IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006144

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Lillian Rose Thomas
Date of birth:	17 May 2000
Date of death:	17 November 2021
Cause of death:	1a: Compression of the neck 1b: Hanging
Place of death:	14 Pettifer Street, Kyabram, Victoria, 3620
Keywords:	Suicide; hanging; ESTA; Ambulance Victoria; Refcomm triage service; impact of COVID-19 pandemic; ambulance delay; ambulance resources.

INTRODUCTION

1. On 17 November 2021, Lillian Rose Thomas (**Lily**) was 21 years old when she died at her home. At the time of her death, Lily lived in Kyabram, Victoria.

2. Lily grew up in the Kyabram area with two older siblings. While Lily was completing her senior schooling, she started working as a make-up artist and later took on other part-time jobs in cleaning and restaurants. Lily and her partner, Ellie, got engaged in 2019 and purchased 14 Pettifer Street, Kyabram, their first home, together at the start of 2020.

3. Lily had a complex medical and mental health history that included diagnoses of complex post-traumatic stress disorder (CPTSD), anxiety, depression, fibromyalgia, obsessive compulsive disorder (OCD), mixed avoidant and borderline personality disorder, and traits of separation anxiety disorder. Lily disclosed to her partner and in journal entries that she had been sexually abused as a young child and sexually assaulted by someone known to her as a young adult, in 2018. In the months leading up to her passing, she sought help from a variety of mental health clinicians, both as an inpatient and in the community, and struggled with anxiety, chronic pain, and frequent thoughts of suicide and self-harm. Lily was chronically suicidal.

THE CORONIAL INVESTIGATION

4. Lillian'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Lillian's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Lillian Rose Thomas 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. I

9. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336.

10. 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.

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

Circumstances in which the death occurred

Background

11. Lily's family recalled that her mental health worsened during the COVID-19 pandemic. According to her partner, Ellie, this was due to both social isolation and financial pressures caused by her limited ability to work. In February 2021, Lily attempted suicide by taking an overdose of paracetamol, her partner's tablets (of unknown type), and other tablets. She disclosed her actions to her partner, who called Lily's mother. Lily's mother came to the house

[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.

and assisted Lily to make herself vomit. She did not go to hospital or seek medical treatment immediately after this incident.

12. On 9 March 2021, Lily attended her regular GP, Dr Caroline Shipley, to report the incident and her increasing anxiety. Dr Shipley prescribed amitriptyline[2] and referred her to consultant psychiatrist Dr Vijay Raj. In a subsequent appointment, Dr Shipley discussed safety planning with Lily, including measures such as calling the Crisis Assessment and Treatment Team (**CATT**) or presenting to an urgent care centre. Ellie agreed to "keep an eye on" Lily's mood and seek help if required.

13. On 26 March 2021, Lily reported to Dr Shipley that every psychiatrist she had tried to consult with was booked out. Dr Shipley suggested a psychologist referral in the meantime and increased her amitriptyline dose. In progress notes, Dr Shipley wrote, "I advised I am quite concerned about Lily and Ellie needs to either ring MH triage or bring her to UCC if Lily has another suicidal episode".

14. On 28 April 2021, Lily consulted with Dr Shipley and advised that Ellie had called the mental health triage phone number several times due to Lily's increasingly erratic and angry behaviour. Lily's medication was switched from amitriptyline to duloxetine, and she was prescribed pregabalin for her fibromyalgia-related pain. In this period, Lily was also using cannabis for pain relief.

15. On 19 May 2021, Lily consulted with Dr Shipley again and reported difficulty sleeping and ongoing neuropathic pain. Her pregabalin and duloxetine doses were increased, and she was given melatonin for her sleep difficulties. She did not attend her GP again for two months.

16. Lily consulted with consultant psychiatrist Dr Vijay Raj for the first time in June 2021. She reported to Dr Raj that she had been experiencing a range of compulsive repetitive actions and frequent nightmares with associated sleep difficulties. She also reported a history of self-harming behaviours, and ongoing, daily thoughts of suicide and self-harm in response to emotional stress. She described her mood as unstable, often feeling worried, anxious or upset, and said she sometimes struggled with anger which could trigger fits of rage and breaking things. Dr Raj recommended that Lily continue the duloxetine and melatonin, and that she be

[2] A tricyclic antidepressant used to treat symptoms of depression, and can also be used for chronic pain management, migraine prophylaxis, diabetic neuropathy and post-traumatic stress disorder.

referred for trauma-focused psychological counselling and therapy, which he regarded as the "mainstay of treatment".

17. Lily consulted with Dr Shipley again on 28 July 2021, mainly in relation to her neuropathic pain. Her pregabalin dose was increased and her duloxetine dose was reduced for reasons not documented. A psychologist referral was discussed but did not occur at this time.

18. Lily returned to Dr Shipley on 19 August 2021 for non-mental health matters (skin lesions).

19. On 1 September 2021, Ellie moved out of the Pettifer Street address and went to stay with her sister, as she was struggling with her own issues. Ellie stated that her relationship with Lily continued, with the couple staying in touch and often visiting each other. She was aware that Lily's cannabis use increased after she moved out of the home.

20. On 2 September, Lily sent a message to Angela Heale, stating that she and Ellie had broken up and she wanted to call in the next few days. Ms Heale is a secondary school teacher and had come to know Lily as her year level coordinator from year 7 through to year 12. Ms Heale and Lily later reconnected via Facebook and Lily had shared details of her mental health struggles and plans for treatment.

21. On the morning of 3 September, Ms Heale called Lily and offered to visit, but Lily declined, stating she would be fine on her own. Ms Heale nevertheless went to Lily's home and stayed for approximately an hour. She recalled that Lily appeared drug-affected, and Lily said she had been smoking marijuana. Lily also reported that she had been experiencing blackouts and would get physically and verbally aggressive towards Ellie, and that this was the reason that Ellie had moved out. Ms Heale continued to offer support, encouragement and assistance to Lily in the weeks that followed, and it is clear that Lily trusted Ms Heale, regularly updating her on her plans and progress with her mental health.

22. On 6 September 2021, Lily consulted with Dr Shipley again and reported that she and Ellie had broken up a few days prior. She requested an increase in her duloxetine and reported "very low mood" and that she could not "control her mood". An urgent referral was prepared to psychologist Suzie Crawford, and Lily was given phone numbers for emergency psychological support services.

23. On 17 September 2021, Lily attended an intake appointment with Ms Crawford at her Kyabram rooms.

24. The next appointment with Dr Shipley occurred on 27 September 2021. Lily reported hitting herself in the face and giving herself a black eye. She reported having experienced suicidal thoughts and presenting to an urgent care centre.

25. From 3 October 2021 to 20 October 2021, Lily was admitted to the Youth Prevention and Recovery Care (**YPARC**) facility in Bendigo. During this admission she was reviewed by a consultant psychiatrist on five occasions and was otherwise reviewed daily by the YPARC team. Lily also ceased her antidepressant (duloxetine), which she believed to be ineffective, and commenced sertraline. To assist with her traumatic nightmares, she was prescribed prazosin. Pregabalin was recommenced due to her reports of increased pain when she stopped taking it. In relation to cannabis withdrawal, Lily was monitored using a withdrawal chart and her withdrawal symptoms and cravings were managed using diazepam that was planned to be ceased by discharge. Discharge planning included engagement with her community mental health clinician, attempts to bring forward her appointment with her psychologist, plans for ongoing contact with her general practitioner, and referral to Spectrum, the state-wide service specialising in personality disorders and complex trauma. Lily declined referral for drug and alcohol counselling. Plans were made for Lily to have a friend stay with her so she would not be alone, and her medication supply was restricted to weekly pick-ups.

26. On 7 October 2021, while still at YPARC, Lily attended a telehealth appointment with Ms Crawford but was groggy due to prescribed medications and detoxing from cannabis use.

27. Following Lily's discharge from YPARC on 20 October 2021, a detailed discharge summary of admission was provided to Dr Shipley.

28. On 8 November 2021, Lily self-presented to the Kyabram Urgent Care Centre (**UCC**) with self-inflicted burns. She reported that she had heated up a pair of scissors and applied them to her neck, face, and thighs. She was reviewed by ECATT in the UCC emergency department and was assessed as being safe to be discharged home. Three days later, on 11 November 2021, Lily attended her GP clinic to have her burns cleaned and the dressings changed. Due to the severity of the burns, the clinic referred Lily back to the Kyabram and District Hospital for ongoing treatment of her burns, and Lily indicated she would be engaging with her psychologist.

29. On 15 November 2021, Lily attended her third and final appointment with Ms Crawford. This appointment was again via telehealth, as Lily felt embarrassed about her still-visible injuries.

When specifically asked if she had further intentions of self-harm or suicide, Lily denied that she did and expressed remorse and embarrassment at having hurt herself and causing a "fuss". She told Ms Crawford that she had plans to buy a van and travel up the east coast of Australia with her dogs.

Events of 17 November 2021

30. At 3:52 am on 17 November 2021, Lily sent a text message to the Lifeline Crisis Support line. She was connected with 'Michelle' and wrote "I'm just struggling with my emotions at the moment. I'm not sure what to say". Lily went on to state that she was unsure whether she would go through with her plans (for suicide) and that she "can't even afford to be alive anymore". She also reported that she was supposed to be getting married that Friday, 19 November 2021.

31. At 5:09 am, Lily wrote to Michelle: "I have taken tablets and I just want my ma to know I really tried hard not to disssaooint [sic] her". She then listed the types and quantities of medications that she had taken. Lily then started to disengage from Michelle, who tried to keep her engaged. Lily stopped responding at around 5:24 am, but Michelle continued to send her messages. When contact could not be re-established, Lifeline contacted 000 regarding concerns about Lily's welfare, which were referred to ESTA police call-taking staff for triage and dispatch of a police unit.

32. At 5:25 am, Lily called Ms Heale. She reported she was unable to get through to speak with someone at Lifeline, that she needed help and that she had taken pills. Ms Heale advised she would call 000 for an ambulance and told Lily to unlock her front door for paramedics.

33. At 5:31 am, Ms Heale phoned 000 and requested an ambulance for Lily at 14 Pettifer Street, Kyabram. She reported that Lily had taken an intentional overdose and was slurring her words. The event was classified as a Priority 3 event and was referred to Ambulance Victoria's Secondary Triage service. Ms Heale provided Lily's phone number, so that the ESTA ambulance call-taker and Secondary Triage practitioner could contact her directly.

34. Both the ESTA ambulance call-taker and Ambulance Victoria Secondary Triage practitioners called Lily on her mobile phone, but there was no answer. Whilst these attempts to contact Lily were being made, no ambulance was dispatched. When attempts were made to dispatch an ambulance, no ambulance resources were available. The attempts to dispatch were then

escalated at 5:52am, eventually resulting in a request for a police welfare check as there were still no ambulance units available to attend Lily's address.

35. As a result of the notification by Lifeline to 000, at about 6:13 am, Victoria Police member Acting Sergeant (**A/Sgt**) Corey Wild received a call from the ESTA Police Communications requesting a welfare check on Lily, with an address of 86 Purdey Street, Tongala (Lily's mother's address). A/Sgt Wild and his offsider, First Constable (**FC**) Robert Morland, arrived at the Purdey Street address at about 6:30 am. They spoke with Lily's mother, Rayleen Thomas, who advised them that Lily lived in Kyabram and provided the correct address.

36. A/Sgt Wild and FC Morland arrived at Lily's Pettifer Street address at 6:49 am. They found the house unlocked, so they walked inside where they located Lily in the bedroom, unresponsive, hanging with a rope around her neck. Police called for urgent ambulance assistance and commenced cardiopulmonary resuscitation (**CPR**).

37. Police ceased CPR at 6:59 am as Lily was cold to the touch. Ambulance Victoria (**AV**) paramedics arrived at 7:05 am and formally pronounced Lily deceased.

Identity of the deceased

38. On 17 November 2021, Lillian Rose Thomas, born 17 May 2000, was visually identified by her stepfather, Warren Read.

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

Medical cause of death

40. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 22 November 2021 and provided a written report of his findings dated 6 December 2021.

41. The post-mortem examination revealed a complex abraded injury and furrow to the neck, consistent with hanging. There were no other injuries to indicate any other persons were involved in the death.

42. Dr Burke found no evidence of any significant disease process.

43. The post-mortem CT scan was unremarkable, showing no skull or facial fractures, and no evident scalp bruising.

44. Toxicological analysis of post-mortem blood samples identified the presence of the following drugs:

    a) Prazosin[3] (~0.1 mg/L);

    b) Sertraline[4] (~0.03 mg/L);

    c) Temazepam[5] (~0.05 mg/L);

    d) Pregabalin[6] (~2.3 mg/L); and

    e) Delta-9-tetrahydrocannabinol (THC)[7] (~67 ng/mL).

45. No alcohol or other common drugs or poisons were detected.

46. Dr Burke provided an opinion that the medical cause of death was *'1(a) compression of the neck'*, secondary to *'1(b) hanging'*.

47. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS

48. On review of the coronial brief of evidence, a number of questions arose regarding:

    a) the triage of Ms Heale's call as a Priority 3 event, particularly in circumstances where Lily did not respond to any of the numerous attempts of the ambulance call-taker or the Secondary Triage service to make phone contact with her; and

    b) the circumstances of the welfare check performed by Victoria Police members.

49. To better understand these matters, further information was obtained from the Emergency Services Telecommunications Authority (**ESTA**) (subsequently re-named as Triple Zero

[3] A medication used to treat high blood pressure and nightmares related to post-traumatic stress disorder.
[4] An SSRI antidepressant used for the treatment of major depression, obsessive-compulsive disorder, panic disorder, social phobia, and premenstrual dysphoric syndrome.
[5] Temazepam is a benzodiazepine used for its sedative and anxiety-relieving effects. It is habit-forming and used in the short-term treatment of insomnia.
[6] An anticonvulsant drug used for neuropathic pain.
[7] The active form of cannabis (marijuana).

Victoria)[8] and Ambulance Victoria (**AV**) regarding the management of Ms Heale's 000 call and the emergency services dispatches on 17 November 2021.

Emergency services triage and dispatch

50. In a statement provided on behalf of ESTA, Mr Thomas Dunbar, Acting Manager of the ESTA Quality & Assurance Team, 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 Lily's case.

51. Mr Dunbar 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 a structured call-taking process, which includes scripted "key questions" that are designed to obtain relevant information from the caller. 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 as at 17 November 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

[8] ESTA was re-named as Triple Zero Victoria after Ms Thomas' 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.

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. 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. Through this process of allocating ambulance resources according to patient needs, in 2024, 453 people per day who did not need an emergency ambulance were instead connected to more appropriate care.

Dispatch of emergency services on 17 November 2021

55. The statements and materials provided on behalf of ESTA and AV established that emergency services were requested, triaged and dispatched in Lily's case along two distinct pathways. The first request in time was initiated by Ms Heale, who first called 000 at 5:31 am. The second request was initiated by Lifeline, who contacted 000 at approximately 5:45 am with concerns for the welfare of a person who had been texting the crisis support line. For clarity, I have examined these two triage pathways separately, though in practice they occurred largely in parallel, and later converged as information was cross-referenced and indicated that the two originating requests for emergency assistance related to the same person.

Ms Heale's request for ambulance assistance

56. Ms Heale first called 000 at 5:31 am to request ambulance assistance for Lily at 14 Pettifer Street, Kyabram. Ms Heale reported that six minutes earlier she had received a phone call from Lily, who had taken an overdose and was slurring her words. The ESTA ambulance call-

taker (**ACT**) obtained information from Ms Heale, 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 as she had been responding appropriately to Ms Heale;

e) The patient was breathing normally; and

f) The patient had taken an unknown substance less than 30 minutes prior to Ms Heale's 000 call.

57. ESTA Event number J21111770137 was created for the address 14 Pettifer Street, Kyabram. The call was assigned an event type "23C7I Overdose/Poisoning, unk or no other code applicable (intentional)", which initiates a Priority 3 response. Priority 3 responses have a target response timeframe of within 60 minutes and are considered suitable for transfer to AV's Secondary Triage service. Because Ms Heale was a third party and not physically present with Lily, the ACT obtained Lily's mobile number so that the ACT could call her for more details. The ACT then attempted to call Lily three times, but she did not answer. The first call was attempted at 5:33:56 am and the third at 5:36:19 am, at which time the ACT left a voicemail message asking Lily to call the ambulance service back on 000.

58. At 5:34 am, an ESTA ambulance dispatcher "held" the event for 30 minutes as required by the relevant ambulance protocols. This means that an ambulance is not immediately dispatched, to allow Secondary Triage up to 30 minutes to obtain further information and further assess the event.

59. At 5:48 am, Ms Heale called 000 for a second time to enquire whether an ambulance had been sent to Lily's address. She advised the ACT she had not been able to reach Lily in the time since her first 000 call. The ACT connected Ms Heale to an AV Duty Manager, who advised Ms Heale that a Secondary Triage practitioner was at that moment speaking on the phone with Lily, and that an ambulance had not yet attended at Lily's address. Ms Heale said she was

considering whether to drive to Lily's address herself, noting that she was more than 30 minutes away, in Shepparton. The Duty Manager said he could not advise Ms Heale on this point but reiterated that the conversation between Lily and the Secondary Triage practitioner was still in progress, and that the outcome of that conversation would determine what action would be taken. This was in fact not the case, as no ESTA call-takers or Secondary Triage practitioners were able to make phone contact with Lily at any time on this evening. ESTA records show that at 5:50 am, a Secondary Triage practitioner 'dispatched' themselves to the event, meaning that the practitioner selected the event from a list of held events. This practitioner did not attempt to contact Lily at this time. It is possible that the AV Duty Manager who spoke with Ms Heale interpreted this "dispatch" as indicating that the Secondary Triage practitioner was at that time speaking with Lily. The Duty Manager suggested Ms Heale could call back in approximately 15 minutes for a further update.

60. At 5:53 am, an AV Duty Manager held the event for a further 30 minutes.

61. At 6:02 am, a different Secondary Triage practitioner "dispatched" themselves to the event and attempted to call Lily, but there was no answer. An SMS message was sent to Lily's mobile phone.

62. At 6:14 am, an Ambulance Dispatcher attempted to dispatch an ambulance to 14 Pettifer Street, but there were no nearby units available. The event was then immediately referred to the AV Duty Manager for a dispatch solution. At 6:15 am, the Ambulance Dispatcher again attempted to dispatch an ambulance to the Pettifer Street address, and again there were no nearby units available.

63. At 6:16 am, the AV Duty Manager held the event for a further 30 minutes and, at 6:18 am, requested that assistance be sought from Victoria Police to conduct a welfare check, creating ESTA event number P2111126573, for a "598 – P EME-THR Police Assist Ambulance' event, with a default Priority 2 response by police.

64. At 6:19 am, the Ambulance Dispatcher notified Victoria Police of the event via the Computer-Aided Dispatch (**CAD**) system, and at 6:24 am, a Police Communications Liaison Officer (**PCLO**) took initial ownership of the event. At 6:28 am, the PCLO transferred the event to the appropriate police dispatch group for an ESTA police dispatcher (**PD**) to manage and refer to a police sergeant in the field. At 6:36 am, the PD dispatched Victoria Police unit WKA306 to 14 Pettifer Street, constituted by A/Sgt Wild and FC Morland.

65. At this time, A/Sgt Wild and FC Morland were already enroute to 14 Pettifer Street, Kyabram in response to an earlier request for police attendance under ESTA event P2111126561. The origins of this earlier request for police assistance are discussed further below. At 6:43 am, information from both requests was cross referenced and the events were identified as relating to the same person.

66. At 6:49 am, A/Sgt Wild and FC Morland arrived at 14 Pettifer Street, Kyabram. At 6:52 am, a PD created an event (E21111710256) "AMB~ASST-U-A Ambulance Assist – Urgent", based on information provided by A/Sgt Wild that they had found Lily unconscious and not breathing, with a rope around her neck. An "Ambulance Assist – Urgent" event is by default a Priority 0 event.

67. At 6:52:17 am, AV dispatched its first ambulance unit, which was 28.7 km away from Lily's address. Between 6:52 and 7:01 am, a total of eight ambulance units were dispatched to 14 Pettifer Street, ranging from 28.7 km to 178.9 km away. At 6:59 am, the AV CAD system recorded that police had ceased performing CPR and that the patient was cold to the touch.

68. At 7:04 am, Ms Heale called 000 for a third time to request update and was put through to an ESTA ACT, who transferred the call to his Duty Manager. The AV Duty Manager advised Ms Heale that she was unable to provide detailed information but confirmed that Lily had not been transported to a hospital.

69. An ambulance arrived at Lily's address at 7:05 am and Lily was formally pronounced deceased.

Lifeline request for police and ambulance assistance

70. At approximately 5:45 am on 17 November 2021, Lifeline contacted emergency services to report welfare concerns for a person (now known to be Lily) who had been texting the crisis support service.

71. At 6:11 am, after conducting various LEAP checks and traces, a Victoria Police Shift Manager (**PSM**) handed the job over to an ESTA police call-taker (**PCT**), and provided the following information:

a) Lifeline had reported concerns regarding a 21-year-old female who had taken some medications, stated to be "16ml Prazsic, 600ml Lyrica, 40ml Tamazapan, 400ml Seroline" [sic];

b) the patient started taking the medications at 4:30-5:15 am;

c) the patient was also smoking marijuana; and

d) the address for attendance was 86 Purdey Street, Tongala and Lily's mobile number was provided.

72. The Purdey Street address was in fact Lily's mother's address and appears to have been obtained in the course of LEAP or other searches, as the address to which Lily's mobile phone number was registered.

73. ESTA Event number P2111126562 was created for the address 86 Purdey Street, Tongala. The call was assigned an event type "597 – P Eme-Thr attempt or threat suicide", which initiates a Priority 1 police response.

74. At 6:13 am, Kyabram police unit WKA306, constituted by A/Sgt Wild and FC Morland, was dispatched to conduct a welfare check at the Purdey Street address, within the police Priority 1 benchmark of 2 minutes and 40 seconds.

75. At 6:14 am, the PCT additionally handed the case details over to an ESTA ambulance call-taker (**ACT**) and ESTA event number J21111770153 was created for the Purdey Street address requesting ambulance response. The event was coded as "23C7I – A Overdose/Poisoning, unk or no other code applicable (intentional)", which initiates an ambulance Priority 3 response and is deemed suitable for Secondary Triage. At 6:15 am, an ambulance dispatcher "held" the event for 30 minutes as required by the relevant ambulance protocols.

76. At 6:16 am, the ACT called Lily's mobile number three times in an attempt to obtain more information, but the calls were not answered and a voicemail message was left asking Lily to call the ambulance service back at 000.

77. At approximately 6:24 am, an AV Secondary Triage practitioner called the mobile number three further times without an answer. Voicemail messages were left and an SMS message sent. At 6:26 am, the event was held for a further 30 minutes.

78. At 6:29 am, A/Sgt Wild and FC Morland arrived at 86 Purdey Street, Tongala and spoke with Lily's mother, Rayleen Thomas, who advised them of Lily's correct home address and explained that Lily had recently been treated in hospital following an incident of self-harm. A/Sgt Wild advised Rayleen that they would attend the Pettifer Street address and check on Lily.

79. At 6:43 am, the police welfare check initiated by Lifeline (ESTA event number P2111126561) was cross-referenced to the police welfare check initiated by escalation of Ms Heale's 000 call (ESTA event number P2111126573) and identified as relating to the same person.

80. At 6:49 am, A/Sgt Wild and FC Morland arrived at 14 Pettifer Street, Kyabram. A/Sgt Wild contacted ESTA via police radio and requested urgent ambulance assistance. As noted above, this prompted a Priority 0 response and multiple ambulances were dispatched from 6:52 am, with the first ambulance unit arriving at the Pettifer Street address at 7:05 am.

Emergency services response

81. Between Ms Heale's first 000 call at 5:30 am and the attendance of police at Lily's address for a welfare check at 6:49 am, a total of 1 hour and 19 minutes had elapsed. An ambulance did not arrive at Lily's address until 7:05 am, a total of 1 hour and 35 minutes after Ms Heale's initial 000 call, and the only reason an ambulance was dispatched at that time was due to the attending police members finding Lily non-responsive. There was no dispatch of an ambulance to the Priority 3 event created from Ms Heale's call, and the target response timeframe of within 60 minutes was not met in Lily's case. Whilst according to AV procedures, Lily's event was suitable for transfer to AV's Secondary Triage service, that service did not make any contact with Lily within that time.

82. Although the target response time for Priority 3 ambulance attendance was not met, the relevant ESTA and AV procedures were followed, and the inability to contact Lily or dispatch an ambulance to her resulted in escalation of the event to a Victoria Police welfare check when it became apparent that there were no available ambulance resources in the area.

83. The inability of Ambulance Victoria to locate an available resource speaks to the ongoing pressures on ambulance resources in Victoria. However, in Lily's specific case, I am not satisfied to the requisite standard that earlier ambulance attendance within the Priority 3 target benchmark of 60 minutes would have prevented her death. Similarly, I cannot be satisfied that earlier police attendance for a welfare check[9] would have prevented Lily's death. The mechanism of Lily's death is hanging, and her death likely would have occurred within minutes of utilisation of the ligature. Having regard to all the available evidence, I am unable to determine when Lily took this action in relation to her calls to Lifeline and Ms Heale. It remains equally possible that she utilised the ligature immediately following the call with Ms Heale, leaving no time for intervention from emergency services, or that it was later in time, and earlier attendance by emergency services may have avoided the outcome in this case. However, I note that Lily did not respond to numerous calls following her conversation with Ms Heale and that she could not be resuscitated by attending police or paramedics. Whilst this lends some support for the proposition that the hanging did not occur just prior to police attendance, I am ultimately unable to determine when the hanging occurred.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lillian Rose Thomas, born 17 May 2000;

    b) the death occurred on 17 November 2021 at 14 Pettifer Street, Kyabram, Victoria, 3620, from 1(a) compression of the neck, secondary to 1(b) hanging; and

    c) the death occurred in the circumstances described above.

85. Having considered all the circumstances, I am satisfied that Lily intentionally took her own life.

86. Whilst Lily was actively seeking assistance for her mental health and was engaging well with practitioners prior to her death, her mental health had clearly been unstable for a substantial period of time, and this instability included inpatient admissions, self-harm and suicide attempts. She was chronically suicidal. However, she was reportedly future-focused in the

[9] Potentially by way of earlier request for a police welfare check by ESTA Ambulance services, or earlier identification of the wrong address being sourced in relation to the notification from Lifeline (although I am not aware of how it could have been identified that the address found in available records was not current).

days before her death, and she specifically denied thoughts of self-harm or suicidality during her last mental health consultation. Whilst she did not leave any specific explanation for her decision, her death occurred in the context of an immediate emotional crisis, with long-standing mental health issues and personal stressors, including relationship difficulties.

87. Based on the information Lily provided to Lifeline and Ms Heale, it appeared that her need for emergency assistance related to a potential deliberate overdose of medication. As outlined above, it is not known at what time Lily instead used a ligature to end her own life. The ambulance response to her stated emergency (the potential deliberate overdose of medication) did not occur within the target response time, and this was primarily due to there being no available ambulance resources. However, having regard to the lethality of the means used, namely hanging, and the uncertainty about what time this occurred, it cannot be known if earlier attendance by emergency services would have altered the outcome in this case.

COMMENTS

88. The inability to dispatch an ambulance in this case, and the apparent ongoing resourcing pressures upon Ambulance Victoria, are a matter of concern relating to public health and safety. I note the ongoing Inquiry into Ambulance Victoria being undertaken by the Legislative Council Legal and Social Issues Committee. The issue of ambulance resourcing, and inability to meet target response times in this case, appear relevant to the issues being examined by the Committee. I have decided to distribute this finding to the Committee to highlight the very real potential human consequences of ambulance resourcing issues in Victoria, as it may assist in informing the work of the Committee on this important issue.

I convey my sincere condolences to Lily'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:

Rayleen Thomas & Warren Read, family of the deceased

Ambulance Victoria

Triple Zero Victoria (C/- Lander & Rogers)

The Inquiry into Ambulance Victoria by the Legislative Council Legal and Social Issues Committee

Sergeant Corey Wild, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 13 August 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.