IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001265

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	William Thomas Gourley
Date of birth:	10 October 1982
Date of death:	7 March 2022
Cause of death:	1(a) Effects of fire
Place of death:	28 King Street, Moe, Victoria, 3825
Keywords:	Nicotine Replacement Therapy, emergency department, absconding, suicide

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

INTRODUCTION

1. On 7 March 2022, William Thomas Gourley (**William**) was 39 years of age when he passed away due to self-immolation in the context of an extended history of mental ill health.[1] William was a proud Aboriginal and Torres Strait Islander on his mum's side, and lived in Moe, on Gunaikurnai Country in Victoria's east.

2. William was born to Suzanne 'Sue' Gourley (**Sue**) and Frank Spitzbart, however, the couple separated, and Sue remarried David Gourley (**David**) before William was two years of age. William and his father had a strained relationship, though *'[William] always wanted to be accepted by [him]'.*

3. During his early childhood, when William was around three or four years of age, he was repeatedly sexually assaulted by a family friend, and later, by family members. It was not until his adulthood that William would disclose these events, including to police.

4. When he was about 13 years old, William commenced smoking marijuana. Reflecting on her son's substance use, Sue stated, *'I wouldn't be surprised if he used daily since a teenager'.*

5. During his secondary school years, William was diagnosed with attention deficit hyperactivity disorder (**ADHD**) and attended a local general medical practitioner (**GP**) for the management of his symptoms. The GP prescribed dexamphetamine to treat William's condition. Sue recalls how William was initially compliant with his medication regime, but as he entered his adolescence *'he started to think he was better'* and eventually stopped them.

6. William left school in Year 11 and commenced a building and carpentry apprenticeship. He did not however, complete his apprenticeship and moved to Melbourne with a friend. William eventually returned to Moe.

7. In 2006, William entered a relationship and welcomed a daughter. He commenced work at a nearby abattoir, but in a workplace incident William sustained a severe injury to his hand. Sue recalls that *'after the injury William began to suffer from depression'.* To manage his

[1] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available here). On the advice of the Coroners Aboriginal Engagement Unit, the term 'passing' will be used instead of 'death' in this Finding, save where required by the words of relevant statutes.

depression, William was prescribed the anti-depressant, fluoxetine. However, his consistency in taking the medication fluctuated over the years.

8. William separated from his then-partner and returned to live with Sue and David. Between 2010 and 2014, William had another daughter with a new partner, followed by two sons to a subsequent partner. He is remembered as a good and loving father: *'there is no doubt that he loved the kids and would do anything for them'.*

9. In August 2016, Sue suggested William attend the Adult Mental Health Service (**AHMS**) operated by Latrobe Regional Health on account of *'low mood, agitation, poor appetite and thoughts of suicide but no known attempt'.* William described his use of cannabis as a means to calm and mitigate his anxiety. Following his assessment, William was diagnosed with an adjustment disorder with depressed mood and anxiety, and ADHD. It was recommended by the AMHS that William's GP commence a Mental Health Care Plan, refer him to a counsellor and continue with the prescribed fluoxetine.

10. In May 2019, William engaged with Ramahyuck, a health and community centre operated by the Central Gippsland Aboriginal Health Service, on account of his marijuana dependence. During his engagement with Ramahyuck, William expressed the desire *'to come off marijuana and get his life back on track'* and maintained short periods of abstinence. William's mental health fluctuated and, at times, he reported minimal to no symptoms, while at other times, he demonstrated increasing paranoid thoughts. He was commenced on the antipsychotic, olanzapine, and referred to multiple services including for mental health counselling.

11. Around the same time, William was also engaged with the Gippsland and East Gippsland Aboriginal Cooperative and was recorded as *'ready to make a change in his life'* with respect to this substance use. In June 2019, Ramahyuck and the Gippsland and East Gippsland Aboriginal Cooperative referred William to a drug rehabilitation program at the Sale Hospital. Following this week-long program, William returned living with Sue and David and his mental state, including depression and paranoia, had observably improved.

12. In August 2019, William presented to the emergency department (**ED**) of Latrobe Regional Hospital (**LRH**) on account of *'extreme paranoia'* in the context of recently ceasing his marijuana use. William was not taking fluoxetine and olanzapine at this time and was admitted as a psychiatric inpatient. After discharge, William was in contact with the Latrobe Valley Acute Community Intervention Service (**ACIS**).

13. Over the ensuing months, William's condition continued to fluctuate. At times, he was *'bright and engaging'* and denied suicidal ideations. However, by February 2021, William reported to his GP that he was experiencing an increase in paranoid thoughts and delusions. This coincides with Sue's recollections of 2020 and 2021 that the COVID-19 pandemic had a profound impact on William: *'it really pushed him over the edge'.*

14. Around the same time, William disclosed his experiences of sexual assault and was referred to the Gippsland Centre Against Sexual Assault and received counselling. He reported his delusions that people were attempting to harm him and expressed his suicidality. However, William did not have a plan to suicide and identified his family and children as protective factors. William was engaged with the service for approximately two months before he ceased responding to their correspondence.

15. In March 2021, William's psychologist re-referred him to the Gippsland Centre Against Sexual Assault. William maintained contact with the service for the following months and in July 2021 informed them that he did not require ongoing counselling and discussed the possibility of recommencing contact in the future should he find it necessary.

16. Ramahyuck medical records of July 2021 report *'good compliance*' with olanzapine and that William was encouraged to consider further drug and alcohol counselling. He was provided with a referral to local mental health services if his condition deteriorated. William continued engaging with his GP at Ramahyuck over the ensuing months and presented as *'well'* though continued to experience anxiety, depression, psychosis and continued marijuana use.

17. In February 2022, William relocated to the Bundaberg region, Queensland, where he lived in a caravan on his friend's property. Within days of his arrival, William's mental health significantly deteriorated, and he expressed delusions that those around him were trying to poison him. On 23 February 2022, William moved to live with a family friend, three hours away in Rockhampton. That week, William began experiencing abdominal pain and associated vomiting.

18. On 26 February 2022, he attended the Rockhampton Base Hospital ED. Investigations were unremarkable however, William's interactions with medical practitioners appeared to trigger his delusions and he came to believe they were also trying to poison him.

19. After he recovered, William contacted Sue and David, and they decided that he should return home. Upon his arrival in Moe on 2 March 2022, Sue recounted how William had told her

that on the train from Melbourne to Moe he was *'sitting next to FBI agents who knew all about him'*.

THE CORONIAL INVESTIGATION

20. William'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

21. 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.

22. 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.

23. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of William'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.

24. This finding draws on the totality of the coronial investigation into the death of William Thomas Gourley 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.[2]

[2] 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

25. On the evening of 5 March 2022, William informed Sue *'that he was going to set his room on fire'*. Evidence indicates that William had made similar remarks to his biological father around this time.

26. On 6 March 2022, William attended a GP appointment at Ashby Street Medical Centre, where he had not previously attended. He expressed *'low mood and suicidal thoughts'*, and divulged his delusions that people were attempting to poison him. The GP advised William to attend the emergency department (**ED**) via ambulance or to be driven by a family member or friend. William insisted he could drive himself.

27. The GP wrote a referral letter to the LRH ED which indicated that William was non-compliant with his medications, experiencing suicidal ideation, delusion, the belief that someone was trying to harm him, auditory and visual hallucinations and indicated that he may pose a danger to himself and others.

28. William drove himself to the LRH ED with *'paranoia and fluctuating auditory hallucinations, and reported marijuana use the day before'*. At 3:41pm, he was triaged and was reportedly '*well'*. The triage nurse noted that William reported feeling paranoid for the last few weeks, had smoked marijuana the day prior but had not done so that day. The nurse noted that he had been referred by the GP but did not consider the contents of the letter. William was triaged a *'Category 4'* to require treatment within the hour and was referred to Mental Health Triage. He agreed to wait in the ED.

29. A Registered Psychiatric Nurse (**the RPN**) received the referral and advised William to wait in the ED cubicle for the assessment. The RPN requested an ED clinician to review him, who *'advised to treat the paranoia with the usual medication, olanzapine – of which the patient denied having this day'* and that Mental Health Triage would review William as soon as possible.

30. Between 4:15pm and 4:30pm, a medical practitioner had *'brief initial contact with William'* and recorded – in notes made later that night – *'unable to complete full assessment, [patient] voicing mental health concerns…[no] immediate physical concerns'*. Olanzapine was ordered for William's paranoia as *'regular medication'*. According to the practitioner's recollection, he was unable to complete the examination as he was called away to another matter, did not

recall sighting the GP referral letter, there were no further observations, physical assessments nor mental state examinations undertaken or recorded and there was no mention of risk to self or others.

31. At approximately 4:30pm, an enrolled nurse (**the EN**) briefly assessed William and reported he was *'alert'* with *'rapid speech and though process'*, and that *'he feels like he is having two personalities'.* There is nothing in the medical records to suggest these observations were escalated. He was administered 10mg olanzapine, though, it was discovered later that night that William did not consume the olanzapine.

32. At 5:23pm, the EN recorded that William was still waiting to be reviewed by the Mental Health Triage.

33. Sometime between 5:30 and 6:00pm, William requested to go outside for a cigarette. William was permitted to leave the ED by a staff member.[3] This was permitted despite William informing staff within the previous hour he did not smoke cigarettes.

34. At approximately 6:00pm, Sue informed LRH ED that William sent her text messages that the ED staff were making him *'quite uncomfortable*' and that he was increasingly paranoid. The EN documented that Mental Health Triage were informed of *'[patient] behaviour'*. In the same entry, the EN recorded that William had not yet returned: *'[patient] requested to go for cigarette and still awaiting [patient] to return to cubicle'.*

35. While outside, at an unknown time, William left the LRH premises and informed his mother that he would be coming home. At 6:26pm, Sue contacted LRH ED and told them of the same. The EN responded to Sue that as William was a voluntary patient, staff could not force him to stay and advised her to contact emergency services if she held further concerns. William's departure was not escalated to the Registered Nurse in charge, or to a senior clinician.

36. That night, the RPN entered medical records in relation to William's attendance and referenced a four-week history of paranoia and hallucinations, and that he was given olanzapine in the ED. There was no reference made to William's risk of harm to self or others, only of his departure: *'William took off from the ED and contacted his mother saying that he is coming home due to paranoia'.*

[3] The identity of the staff member is not clear on the available evidence.

37. At approximately 7:00pm, the RPN telephoned Sue and during the telephone call, William returned home, however, refused to speak with the RPN. Sue informed the RPN that William did not consume the olanzapine provided in the ED, and that the previous night William expressed his intention to set his bedroom alight. The RPN advised Sue to contact emergency services and have William return to the ED via ambulance. Sue stated that she would monitor him overnight, and that he could take the olanzapine he was previously provided while in Queensland. The RPN accepted Sue's suggestion and categorised William as Category D – semi-urgent and requiring treatment within 72 hours – with a plan for follow-up with Latrobe Valley ACIS.

38. William left the Moe residence, obtained some marijuana, and returned home at approximately 11:00pm. He spoke with Sue and asked if it was *'too late'* to get help, Sue reassured him it was not. At approximately 11:05pm, she telephoned emergency services to request an ambulance. The call taker informed Sue that a further triage call-back was required and to keep her mobile phone nearby.

39. Soon thereafter, Sue heard an alarm go off within the house. David and Sue searched for the source of the alarm and identified *'smoke coming from William's door'.* They attempted to enter his bedroom; however, he blocked their entry and replied, *'don't open it, go away'.*

40. David retrieved a fire blanket, managed to open the door and upon entering, they observed multiple items within the room were alight. Sue recalls that William was making deliberate contact with the fire *'trying to set himself alight',* and observed there was '*fire on his skin'.* William moved to the bathroom and *'barricaded the door'.* Sue and David contacted emergency services.

41. At approximately 11:20pm, Fire Rescue Victoria arrived, tended to Sue and David and began to retrieve William from the burning residence. David was transported via helicopter to hospital where he was treated for severe smoke inhalation, and eventually recovered.

42. Firefighters retrieved William from the fire and paramedics performed cardiopulmonary resuscitation (**CPR**) for approximately 50 minutes, with no success. At 12:11am on 7 March 2022, William was declared as having passed away.

43. Firefighters eventually extinguished the fire, and the scene was examined by Nicole Bond (**Ms Bond**), a forensic officer of the Victoria Police Forensic Services Centre. Ms Bond provided a written report dated 17 March 2022 which contained her conclusion that the fire was due to

the *'ignition of combustible materials on the bed in [William's] bedroom, such as the mattress and/or any bedding that may been originally present…There were no apparent accidental sources of ignition on the bed…I considered direct ignition of the mattress or bedding, by means such as a match or cigarette lighter to be the most likely source of ignition'.*

Identity of the deceased

44. On 9 March 2022, scientist Dr Jeremy Graham (**Dr Graham**) of the Victorian Institute of Forensic Medicine (**VIFM**) compared fingerprint impressions taken of the deceased, against fingerprint impressions taken by Victoria Police of William Gourley during his life and determined these fingerprint impressions to be consistent with one another. Dr Graham completed an Identification Report to this effect.

45. My colleague, Coroner Sarah Gebert, reviewed the available evidence and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was William Thomas Gourley, born 10 October 1982. Accordingly, her Honour signed a Determination by Coroner of Identity of Deceased (**Form 8**), dated 9 March 2022.

46. I have reviewed the relevant evidence in this regard, and I am satisfied that identity has been established to the applicable standard, *on the balance of probabilities*.

Medical cause of death

47. Forensic Pathologist Dr Judith Fronczek (**Dr Fronczek**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of William Gourley on 10 March 2022. Dr Fronczek considered the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and medical records and provided a written report of her findings dated 6 October 2022.

48. The post-mortem examination revealed burn injuries to approximately 30% of the body and soot in the deeper airways. Also identified was cardiac hypertrophy – an enlargement of the heart – which is commonly caused by hypertension. This was not considered to have contributed to the death.

49. Toxicological analysis of post-mortem samples identified the presence of the following compounds:

Carboxyhaemoglobin	~ 30% saturation

Hydrogen Cyanide	~ 0.26 mg/L
Olanzapine	~ 0.2 mg/L
Delta-9-tetrahydrocannabinol	~ 471 ng/mL

50. Dr Fronczek stated that carboxyhaemoglobin is formed upon the inhalation of carbon monoxide, a gas produced by the combustion of organic molecules. Hydrogen cyanide is a gas produced by the combustion of plastic products. The combined effect of elevated carboxyhaemoglobin and the presence of hydrogen cyanide can cause significant cellular asphyxia.

51. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) EFFECTS OF FIRE.

MEDICAL TREATMENT PROVIDED TO WILLIAM BY LATROBE REGOINAL HOSPITAL

Sentinel Event Report submitted by Latrobe Regional Health

52. William's passing constituted a Sentinel Event category 11 being an *'adverse patient safety events resulting in serious harm or death'*. A panel was formed of internal and external medical practitioners, who undertook a Root Cause Analysis of the events leading to William's passing while he was at the LRH ED.

53. The panel completed a Sentinel Event Report (**the Report**) which was submitted to Safer Care Victoria in September 2022. In the report, the panel identified areas of concerns and made key findings and recommendations.

Triage of William in Latrobe Regional Hospital

54. The Report considered the triage process applied to William on 6 March 2022, and determined that the Category D triage rating did not adequately reflect the seriousness of William's condition.

55. In response, the Report contained two findings on the factors which contributed to this shortcoming. First, that William drove himself, ambulated into the ED, was '*well-presented [in] appearance and compliant with instruction*' lead medical practitioners to triage him as Category 4 in spite of the referral which detailed significant concerns. Second, William

belonged to a '*socio-economically disadvantaged community in which there is significantly high mental health issues and presentations to the Emergency Department are frequent'* lead to him being triaged as Category D.

56. The panel put forward a recommendation in response to these findings, namely to '*create an initial mental health risk screening for use at the emergency triage point, which identifies impending risk of harm'*.

57. Latrobe Regional Health have indicated that the risk screen tool is currently being developed by their IT service provider and will be incorporated into LRH's electronic medica record to enable non-mental health trained ED staff to undertake an initial risk screen for suicide and/or self-harm, non-suicidal self-harm, aggression and absconding. LRH considers the new tool will result in the immediate identification of patients in need of risk assessment and observation.

Delayed mental health assessment

58. William arrived at LRH ED and was triaged at approximately 3:41pm as category 4, requiring medical treatment within the hour. However, by the time he left the ED, some two hours had elapsed, and he had not been assessed by Mental Health Triage. I note that at the time the Mental Health Triage was attending to two acutely unwell patients within the ED and responding to high priority triage calls from other EDs in the region.

59. On this point, the Report found there was an '*increased demand on mental health resources'* in the ED at the time of William's presentation. This prevented medical practitioners from assessing William '*within the appropriate timeframe'* and consequently, William did not receive a mental health risk assessment.

60. The panel recommended that '*the emergency department triage nurse refers to a Mental Health practitioner/Registered Nurse when a consumer presents with a Mental Health illness/deterioration in known condition'* and encourage consideration of introducing a Mental Health Triage Registered Nurse role to the ED. In a response provided by LRH since the Report, it stated that such a role has been established is designed to *'support the patient journey by supporting ED triage assessment, provide expert advice to Emergency Department staff in early prevention strategies, and work towards the development of a MH plan for the patient*'.

61. As of April 2024, LRH was recruiting for the role but stated the difficulty in securing a suitable candidate, particularly in a regional area, '*cannot be overstated'*.

Leaving the Emergency Department for a cigarette

62. Sometime between 5:30 and 6:00pm, William asked LRH staff whether he could go outside and smoke a cigarette. He was permitted to do so, unsupervised, and during which time he drove himself home. On this point, the Report found that the combination of a reported history of aggression by William towards staff and a smoke-free policy on hospital premises meant that LRH staff *'are reluctant to intervene when patients smoke'*. This results in patients, such as William, leaving the ED unsupervised.

63. The panel put forward a recommendation on this point:

> *'To review current smoking policies and to facilitate a protocol consistent across Latrobe Regional Health, and for clinical observations to be compared to the Fagerström test*[4] *throughout the consumers presentation to monitor nicotine withdrawal and implement clinical management of nicotine dependency*.'

Failure to follow hospital policies following William's departure

64. The Report identified that ED staff did not follow applicable LRH protocol with respect to patients, who are not subject to an Inpatient Assessment Order under the *Mental Health Act* – as it was then applied[5] - and who leave the ED prior to an assessment. In such circumstances, ED and/or mental health staff are required to report the patient's departure to Victoria Police.

65. On this point, the Report made two findings. First, when the ED staff was notified by Sue that William had left the ED and returned home, staff advised the family to contact emergency services and did not contact Victoria Police as required by the LRH protocol. Secondly, the communication from Sue that William had left the ED and returned home was not escalated to the Registered Nurse in charge or to Mental Health Triage clinicians.

66. A corresponding recommendation was made to '*review current existing protocol to notify Victoria Police*' and to '*develop in policy an escalation process for ED staff when the patient's*

[4] According to the National Institute of Health, the Fagerström test for Nicotine Dependence is a standard instrument for assessing the intensity of physical addiction to nicotine. The test was designed to provide an ordinal measure of nicotine dependence related to cigarette smoking. Information available at Instrument: Fagerstrom Test for Nicotine Dependence (FTND) | NIDA CTN Common Data Elements (nih.gov).

[5] The *Mental Health Act 2014* (Vic) has now been replaced with the *Mental Health and Wellbeing Act 2022* (Vic).

family/carer/significant other notifies the Emergency Department staff that the patient has left the hospital prior to assessment/planned discharge'.

CORONERS PREVENTION UNIT

67. To better understand the actions of LRH and the adequacy of treatment provided to William, I sought the assistance of the Coroners Prevention Unit (**CPU**).[6] The CPU considered the Report produced by LRH, provided its opinion and identified other areas of concern which had not been addressed.

68. With respect to the triage process, the CPU commented that while the implementation of the risk screening addresses some of the concerns identified by Findings 1 and 2 of the Report, it does not address the 'attitudinal bias' that was identified by the panel to have contributed to the inappropriate triage of William's need, namely that he appeared *'well'*.

Escalation of William's deteriorating mental state

69. Having reviewed the medical records of LRH relevant to William's presentation on 6 March 2022, the CPU identified two occasions in which the Enrolled Nurse (**the EN**) documented deteriorations in William's mental state, but there is no evidence of escalation to senior staff.

70. The first of these occasions was recorded at 4:29pm when William appeared *'unsettled and fidgety'* with *'rapid speech and thought process'* and expressed that he felt as though he had *'two personalities'*. The CPU advised that these symptoms indicated a more pervasive, mental health issue than had been suggested by the Triage Registered Nurse. This information was not communicated to senior nursing, medical or mental health staff.

71. The second occasion occurred at 6:00pm when the EN became aware, from Sue, that William was experiencing increased paranoia. The EN informed the Mental Health Triage of this information, however, it was not escalated to senior nursing or medical staff. By this time, William had requested to smoke a cigarette and had left the cubicle.

72. The factors which contributed to the failure to escalate these deteriorations remain unclear. The CPU opined they were likely to encompass organisational and workforce factors

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

including a lack of escalation protocols and knowledge of signs of deterioration among non-mental health trained staff.

73. The National Safety and Quality Health Services Standards (**NSQHS Standards**) of 2021 address eight '*high-prevalence adverse events'* and acts as a quality indicator to maintain the safety and standard of Australian healthcare services. All public and private hospitals are required to be accredited to the NSQHS Standards.

74. The NSQHS Standards discusses the need to recognise and respond to acute deterioration to '*ensure that a person's acute deterioration is recognised promptly, and appropriate action is taken'*. It requires that health organisations have protocols specifying criteria for the escalation of care which includes indicators of a deterioration in mental state and worry or concern of family members about acute deterioration.

75. The CPU commented that attention to the factors which precipitated the failure to escalate will assist LRH to ensure they meet the criteria of the NSQHS Standards.

Care provided by the Mental Health Triage clinician

76. During William's time at the LRH ED, the Registered Psychiatric Nurse (**RPN**) did not conduct a face-to-face assessment. Rather, their decision making was guided by information provided by the Triage Registered Nurse, the EN and Sue. The evidence indicates that the RPN was not alerted to the risks identified in the GP's letter that accompanied William's presentation.

77. As a consequence, the RPN did not prioritise reviewing William, did not make a concerted effort to contact his family when he returned home, and rather than contacting Victoria Police or an ambulance, accepted Sue's offer to monitor William overnight and for further contact the following day.

78. When the RPN triaged William, at approximately 7pm, they considered that he had insufficient evidence to invoke a mandatory treatment order until the *Mental Health Act 2014:*

> *'There was nothing in the information I had…which made me think that I should call the police and request that [William] be brought back to Hospital under a compulsory assessment order'.*

79. This assessment was made despite that during the telephone call, Sue *'reported that the previous night, [William] had told her that he was going to set his room on fire'* and that

William had not consumed the olanzapine provided to him while in the ED. Having received this information, the RPN made a referral to ACIS for follow-up.

80. The *'LRH Mental Health – Triage Protocol'* does not provide guidance specific to the circumstances which occurred on 6 March 2022 – being one where an individual presents to ED on account of mental ill health, requires a face-to-face triage though voluntarily leaves prior to an assessment occurring. However, the protocol does require the clinician to gain sufficient information about the situation in order to determine the most timely and appropriate response to meet the patient's needs. It also requires for the clinician to obtain the patient's consent to any referral.

81. It is apparent that the RPN did not have sufficient information when they triaged William during this telephone call, nor did he obtain William's consent for the ACIS referral – he instead relied on Sue's belief that William would accept the referral.

82. Of his decision to not speak directly to William, the RPN stated:

> '*It is not uncommon in circumstances like this for a patient to not want to talk to me'*

83. And further that,

> *'I did not consider that I needed to have a direct conversation with [William] or that I had any basis to insist that he talk to me'.*

84. The CPU opined that given that William presented to the ED with psychotic symptoms, and that his poor mental state was made known to the RPN by Sue, it follows that optimal clinical care would have been to speak directly to William at that time.

ACTIONS TAKEN BY LATROBE REGIONAL HEALTH IN THE TIME SINCE WILLIAMS' PASSING

Nicotine Replacement Therapy

85. In a response provided by LRH to the Court in April 2024, it indicated that it has developed a policy regarding Nicotine Replacement Therapy, with the intention to *'reduce or eliminate a patient's need to smoke'*, and consequently reduce their need to leave the hospital premises. LRH acknowledged that Nicotine Replacement Therapy is not *'perfect'* given that '*many patients refuse'* the treatment. It remains that Nicotine Replacement Therapy is an invaluable tool in maintaining supervision of patients receiving or waiting for treatment.

86. The LRH policy, entitled '*Clinical Management of Nicotine Dependency among Patients Guideline',* discusses the recording of a patient's smoking status upon their presentation to the ED, completion of a Fagerstrom test to assess the patient's nicotine dependence and associated Nicotine Replacement Therapy dosage and for the administration of Nicotine Replacement Therapy, including by nursing staff.

87. The policy does not make specific reference to the use of Nicotine Replacement Therapy in an ED setting, nor to the risk of patients leaving the premises in the absence of appropriate Nicotine Replacement Therapy. In their response dated April 2024, LRH indicated it *'plans to expand [Nicotine Replacement Therapy] use within the ED'.*

Patient Absconding

88. A new policy proposed to be implemented by LRH, entitled '*Mental Health – Emergency Department (LRH) Protocol'* continues to require ED staff to contact Victoria Police when an at-risk voluntary patient leaves ED prior to assessment. However, the policy does not establish a clear escalation pathway in such circumstances.

89. The LRH '*Mental Health and Police Response Protocol'* has been updated since William's passing to specify that mental health clinicians can seek assistance from the Mental Health and Police Response team with respect to welfare issues.

90. LRH did not indicate whether they have educated staff on their responsibility to minimise future non-compliance with the protocol. The Report does not make it clear what factors contributed to the ED staff failing to escalate William's departure. It is possible that the paucity of documentation about William's risk at the time of his presentation and triage may have influenced the decision-making process.

THE UTILITY OF NICOTINE REPLACEMENT THERAPY

91. The circumstances of William's passing forms part of a broader pattern of individuals who attend hospital EDs, request to a smoke a cigarette, and having been permitted to leave the hospital to do so, abscond and take their own lives.

92. The issue faced by medical practitioners when patients request to smoke is multi-faceted. First, smoking is widely known to negatively impact health, not limited to bringing about or exacerbating pre-existing mental health conditions including depression and anxiety. Nicotine dependency is a well-documented and recognised addition, including by the Centre for Addiction and Mental Health. Individuals experiencing nicotine withdrawals can experience

a range of symptoms and in the context of an ED presentation due to mental ill health, includes restlessness, anxiety and depression.

93. Second, it is illegal under Victorian legislation to smoke within four metres of a hospital or other health service.[7] Additionally, multiple Victorian hospitals, including LRH, have policies which render their entire premises '*smoke-free'*. The combined effect of these rules is that patients, who experience nicotine dependency and seek to smoke, must depart the hospital premises, and consequently are away from medical supervision in order to do so.

94. It is concerning that patients, who present with mental ill health, awaiting treatment in the ED may face little resistance from staff when they request to leave the building in order to smoke. These lapses in supervision are particularly concerning amongst those who have not yet received a comprehensive mental health assessment and their risk of harming themselves or others remains undetermined.

95. In William's instance, he was a voluntary patient and based on the assessments of the ED staff – whether or not those were entirely appropriate – he was not under direction for close monitoring. These factors likely contributed to the decision to not discuss an alternative, or more a secure, means to fulfil his desire for a cigarette. In addition, according to information provided by William to LRH staff within the hour prior to his request, he had informed them that he was not a cigarette smoker. It follows that had this information been considered by LRH staff, there was a possibility for them to engage in a fruitful discussion as to his mental state and distress at that time.

96. Such circumstances speak to the utility of Nicotine Replacement Therapy, particularly in ED settings. The administration of Nicotine Replacement Therapy to individuals who present to the ED and who experience nicotine dependency, presents a viable alternative to this longstanding issue and may obviate the need for patients to leave hospital premises. Such considerations are not new and have been the subject of pertinent coronial comment and recommendations for some time.

97. In 2020, I handed down my findings into the 2016 death of Ms T. Ms T absconded from hospital having asked to smoke a cigarette prior to a mental health assessment being completed, and subsequently suicided. I recommended for the development of a guideline

[7] *Tobacco Act 1987* (Vic) s 5RH.

specific to the assessment, prevention and management of withdrawal symptoms from nicotine in patients while in an emergency department.[8]

98. In response to my recommendation, the Victoria Network of Smokefree Healthcare Services, in conjunction with representatives from Quit Victoria, the Tobacco Control Unit of the Department of Health and Human Services and from many Victorian health services, created the *'Guidance for managing nicotine dependence & withdrawal in emergency care settings'*.[9] The Guidance acknowledges the risk of nicotine withdrawals in emergency care settings, including patient anxiety and discomfort, behavioural challenges of aggression and violence and the risk of absconding. It continues that the management of nicotine dependence is aided by health services policies and procedures which support timely access to nicotine replacement therapy in emergency care.

99. More recently, Deputy State Coroner Spanos investigated and handed down findings with respect to the 2021 death of David Van Vledder, who died in alarmingly similar circumstances.[10] Deputy State Coroner Spanos recommended that the relevant heath service implement a system of assessing and treating a patient's nicotine dependence.

100. That these deaths have occurred in similar circumstances over almost a decade, and in association with different health services across the State is a worrying indicator that patient absconding related to smoking remains largely unmitigated. I reiterate that LRH's updated policy, '*Clinical Management of Nicotine Dependency among Patients Guideline',* does not specifically address Nicotine Replacement Therapy in ED settings.

CULTURAL SAFETY

101. The Sentinel Event Report conducted after William's passing erroneously stated he was not of Aboriginal or Torres Straight Island descent. This has since been addressed by LRH as being *'due to an oversight'*.

[8] Finding into Death Without Inquest regarding the death of Ms T (COR 2016 0427), Finding published 27 May 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-06/MsT_042716.pdf.

[9] 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.

[10] Finding into Death Without Inquest regarding the death of David Van Vledder (COR 2021 001315), Finding published 24 April 2023, available at COR 2021 001315 Form 38-Finding into Death without Inquest_Signed.pdf (coronerscourt.vic.gov.au).

102. LRH further stated that even if William's status as Aboriginal and Torres Strait Islander was known to the panel during the Root Cause Analysis, it is *'unlikely any recommendations would have been made'*.

103. On the evidence available, it is unclear whether the LRH ED staff were aware that William was Aboriginal and Torres Strait Islander. Prior to his arrival at the ED, William was already registered in the Client Management Interface, a statewide database registering an individual's interactions with mental health services, and which captures information including Aboriginality. According to the RPN, they did not see whether the box on the Client Management Interface regarding William's Aboriginality, had been *'ticked'*.

104. LRH stated that *'[William's] Aboriginality would not have changed the treatment he received in the ED'* and further that *'if he had been admitted…his Aboriginality would have prompted and necessitated he be seen by the Aboriginal Liaison Team within a few hours'*.

105. I have considered the LRH response and note it does not acknowledge that Aboriginal and Torres Strait Islander people suicide at a disproportionate rate in comparison to their non-Indigenous counterparts. In March 2024, the Court released its report entitled *'Suicides of Aboriginal and Torres Strait Islander people in Victoria'* which captured data of suicides among the Indigenous population between the years of 2018 and 2023.[11] The data demonstrates that Indigenous people suicide at a rate of 28.4 suicides per 100,000 people, which is disproportionately elevated when compared to 10.8 suicides per 100,000 for non-Indigenous people. I emphasise that Aboriginal and Torres Strait Islander suicides occurred more frequently in rural areas, than in metropolitan Melbourne.

106. While an appreciation of William's Aboriginality may indeed not have impacted the treatment he received at the LRH ED – relating to an escalation of his deterioration, consideration of the GP letter, or a timely face-to-face assessment - it remains that he belonged to a demographic which experience increased rates of suicides particularly in rural settings, and that a keen understanding of the intersection of these factors may have led to a re-evaluation of his risk.

COMMENTS

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

[11] *'Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018-2023'* Coroners Court of Victoria (7 March 2024). Accessible at: https://www.coronerscourt.vic.gov.au/suicides-aboriginal-and-torres-strait-islander-people-victoria-2018-2023.

1. The circumstances of William Gourley's passing bring into sharp relief a multitude of issues currently affecting the State's health service. Many of these issues were addressed by the 2021 Royal Commission into Victoria's Mental Health System (**RCVMHS**).
2. The RCVMHS acknowledged the serious shortages in the mental health workforce, especially in rural and regional areas, with Recommendation 40 seeking to address the issue by establishing an incentive scheme to attract and retain mental health and wellbeing workers to rural and regional mental health and wellbeing services.[12] Subsequently, the Victorian Government funded the Regional Mental Health Workforce Incentives Program, which commenced in July 2022 to attract, relocate and retain workers to priority positions in state-funded mental health and Alcohol and Other Drug services across rural and regional Victoria.[13] Such programs are likely to be of some assistance to regional services seeking to recruit experienced mental health nurses.

3. However, workforce issues are likely to remain an issue for some time with the National Mental Health Workforce Strategy 2022-2032 predicting a significant rise in the national shortfall of mental health nurses by 2030, with the solution requiring actions by governments, regulators, professional colleges, education providers, peak bodies and the mental health sector more broadly.[14]

4. With respect to emergency departments in particular, the RCVMHS Recommendation 8 'Responding to Mental Health crises' spoke to the need to improve emergency departments' ability to respond to mental health crises by establishing a classification framework for all emergency department, based on their capability to respond to people experiencing mental health crises, using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and, ensuring that there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region.

5. Additionally, Recommendation 35 'Improving outcomes for people living with mental illness and substance use or addiction' stated that by the end of 2022, in addition to Recommendation

[12] *Royal Commission into Victoria's Mental Health System* (February 2021), Final Report, Summary and recommendations, Parl Paper No.202, Session 2018-21 (document 1 of 6). Recommendation 57 of the RCVMHS also included actions pertaining to workforce planning and structural reform aimed at developing a mental health and wellbeing workforce of appropriate size and composition across Victoria, but were not specific to regional and rural Victoria.

[13] Regional Mental Health Workforce Incentives, accessible at: https://www.rwav.com.au/regional-mental-health-workforce-incentives/.

[14] Department of Health and Aged Care (2002). National Mental Health Workforce Strategy 2022-23. https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf

8, ensure that all mental health and wellbeing services, across all age-based systems, including crises services, community-based services and bed-based services provide integrated treatment, care and support to people living with mental illness and substance use or addition, and do not exclude consumers living with substance use or addiction from accessing treatment, care and support.

6. In July 2022, the Victorian Government released the 'Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services'.[15] The Guidance however, does not discuss nicotine addiction nor the utility of Nicotine Replacement Therapy in the context of treatment for mental ill health in emergency settings.

RECOMMENDATIONS

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

1. In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that **Latrobe Regional Health**, in consultation with the Victorian Network of Smokefree Health Services Guidance for Managing Nicotine Dependence & Withdrawal in Emergency Care Setting, implement a procedure specific to its emergency department regarding a patient's smoking status, and where clinically indicated, administer an assessment of nicotine dependence and provide appropriate Nicotine Replacement Therapy.

2. In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that **Latrobe Regional Health** consider adopting William Thomas Gourley's matter as a case study to highlight the importance of a comprehensive triage and of staff responsibilities when identifying and escalating a patient's deterioration, and in circumstances of a patient's departure from the emergency department.

3. In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that the **Secretary of the Victorian Department of Health**, consider and develop models for educating Victorian healthcare services on the need and utility of Nicotine Replacement Therapy in the context of patient safety and minimising the risk of

[15] Recommendation 35 Improving outcomes for people living with mental illness and substance use or addition, *Victorian Department of Health* (Web Page) Accessible at: https://www.health.vic.gov.au/mental-health-reform/recommendation-35.

absconding, and with the view to implement a consistent approach across all Victorian public hospitals.

FINDINGS AND CONCLUSION

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

   a. the identity of the deceased was William Thomas Gourley, born 10 October 1982;

   b. the death occurred on 7 March 2022 at 28 King Street, Moe, Victoria, 3825;

   c. I accept and adopt the medical cause of death as ascribed by Dr Fronzcek and I find that William Thomas Gourley died due to the effects of fire in circumstances where he intended to take his own life.

2. AND I find that the treatment that William Thomas Gourley received while at the emergency department of Latrobe Regional Hospital, on 6 March 2022, was suboptimal. I find that there was an unfortunate chain of events set in motion upon his arrival, when he received a cursory review at triage such that key information regarding his acute mental ill health and level of risk was not properly considered.

3. AND having commented on Latrobe Regional Health's non-compliance with its own policy on patient absconding, I find that, upon learning of William Thomas Gourley's departure from the emergency department, Latrobe Regional Health staff's actions fell short of those expected from them.

4. AND FURTHER, I am unable to definitively find that William Thomas Gourley's passing could have been prevented having regard to the preceding chain of events. I consider that William Thomas Gourley had a history of suicidal ideation and had evinced an intention to set his house on fire in the days prior to his passing. I nonetheless find that the actions taken by Latrobe Regional Hospital represented several missed opportunities to reevaluate William Thomas Gourley's risk and provide him with appropriately prompt medical treatment.

I convey my sincere condolences to William'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:

Frank Spitzbart, Senior Next of Kin

Suzanne Gorley, Senior Next of Kin

Latrobe Regional Health

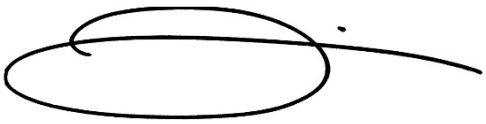
Victorian Network of Smokefree Health Services

The Secretary of the Department of Health

The Chief Psychiatrist

Senior Sergeant Kaine Pawson, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 10 January 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 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.