IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 001315

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	David Bramwell Van Vledder
Date of birth:	18 August 1982
Date of death:	12 March 2021
Cause of death:	1(a) Drowning
Place of death:	Cunningham Pier, Geelong, Victoria
Key words:	Mental health, emergency department presentation, absconding, nicotine dependence, drowning

INTRODUCTION

1. On 12 March 2021, David Bramwell Van Vledder was 48 years old when he took his own life by drowning. At the time, Mr Van Vledder lived alone in Grovedale and had been employed as a used car salesman for about 12 months preceding his death. He had previously worked in the mining industry out of Perth on a fly-in basis.

2. According to his mother, Lois Van Vledder, her son was the youngest of three children with an older brother and older sister and was a lovely child who had a happy childhood. Mr Van Vledder was close to his father and was very badly affected when he died of cancer some nine years earlier.

3. Mr Van Vledder reportedly began drinking alcohol during his early adulthood and later developed a habit of regular binge drinking. According to his general practitioner, Dr Tristan Crowe, Mr Van Vledder had been counselled about his problematic alcohol use on several occasions. Mr Van Vledder's medical history also included severe asthma and chronic allergic rhinitis for which he was prescribed prednisolone at varying doses for several years, until more recently when he was treated with monthly injections of mepolizumab.

4. In April 2020, Mr Van Vledder presented to Dr Crowe with symptoms of depression, which included low self-esteem, suicidal thoughts, low appetite, and poor sleep. A mental health care plan was completed, and Mr Van Vledder was referred to a psychologist. He was also prescribed an antidepressant (Zoloft) but it is unclear if he ever took any.

THE CORONIAL INVESTIGATION

5. Mr Van Vledder'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.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.

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

9. This finding draws on the totality of the coronial investigation into Mr Van Vledder's death, 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.[1]

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

Identity of the deceased

10. On 17 March 2021, Coroner Jacqui Hawkins made a formal determination identifying the deceased as David Bramwell Van Vledder, born 18 August 1982, based on expert fingerprint evidence.

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

Medical cause of death

12. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 15 March 2021 and provided a written report of his findings dated 19 March 2021.

13. The post-mortem examination was consistent with the reported circumstances.

14. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any other commonly encountered drugs or poisons.

15. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Drowning"*.

[1] 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.

16. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

17. Mr Van Vledder's employer, Justin Hanneysee, described Mr Van Vledder as increasingly paranoid in the months leading to his death.

18. Mrs Van Vledder last saw her son on 5 March 2021 at his aunt's funeral. She described him as *"quiet, more quiet than normal".* She last spoke to him on 9 March 2021 when he called to see how she was going.

19. At 7.53am on the morning of 12 March 2021, Mr Van Vledder presented to the emergency department (**ED**) at University Hospital Geelong. At this time, he was seen by the triage nurse and disclosed that he had *"scattered thoughts"* and *"wished he was dead".* He denied self-harm and reported that he drank alcohol every night. Mr Van Vledder had no previous mental health diagnosis according to the mental health database and his own account. He was triaged as a Category 3, which required him to be seen by a doctor within 30 minutes. A breath alcohol reading was taken and returned a negative result.

20. At about 8.00am, Mr Van Vledder was referred by triage to the Emergency Mental Health (**EMH**) team. The referral was declined as Mr Van Vledder had no acute issues and did not have a history of mental health issues. A request was made for Mr Van Vledder be reviewed by the ED Registrar before making a further referral.

21. At about 8.20am, Dr Teak McPadden, ED Registrar, reviewed Mr Van Vledder. He reported experiencing suicidal ideation for past few days and Dr McPadden described Mr Van Vledder being *"candid"* about his plans for suicide, which included plans to drive a car off a bridge or to put a spear gun into his mouth and shoot himself. He had been sleeping poorly and hated himself and thought everyone else also hated him. He did not report a history of mental health concerns. On examination Mr Van Vledder had a depressed affect and was teary. He was noted to have slow speech and poor eye contact. Noting Mr Van Vledder to be at high-risk of self-harm, Dr McPadden subsequently referred Mr Van Vledder to Mental Health triage, which referral was accepted.

22. Dr McPadden explained to Mr Van Vledder that he would be seen by mental health shortly and remained in the ED waiting area whilst awaiting that assessment.

23. At approximately 9.15am, Mr Van Vledder left the ED without undergoing the mental health assessment.

24. At 9.36am, a Mental Health clinician telephoned Mr Van Vledder at which time Mr Van Vledder advised that had left the hospital because he needed to rest. He said he was feeling okay and did not require mental health review. The clinician informed Mr Van Vledder about his concern, given that he had expressed suicidal intent with plans to the ED doctor. Mr Van Vledder adamantly denied any ongoing suicidal intent or plan. He again stated, *"I am fine, I need some rest".* Mr Van Vledder was encouraged to re-present to ED for mental health review if need be and he agreed to do so. Based on their phone call, the Mental Health clinician noted no current acute psychiatric risk concerns and documented a low threshold for 000 notification for a welfare check. A referral with the Acute Psychiatric Team was made for follow up in accordance with the relevant protocol.

25. At 9.40am, Mr Hanneysee telephoned Mr Van Vledder as he had not arrived at work and was late. Mr Hanneysee later recalled that Mr Van Vledder had been rambling and did not make sense during their conversation and had been extremely paranoid.

26. Mr Van Vledder subsequently attended his workplace and told Mr Hanneysee that people were trying to *"ruin"* him and he had wanted to take his own life that morning. Mr Hanneysee described Mr Van Vledder as acting in a delusional and paranoid manner. Concerned, Mr Hannysee suggested that Mr Van Vledder go to hospital to which he replied that he had just returned from hospital. Mr Hanneysee offered to drive him back to hospital, but he declined, saying he would go later that day before leaving in his car.

27. Mr Hanneysee telephoned later to check on him. Initially, there was no answer, but Mr Hanneysee was able to speak to Mr Van Vledder at about 11.15am. He sounded flat, was quietly spoken and said he had booked an Uber and had to go.

28. At 11.39am, Mr Van Vledder returned to the ED. At 11.54am he was assessed by a triage nurse and the ED Registrar was informed of his return. Mr Van Vledder was assessed by the Associate Nurse Unit Manager (**ANUM**), and reported that he had had a brief discussion with Mental Health that morning but was distressed when put back in the waiting room and so left. He advised that he was feeling unsafe and suicidal. Mr Van Vledder presented with a packed suitcase seeking admission and help.

29. At 12.00pm, Dr McPadden accompanied Mr Vledder to the mental health review room and completed an ED Mental Health Risk Screening. The main reported problem was noted as

'suicidal', and it was further noted that he had ideation with plans and means. Dr McPadden noted that Mr Van Vledder required a referral to psychiatric triage and under 'risk of absconding', that Mr Van Vledder was expressing a desire to leave the department.

30. At 12.15pm a Mental Health Triage Nurse assessed Mr Van Vledder who reported that his mental state had declined over the past six weeks without identifiable triggers or stressors; that he was a long-term alcohol user and had recently been drinking two bottles of wine daily; but reported no active suicidality or deliberate self-harm plan or intent. The clinical notes recorded that this was in contradiction to the entry following the initial interaction with Dr McPadden. A suicide risk assessment was conducted by the Mental Health Triage Nurse who assessed Mr Van Vledder's overall suicide risk as low. It was noted that he had expressed passive suicidality in the context of post alcohol use and there was a risk of misadventure.

31. The Mental Health Triage Nurse was of the opinion that as Mr Van Vledder had self-presented to ED and was accepting of assistance and further assessment, he did not meet the criteria under *Mental Health Act 2014*, which would have allowed compulsory psychiatric assessment and treatment. Noting that Mr Van Vledder preferred not to be admitted to the inpatient mental health unit, the nurse formed a plan for a short medical admission for bloodwork, a CT scan, and detox. This would also give staff the opportunity to observe him for mental health symptoms. Mr Van Vledder was open to the medical assessment.

32. At about 12.45pm, the nurse spoke to Dr George Xidias, the Mental Health registrar, who agreed that Mr Van Vledder did not fit the *Mental Health Act 2014* criteria. Dr Xidias felt there may have been an organic component with a differential diagnosis of alcoholic hallucinations and alcohol withdrawal, but with the potential of a primary psychotic illness.

33. Dr Xidias made a provisional diagnosis of alcohol hallucinosis with a plan for a medical admission for detoxification. Mr Van Vledder was informed and agreed with the plan. A CT scan and bloods were booked and a prescription for diazepam 10mg was written.

34. According to the Mental Health Triage Nurse, by the time this had all been arranged, Mr Van Vledder had been in the mental health room for almost 45 minutes. He asked to leave the emergency department briefly to have a smoke. As Mr Vledder was a voluntary patient at the time, he was allowed to leave the ED on the proviso that he left his suitcase behind as an incentive for return. The nurse also noted that Mr Van Vledder was not displaying any active suicidality at the time.

35. At about 12.55pm, Mr Van Vledder left the hospital and unbeknownst to clinical staff, hailed a taxi.

36. The Mental Health Triage Nurse remained in the ED organising the admission. At 12.59pm, he left the ED to look for Mr Van Vledder. A second attempt was made to find Mr Van Vledder about 15 minutes later, but he could not be found.

37. At 1.21pm, Dr McPadden attended the Mental Health room to find Mr Van Vledder was no longer there. Four attempts were made to contact Mr Van Vledder but he but did not answer.

38. Dr Xidias and the ED ANUM were notified. A phone call was made to Mr Van Vledder's general practitioner at Belmont Bulk Billing Clinic in an attempt to obtain next of kin details. Mr Van Vledder's mother was listed as his next of kin but without her contact details.

39. At about this time, members of the public saw a man jump off Cunningham Pier at Eastern Beach, Geelong, into the water fully clothed. This man was later identified as Mr Van Vledder. He was observed to swim out about 30 metres before stopping to tread water and then seen to start bobbing up and down vertically in the water, appearing to try to push himself down. A bystander on the pier subsequently called emergency services about the man's behaviour.

40. Two paddleboarders observed Mr Van Vledder in the water fully clothed yelling indiscernible words. The male paddleboarder paddled over to Mr Van Vledder and offered to tow him back to the pier but Mr Van Vledder continued pushing himself down into the water. Concerned for his own safety, the paddleboarder kept his distance but offered Mr Vledder a tow again.

41. A short time later, the male paddleboarder, who happened to be an off-duty paramedic, observed Mr Van Vledder gulping and breathing in water before becoming unresponsive face down in the water. He paddled over to Mr Van Vledder again and, with difficulty, turned him over. He found him to be cyanosed, mottled, non-breathing, and pulseless. The male paddleboarder yelled out to the other bystanders to update emergency services about Mr Van Vledder's condition and provided two precordial thumps in an attempt to revive Mr Van Vledder but these were unsuccessful.

42. A bystander jumped into the water and assisted the paddleboarder to tow Mr Van Vledder back to the pier. They struggled to get him back to the pier and by the time they reached the pier, Mr Vledder was estimated to have been without oxygen for at least 10 minutes.

43. Responding Ambulance Victoria paramedics and Country Fire Authority members arrived at the scene at 1.34pm, later joined by Victoria Police members. Once Mr Van Vledder was extricated from the water, cardiopulmonary resuscitation was commenced but he could not be revived and was verified deceased by paramedics at the scene at 1.40pm.

44. At 2.06pm, Dr McPadden made retrospective notes of his discussion with the Emergency Mental Health clinician about Mr Van Vledder's presentation. He noted escalating alcohol use on a background of chronic alcohol intake and an emergence of paranoid ideation and auditory hallucinations. It was noted that Mr Van Vledder had unfortunately left the ED and they were unable to review his mental state at the time, but the primary diagnosis was alcoholic hallucinosis and alcohol withdrawal with a differential diagnosis of primary psychotic illness. Dr McPadden recommended that Mr Van Vledder be contacted again, otherwise a welfare check needed to be arranged with the police.

45. At 2.12pm Dr McPadden noted in Mr Van Vledder'ss clinical records that he had left the hospital for the second time that day. He noted that the plan for management of Mr Van Vledder on representation included CT brain, pathology, and commencement of alcohol withdrawal management. He noted that if the results were normal, he would then be for psychiatric admission or for psychiatry to cross-refer to general medicine with a clear mental health plan. Dr McPadden noted that this had already been discussed with the psychiatric registrar who was happy to refer Mr Van Vledder for the purposes of Acute Ward Service management and then re-review once his alcohol withdrawal had stabilised.

46. At about 3.00pm, hospital staff contacted Victoria Police and requesting a welfare check in relation to Mr Van Vledder who was for referral to the Community Acute Intervention Service Outreach for a home visit on 13 March 2021 if he did not re-present to the ED, whether escorted by police or otherwise.

47. At 3.17pm a police member called the hospital and reported that Mr Van Vledder had died.

FAMILY CONCERNS AND FURTHER INVESTIGATION

48. Mrs Van Vledder wrote to the Court with concerns that her son was allowed to leave hospital to smoke as she knew he had not smoked in 20 years.

49. Given his recent presentations to the ED, I obtained advice from the Coroners Prevention Unit[2] (**CPU**) about the care Mr Van Vledder received during these presentations. As part of this process, I obtained a further statement from Dr Simon Woods, Chief Medical Officer at Barwon Health.

Treatment at University Hospital Geelong generally

50. The CPU advised that the treatment at University Hospital Geelong seemed generally reasonable.

51. Mr Van Vledder was a voluntary patient seeking help and did not satisfy the criteria for the *Mental Health Act 2014*. He was seen relatively quickly by triage, the ED doctor, and mental health team.

52. After he left hospital the first time, the mental health clinician appropriately and promptly called and conducted a risk assessment during which no immediate risks were identified. However, the clinician attempted to convince Mr Van Vledder to return to hospital which he declined. There was no indication that a welfare check was required at the time and it appeared that the extent of his psychotic symptoms was unknown until his second presentation. Even then, Mr Van Vledder's reports of psychotic symptoms were not clear/overt.

53. When Mr Van Vledder re-presented, he was again seen relatively quickly by triage, the ED doctor, and mental health team. It was thought that his presentation may have been physiological/organic in nature and further investigations was required. The CPU considered this was an appropriate course as, in the absence of illicit substance use or significant history of mental illness, a late onset psychosis should raise suspicion of a physiological cause. Mr Van Vledder came with his bag packed and clinical staff deemed that a medical admission for further physical investigation and alcohol detox was appropriate.

54. The CPU advised that when Mr Van Vledder asked to go outside for a cigarette, it was appropriate that he was allowed to leave as he was a voluntary patient. Put another way, clinical staff were unable to prevent him from leaving as he did not satisfy the criteria for compulsory treatment under the *Mental Health Act 2014*. Assessing Mr Van Vledder's response to the request to leave his bags in ED would have provided further indication of his

[2] The Coroners Prevention Unit is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

intent, and he did not appear concerned by this request which would have provided some reassurance that he was not planning to leave.

55. The Mental Health Clinician went out to check on Mr Van Vledder after about three minutes, and likely did so considering he had earlier left without treatment and expressed a desire to leave despite also requesting admission.

56. When the Mental Health Clinician could not locate Mr Van Vledder, he went to two nearby shops that sell cigarettes looking for him. He then returned to the hospital and informed the psychiatric registrar, called Mr Van Vledder multiple times, called his general practitioner to obtain next-of-kin details (which were unavailable), and then called police for a welfare check. The CPU considered that all of these actions were reasonable.

Lack of assessment of Mr Van Vledder's nicotine dependence

57. There was no evidence on either presentation that Mr Van Vledder was asked about his smoking status or amount of nicotine intake at triage, during the assessment by the ED doctor, or by the mental health clinician.

58. Dr Woods confirmed that Mr Van Vledder was not assessed for nicotine dependence during his ED presentation.

59. Mr Van Vledder asked to leave ED for a cigarette and was advised that this was allowed. However, he appeared to have left immediately left and suicided within a few minutes. Had Mr Van Vledder been assessed for nicotine dependence on arrival and reported not being a smoker, his request to leave for a cigarette likely would have raised suspicion about his true intent on leaving the hospital, especially considering he had left against medical advice earlier.

60. Alternatively, had Mr Van Vledder reported being a smoker, assessment of nicotine dependence and appropriate treatment early during his ED presentation would have reduced the likelihood of nicotine withdrawal and a request to leave for a cigarette, if in fact he needed to smoke at all.

61. In the Finding into Death Without Inquest regarding the death of Ms T,[3] Coroner Audrey Jamieson recommended that the Victorian Network of Smokefree Health Services (**VNSHS**) develop a guideline for assessment and treatment of nicotine dependence specifically for EDs,

[3] The deceased in that case also left ED for a cigarette and suicided. Finding published 27 May 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-06/MsT_042716.pdf.

given the rate of smoking in people with a mental illness and the rate of ED visits in people with a mental illness, and the unique challenges of the ED environment which can lead to inadequate assessment and treatment of nicotine dependence (which can result in aggression, distress, discomfort and patients leaving against medical advice). This guideline was developed[4] with the input of Barwon Health physicians.

62. The VNSHS *Guidance for managing nicotine dependence & withdrawal in emergency care settings* specifically notes its rationale to include addressing the risk of absconding (or in this case, leaving against medical advice), and that *"Smoking status, nicotine dependence and nicotine withdrawal risk should be identified as soon as possible (at triage) to enable timely management".*

63. In his response, Dr Woods was not clear whether the VNSHS guideline has been implemented in Barwon Health ED. However, he stated that Dr Belinda Carne (one of the Barwon Health contributors to the VNSHS Guidance for Managing Nicotine Dependence & Withdrawal in Emergency Care Settings) has been liaising with the Drugs and Therapeutics Committee and has partnered with Deakin University to research the benefit of nicotine replacement therapy in reducing agitation in ED patients and the benefits of early protocolised nicotine replacement therapy from triage. Dr Woods also stated:

> *Barwon Health has a Nicotine Replacement Therapy policy in place … This policy is applicable to patients in the Emergency Department and details the modes of delivery of nicotine for patients to consider. Barwon Health also has a policy in place for Inpatient Assessment and Management of Smoking Dependence … In accordance with this policy a plan for nicotine replacement therapy would have been considered as part of his general medical admission.*

64. The Barwon Health Inpatient Assessment and Management of Smoking Dependence policy notes that *"every patient attending our ward should be asked about smoking"*. However, it appears this policy does not apply to ED.

65. The other document to which Dr Woods referred was a fact sheet for staff and patients about Nicotine Replacement Therapy. This document was not a policy/procedure/guideline for assessing nicotine dependence in ED and only provides guidance about the use of nicotine

[4] Victorian Network of Smokefree Healthcare Services, Guidance for managing nicotine dependence & withdrawal in emergency care settings, available at: https://www.smokefreevictoria.com.au/static/uploads/files/guidance-information-management-of-nicotine-withdrawal-and-dependence-in-emerg-care-wfycbrfghpbl.pdf.

replacement therapy, but not expectations about who should be assessed for nicotine dependence or under what circumstances.

66. It would be reasonable for Barwon Health to ask every patient at triage in ED about their smoking status, and where clinically appropriate that this trigger further assessment and management of nicotine dependence during the ED episode of care. Had this occurred, it may have reduced the likelihood of Mr Van Vledder leaving ED on the second occasion, either due to adequate control of nicotine withdrawal or due to increased suspicion on the part of staff when he asked to leave for a cigarette despite having denied being a smoker.

67. However, the CPU noted that Mr Van Vledder was a voluntary patient and could not be forced to engage in a nicotine dependence assessment, to accept nicotine replacement therapy or to remain in ED if he wanted to go out for a cigarette.

68. I accept the advice of CPU.

Delay in reporting Mr Van Vledder's absence to Victoria Police

69. The CPU identified a two-hour period between Mr Van Vledder leaving for a cigarette and Victoria Police being notified.

70. Dr Woods's statement did not shed any further light on this delay. He confirmed that for 15 minutes from 12.59pm, a mental health clinician searched for Mr Van Vledder, attempts were then made to contact Mr Van Vledder by phone and to obtain his next of kind details from his general practitioner (which were unavailable), before police were notified at 3.00pm. It is not clear that these attempts took the full one hour and 45 minutes.

71. Despite the length of this delay, the available evidence suggests that delay was not a causal or contributory factor in Mr Van Vledder's death as bystanders called emergency services about 20 minutes after he left ED (five minutes after the mental health clinician finished searching for him) and Mr Van Vledder was pronounced deceased about 40 minutes after leaving ED.

72. According to Dr Woods, a notification to police about a patient's absence is based on clinical judgement and there is no absolute obligation to call police. As he put it in his statement, the 'circumstances did not indicate that immediate notification to the police was necessary. Nevertheless, when initial attempts to locate Mr Van Vledder were unsuccessful and he did not subsequently return of his own volition, police were notified'.

73. It should be noted that the decision to notify police at 3.00pm was based on the same unchanged (and no additional) information that was available to clinicians earlier and the decision to notify the police could have been made earlier.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was David Bramwell Van Vledder, born 18 August 1982;

    (b) the death occurred on 12 March 2021 at Cunningham Pier, Eastern Beach, Geelong, Victoria;

    (c) the cause of Mr Van Vledder's death was drowning;

    (d) the death occurred in the circumstances described above; and

    (e) the available evidence supports a finding that Mr Van Vledder intentionally took his own life.

COMMENTS

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

75. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

76. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 758 deaths in 2022.[5]

77. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

[5] Coroners Court Monthly Suicide Data report, February 2023 update. Published 21 March 2023.

78. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. In line with the Victorian Network of Smokefree Health Services Guidance for Managing Nicotine Dependence & Withdrawal in Emergency Care Setting, I **recommend** that **Barwon Health** considers asking all patients presenting to Emergency Department about their smoking status on each presentation, and, where clinically appropriate, that this trigger a further assessment of nicotine dependence and appropriate management.

I convey my sincere condolences to Mr Van Vledder's 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:

Lois Van Vledder, senior next of kin

Barwon Health (care of K&L Gates)

Senior Constable Chistopher Whitfield, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 03 April 2023

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.