services response

66. Between Ms Crisp's first 000 call at 1:00 pm and the arrival of paramedics at Sheridan's address at 2:19 pm, a total of 1 hour and 19 minutes had elapsed. The Priority 3 target response time of dispatch within 60 minutes was not technically met in Sheridan's case, although I note that ambulance dispatch was placed on hold for a period of time whilst the Secondary Triage service attempted to make contact in accordance with policy. Whilst according to AV procedures, Sheridan's case was suitable for transfer to AV's Secondary Triage service, that service did not make any contact with Sheridan within that time.

Expert opinion

67. To better understand the impact of delay in Sheridan's case, an expert opinion was obtained from Associate Professor Narendra Gunja, a specialist medical practitioner in clinical and forensic toxicology and emergency medicine. A/Prof Gunja reviewed the available evidence in Sheridan's case and provided his opinion regarding interpretation of the toxicology results and whether earlier medical intervention could have prevented Sheridan's death.
68. A/Prof Gunja observed that the post-mortem toxicology report confirmed Sheridan had recently ingested paracetamol, codeine, lamotrigine, quetiapine, sertraline and diazepam, likely within 12 hours of her death. Nordiazepam, a metabolite of diazepam, was also detected. A/Prof Gunja explained that the paracetamol and codeine were detected at concentrations suggestive of a small to moderate overdose, while the concentration of lamotrigine suggested a large overdose of that drug. He considered that Sheridan likely also ingested a significant overdose of quetiapine. A/Prof Gunja considered that overdose of sertraline and diazepam was also possible, but that it was unlikely that those two drugs had a significant contribution to the death.
69. A/Prof Gunja explained that lamotrigine in large-dose ingestions causes coma, seizure activity and cardiac arrhythmias. As toxicity progresses, the patient becomes profoundly hypotensive and the heart rhythm deteriorates to brady-asystole (slow heart rate to cardiac arrest). In cases of massive ingestion of lamotrigine, without any medical intervention, peak toxicity is likely to occur at 2-3 hours post-ingestion, and death within 4-6 hours. The effects of quetiapine, in overdose, would have been additive in causing coma and hypotensive shock.
70. When asked whether it was possible to determine the quantities of drugs ingested by Sheridan or the timing of ingestion from the post-mortem concentrations described in the toxicology

report, A/Prof Gunja explained that post-mortem concentrations themselves cannot be used to determine the time of ingestion, other than the likelihood that the detected drugs were ingested on the day of death. Given Sheridan's known movements on the morning of 2 January 2021, I am satisfied, however, that Sheridan most likely ingested the drugs between 11:00 am, when she left her mother's house, and 1:00 pm, when she sent a message to Ms Crisp advising she had 'done it again'.

71. Regarding the amounts ingested, A/Prof Gunja added that it is not possible to determine the dose ingested with any certainty, but that case reports published in scientific literature and the clinical trajectory in Sheridan's case suggest that she likely ingested more than 4 g of lamotrigine and more than 2 g of quetiapine.
72. With respect to the likelihood of survival if Sheridan had received earlier medical care, A/Prof Gunja acknowledged that whilst it is not possible to determine this with any great certainty, the earlier Sheridan was attended by paramedics and transported to hospital, the higher the likelihood of survival.
73. A/Prof Gunja explained that the trajectory of deterioration after overdose begins with absorption of the ingested drug(s), which occurs over the first 1-2 hours. During this absorption phase, patients may vomit or have no symptoms at all, and the administration of activated charcoal within an hour of ingestion can have a significant effect in preventing absorption of the drug. Once the drug is absorbed into the systemic circulation via the gut, it is distributed around the body, including to the target organs. In the case of lamotrigine and quetiapine, the target organs are the brain, heart and blood vessels. These drugs act on receptors in the target organs to cause their toxic effects.
74. A/Prof Gunja observed that Sheridan appears to have gone into cardiac arrest soon after ambulance officers arrived at around 2:30 pm. If ingestion did occur between 11:00 am and 1:00 pm, this deterioration therefore occurred at 1.5 to 3.5 hours after ingestion. He opined that if medical help had arrived within minutes of the first 000 call at 1:00 pm, and if Sheridan had been transported to a hospital emergency department by 1:30 pm, it is likely she would have been in an environment that was able to provide optimal resuscitation and the best chance of survival. A/Prof Gunja further opined that it was entirely possible that, had Sheridan been transported to an emergency department by 2:30 pm, she may still have succumbed to the effects of poisoning, depending on the dose ingested and severity of toxicity. An opinion was

also given that massive ingestion of lamotrigine, such as greater than 10 mg, may not be survivable despite early transport to hospital and intensive resuscitative efforts.

75. With regard to treatment of drug toxicity, A/Prof Gunja explained that a life-threatening overdose of lamotrigine and quetiapine requires airway protection and ventilation, blood pressure support for hypotension and management of complications such as arrhythmias and seizures. Ambulance officers, with the help of any intensive care paramedics as needed, are able to intubate patients, give intravenous fluids, administer benzodiazepines for seizures, and perform CPR. While these interventions are lifesaving, an overdose of this nature would have required additional specialist care for inotropes and vasopressors, haemodialysis and arrhythmia management, all of which require hospitalisation.
76. Ultimately, A/Prof Gunja opined that Sheridan's chances of survival were dependent on several factors, namely:
 - a) the doses ingested – estimated to be large overdoses of lamotrigine and quetiapine;
 - b) the timing of ingestion – estimated to be between 11:00 am and 1:00 pm; and
 - c) the availability of medical care to support life with airway intervention and cardiovascular resuscitation.
77. A/Prof Gunja considered it possible that even with this information and availability of clinical care soon after ingestion, Sheridan may still have succumbed to severe poisoning. Nevertheless, her best chance of survival would have been arrival at a hospital emergency department within 1 hour of the first 000 call. While this is by necessity a somewhat artificial cut-off point, A/Prof Gunja considered that the necessary resuscitative actions in those early minutes might have prevented, or at least better managed, the life-threatening clinical deterioration that occurred at 2:30 pm.
78. A/Prof Gunja concluded that, based on the available information, Sheridan died from a large overdose of lamotrigine and quetiapine causing severe acute neurological and cardiovascular toxicity. This likely manifested as coma, cardiac arrhythmia and hypotensive shock, all of which ultimately led to cardiac arrest, approximately 3 hours after the overdose. He opined that the inability to attend Sheridan in an expedient manner contributed to the lack of early resuscitation available, and to her deterioration occurring at the scene, rather than in a hospital emergency department.

Ambulance Victoria response

79. In a statement on behalf of AV, Mr Andrew Keenan, AV Director of Patient Safety and Experience, outlined the findings of the internal review undertaken by AV into Sheridan's case. Those findings included an acknowledgment that, as at 2 January 2021, "[t]here was no expectation to escalate the case to either Triage Team Leader(s), or Duty Manager and/or Clinician in relation to 'no answer' to the call-back calls".
80. Mr Keenan explained that at the time of Sheridan's death, version 5 of the relevant AV Operational Work Instruction, '*Referral Service: Performing Secondary Triage*', stated:
- "...if the caller is unable to be contacted by either mobile or landline despite the actions above, the case is then returned to the ERTCOMM [emergency ambulance response] pending box with appropriate comments to be managed by the ESTA dispatcher..."
81. Mr Keenan noted that in Sheridan's case, a Secondary Triage Practitioner (STP) attempted to call Sheridan at 1:28 pm. If there was no answer on call-back, Operational Work Instructions current at that date instructed that the event should be marked "No answer" in the Triage Service status box. The STP correctly updated the event to "No answer" in the Triage Service status box at 1:37 pm and updated the CAD system to state that they had made three outbound calls to the patient, with no response, thus no secondary triage was performed. This was in accordance with AV policies and procedures at the time. The STP should additionally have sent "an SMS text to the "000" caller/patient advising that AV [was] attempting to contact them and to remain by their phone for contact", which was not done. Because no voice contact had been made with the patient, the secondary triage was "incomplete" (i.e. no further information had been obtained) and/or was unable to be performed, resulting in no change to the disposition, and therefore the event remained as a Priority 3. The STP returned the event to the pending list, with appropriate comments, for management by the ESTA ambulance dispatcher in accordance with AV's policies and procedures.
82. Mr Keenan confirmed that at the time of writing his statement in December 2023, this Operational Work Instruction had been updated on three occasions since Sheridan's passing, including with the addition of directions for Triage Practitioners in circumstances where secondary triage is unable to be performed. Version 8 of the Operational Work Instruction, approved on 5 April 2022, relevantly included the following instructions:

6. Unable to perform secondary triage

If adequate information is obtained to indicate an emergency ambulance response is required despite an inability to complete triage, the Triage Practitioner will:

- update the event coding to the appropriate emergency response
- return the event to pending
- add supporting remarks to CAD
- where practicable, support the caller to recognise deterioration in the patient and to contact 000 if this occurs.

If there is incomplete information obtained (through inability to make contact or unwillingness of callers to provide further information for example), the Triage Practitioner will:

- Use all available information and clinical reasoning (CAD, LOI, triage history) to update the event coding to an appropriate emergency response (REF00/01/02/03). Mark the status as “NO ANSWER” in the event of being unable to make contact on call back or “COMPLETED” in the event that the caller is unwilling to provide further information.
- return the event to pending for management by the ESTA dispatcher.
- where practicable, encourage the caller to contact 000 if deterioration occurs.
- update remarks in CAD as appropriate.

83. Mr Keenan explained that under this updated policy, the STPs will use “all information available to them and return the event to pending as a ‘REF0x’” to denote the STP’s review of the event and then categorise that event back with the appropriate priority based on that information. The change, in essence, is that the event will not be *automatically* returned to pending with its original priority coding.

84. I note that whilst these additions clarify the steps to be taken by STPs where contact cannot be made with the patient, they do not substantively change the process of escalating a call where a patient is alone and does not respond to attempts to make phone contact.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Sheridan Louise Burnell, born 18 March 1996;

- b) the death occurred on 2 January 2021 at 106 Canterbury Road West, Lara, Victoria, 3212, from 1(a) mixed drug toxicity; and
 - c) the death occurred in the circumstances described above.
86. I am satisfied that Sheridan's mental health care was reasonable and appropriate. Her engagement with various clinicians was longstanding and she appears to have been well engaged with her treating team and well supported by them. I note that she accessed assistance for her mental health both in the community and by way of inpatient admission and knew where to seek assistance when needed. Her suicidal ideation fluctuated, and there is no evidence that recent risk assessments were not appropriate.
87. Sheridan was prescribed medication for the treatment of her mental health, yet access to this medication also posed a risk to her having regard to her history of drug overdose. However, there is no evidence that her medication regime was not appropriate. Sheridan's friends did their best to assist her in managing the risk of deliberate overdose, and I commend them for their care and support of Sheridan in difficult circumstances. It appears that the medication ingested by Sheridan was sourced by her from the medications in the box that was usually hidden in her friends' bedroom and it was unexpected that this would occur. It is likely that Sheridan sought this container out in the context of heightened feelings of distress when she was alone in the home on 2 January 2021.
88. There is no doubt that Sheridan ingested a significant amount of medication on the day of her death, and I note that she had a complex history of mental health issues, previous prescription drug overdoses and self-harming behaviours. She also had proximate personal stressors of significant life changes and changing family dynamics. The combination of this evidence tends to suggest that she intended to end her life, but equally may suggest that she was in a moment of crisis and seeking help. I also note that on this occasion, she contacted both Ms Crisp and Ms Packer to tell them she had taken medication and to effectively seek their assistance. In my view, this evidences an intention by Sheridan to seek help at a point in time before she was acutely affected by the drugs she had ingested and ultimately, on the balance of probabilities, it is inconsistent with an intention to end her life.
89. Having considered all the circumstances, I am satisfied that Sheridan's death was the consequence of the deliberate ingestion of prescription drugs. However, I am not satisfied to the requisite standard that Sheridan intended to take her own life.

COMMENTS

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

90. Sheridan's emergency was reported to AV by her friend, Ms Crisp, who requested an ambulance on her behalf. On the basis of the information known to Ms Crisp and provided to the ambulance call-taker, the structured call-taking process resulted in Sheridan's event being categorised as a Priority 3, non-urgent event. In accordance with AV policy, the call was referred to the Secondary Triage service. The triaging of her case in this manner meant that for a period of 30 minutes between 1:00 and 1:30 pm, when the job was initially "held", there was no attempt to dispatch an ambulance to Sheridan.
91. At 1:41 pm, Sheridan's event was "held" for a further 30 minutes by an AV Communications Support Paramedic (CSP) so that the ambulance dispatcher and AV communications staff could look for a dispatch solution. At 1:51 pm, the CSP "held" the event a second time for 30 minutes or until ambulance unit LAAR7366 became available. This unit was due to complete a mandated meal break at 2:08 pm. At 2:10 pm, ambulance unit LAAR7366 was dispatched to Ms Burnell's address. In a statement dated 21 January 2026, AV Operational Communications Advisor Matthew Shields explained that efforts to identify available ambulance resources continue while an event is "held", and that the purpose of placing an event on hold is to facilitate the identification of a dispatch solution when an appropriate resource is not immediately available.
92. Whilst the target response time for a Priority 3 event is 60 minutes, there was effectively no attempt to find an ambulance resource for Sheridan for 37 minutes as a result of the referral to the Secondary Triage service. When an ambulance was ultimately dispatched at 2:10 pm, it was already 10 minutes outside of the Priority 3 target response time of 60 minutes. Referral to a Secondary Triage Practitioner may have been appropriate in Sheridan's case, but it did delay attempts to dispatch an ambulance. It is unclear, however, what the impact of this delay was.
93. The available evidence does not establish the precise time that Sheridan ingested the medications which caused her death, but I am satisfied on the balance of probabilities that it was at some point between 11:00 am and 1:00 pm on 2 January 2021. However, the timing of her deterioration after that period is difficult to ascertain. It cannot be known how quickly Sheridan deteriorated, but the most likely explanation for Sheridan not answering the calls

from the STP or the further text messages from her friends is that her medical condition had deteriorated to a point where she was non-responsive and unable to do so by that time.

94. Once an ambulance was available and dispatched, it arrived quickly thereafter. The difficulties paramedics encountered in gaining access to Sheridan's address caused some delay in administering medical treatment, but I am satisfied that by the time they were on scene, the opportunity for Sheridan's deterioration to occur in a hospital setting had passed and her death likely could not have been prevented by that stage.
95. I accept the expert evidence of A/Prof Gunja that Sheridan's death was not inevitable, and that her best chance of survival would have been if she had arrived at a hospital emergency department within one hour of the first 000 call. I am therefore satisfied that Sheridan may have survived her emergency with earlier paramedic attendance and transfer to hospital within that 60-minute time frame. Her best chance of earlier ambulance attendance was for dispatch to be attempted immediately following the first 000 call and acceptance of the event in CAD. I note, however, that the target response time would still have been 60 minutes and it cannot now be known if an ambulance would have been available to attend Sheridan's emergency if dispatch had been attempted immediately after the 000 call.
96. The use of the Secondary Triage process meant it was unlikely an ambulance was going to be dispatched within 60 minutes of the 000 call and, as events transpired, an ambulance was not dispatched within that timeframe. Whilst Sheridan's death may have been prevented with earlier ambulance attendance, I am satisfied that the categorisation of the request for ambulance in her case and the use of the Secondary Triage process was appropriate, as it was in accordance with AV policy.
97. Even though use of the Secondary Triage service was appropriate, Sheridan's case demonstrates the obvious risk associated with diverting cases to the AV Secondary Triage when a patient is alone: namely, the patient may not be able to respond to Secondary Triage contact if there is a deterioration in their clinical condition such that they are incapacitated and unable to answer. In such circumstances, there is no one present with the patient that can advise ambulance call-takers that such a deterioration has occurred and that the patient may need a higher priority ambulance dispatch.
98. I also acknowledge the evidence given by Ambulance Victoria regarding the utility of the Secondary Triage service in reserving ambulances for the most urgent cases, and the large volume of cases that can be diverted from requiring an ambulance as a result of the service.

This benefits the system of emergency ambulance dispatch overall, and is no doubt of great utility in reserving valuable ambulance resources for cases where urgent paramedic attendance is needed.

99. There is clearly a balance to be achieved between mitigating risks to patient safety and utilising valuable resources in the most appropriate way. As part of the coronial investigation, Ambulance Victoria was therefore asked to consider and respond to the following enquiries about potential prevention opportunities arising from Sheridan's case:

- a) whether it was appropriate to utilise the Secondary Triage Service in cases where the caller is a third-party seeking ambulance assistance for another person who is known to be alone;
- b) whether a 30-minute hold period on ambulance dispatch is appropriate when an event is referred to the Secondary Triage service, particularly in circumstances where the caller is a third-party seeking ambulance assistance for another person who is known to be alone.
- c) whether, in cases where the caller is a third-party seeking ambulance assistance for another person who is known to be alone, and where no contact can be made following referral to the Secondary Triage service, Priority 3 cases should automatically be allocated a higher priority.

100. In response, Ambulance Victoria provided detailed information about the status of current triaging protocols, including the following:

- a) The current Computer-Aided Dispatch (CAD) system is reaching end-of-life and has limited scope for modification. Triple Zero Victoria (TZV) informed AV of a freeze on CAD system customisations or configuration changes effective from 31 March 2025 whilst TZV are in the process of implementing a replacement system over the next two-to-three years.
- b) The Advanced Medical Priority Dispatch System (AMPDS) which is used by AV and TZV to process and categorise calls is a commercial product produced by the International Academies of Emergency Dispatch (IAED). AV and TZV cannot independently make changes to the questions contained within the system, or make changes to the event types available for selection. The IAED undertakes an evidence-

based, peer reviewed approach to updating and reviewing the AMPDS, with any such changes applying to all users of the system.

- c) The TZV call taking process, facilitated via CAD and AMPDS, includes questions regarding the proximity of the caller to the patient (e.g. whether the caller is the patient, on scene with the patient, not on scene with the patient, or another agency acting as a relay), however callers are not specifically asked if the patient is alone.
- d) There is currently no scope for AV to amend the AMPDS or CAD systems to add this question, or to alter the algorithm such that the patient's status of being alone results in the allocation of a different event type compared to a patient who is not alone. As such, there is no opportunity to automatically escalate a call, or prevent a call from being allocated to Secondary Triage, on the basis that the patient is alone. However, this can be done by manual review on a case-by-case basis.
- e) AV has recently updated its policies to recognise that some patients have a potentially heightened clinical risk (such as due to their age, vulnerable status or if they are alone) and to facilitate earlier management or potential priority escalation. However, this process can only commence once the call has been allocated to a Triage Practitioner or other AV communications staff member as it requires manual review and intervention.
- f) AV policy was also updated recently to improve the process when there is no answer on call back. The updated policy includes reviewing alternative contact numbers, contacting the original 000 caller for further information and upgrading the event should there be sufficient clinical information or concern to do so.
- g) There are a variety of reasons why a patient may not be able to be contacted including: wrong number recorded or no number available, technical issue (e.g. no reception), phone on silent/do not disturb and the patient not wanting/refusing to answer or purposely not answering to prompt an ambulance response. For these reasons, the automatic escalation of cases where a patient is unable to be contacted, on the assumption of a deterioration, would likely result in an over-response and have a detrimental impact on the overall service.
- h) In Sheridan's case, it is unlikely that re-allocating her call to a higher priority (such as from Priority 3 to Priority 2) after no contact could be made would have resulted in a

faster ambulance response as the mandated meal break for the dispatched unit would still have been applicable.

101. I accept AV's position in this regard. I also accept that the issues raised in this case with regard to the risk assessment of patients and best use of limited resources are not without complexity, and ultimately I have not identified any specific prevention opportunities arising from this case.

I convey my sincere condolences to Sheridan's friends and family for their loss.

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:

Heidi Burnell, Senior Next of Kin

Rodney Burnell, Senior Next of Kin

Kathryn Crisp, Applicant

Ambulance Victoria (C/- K & L Gates)

Triple Zero Victoria (C/- Lander & Rogers)

Dr Shankar Srinivasan (C/- Meridian Lawyers)

Barwon Health

Senior Constable Warren Normoyle, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 24 June 2026

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
